Frequently Asked Questions (FAQ)

ICF-IID Authorization

Why do some beneficiaries have an authorization period of a full year while others have only six months?

The full date span displayed is how Telligen tracks units and dates in the system. ICF-IID reviews are approved every six (6) months, and Continued Stay Reviews build off the original request. Providers should focus on the **End Date** of the authorization to ensure they submit a Continued Stay request before the authorization expires.

What are the timelines for entering Continued Stay Reviews?

Continued Stay Reviews are due **every six months**. Providers can submit up to 60 days before the due date, **if** the provider has the required 6 months of documentation required

When should an Initial/Concurrent Review be submitted for a newly admitted beneficiary?

The Concurrent Review is due six months after the admission date of the beneficiary.

How are the dates of service determined for ICF/IID reviews?

The start date should reflect the beginning of the six-month period being reviewed. In the comments section, providers can enter the beneficiary's actual admission date to ensure accurate tracking.

Is beneficiary coverage a determining factor for ICF-IID reviews?

No, the beneficiary's coverage does not impact approval or denial. The system defaults to the first active policy available, but providers should verify the correct Member ID via the MESA system. A review is required every six months, regardless of insurance status.

What procedure code should be used when submitting a Concurrent or Continued Stay Review?

The default procedure code is 99233 (monitoring and evaluation code). Providers do not need to add, change, or delete this code.

Is the InterQual process required for every review?

Yes, the InterQual process must be completed with each review. If there are no clinical guidelines applicable, providers should enter a justification in the text box provided.

Are all ICF-IID reviews considered retrospective?

No. The first review for a beneficiary is a Concurrent Review. Every review after that is a Continued Stay Review and must be submitted prospectively.

How many months of progress notes need to be submitted?

Each review requires six months of progress notes to support the request.

How long after admission should providers submit a review for a continued length of stay?

A Concurrent Review is due six months after admission, and each Continued Stay Review is due every six months thereafter. Providers can submit up to 60 days before the due date and provide the full 6 months of documentation required.

What documentation is required for ICF-IID reviews?

- Providers must submit the following:
  - Most recent History & Physical
  - Last six months of progress notes
  - Physician orders and medication lists
  - Individual Support Plans
  - Evaluations and assessments completed during the review period
  - Evidence of metabolic monitoring (for those on atypical antipsychotics)

How will providers be notified when a review is due?

Telligen will send notifications 30 days before the beneficiary's recertification end date. Weekly reminders will also be sent every 7 days until the certification end date. Providers should ensure their contact information is up to date in the system.

How long are approvals valid?

Approval remains valid for the date range specified in the request.

How can providers verify a beneficiary's eligibility?

Providers can verify eligibility through the MESA Provider Portal by logging in, selecting the 'Eligibility' tab, and searching by Member ID, Social Security Number, Date of Birth, or Full Name. Ensure that coverage is Fee-for-Service for the requested Date of Service.

What is the timeframe for responding to a Request for Information (RFI)?

Providers have 10 business days to respond to an RFI. Failure to respond within this timeframe may result in denial.

What are the appeal options and timeframes?

- Reconsideration (1st Level Appeal): Must be submitted within 30 calendar days from the outcome letter.
- Peer-to-Peer (P2P) Review: Providers can request a discussion with a Telligen physician.
- Administrative Appeal: If dissatisfied with the outcome, an appeal can be submitted to the Mississippi Division of Medicaid.

What should providers do if a prior authorization request is denied?

- Review the denial reason in the portal and determine if additional documentation is needed.
- If the denial was due to missing information, submit a 'Request for Information (RFI)' response within 10 business days.
- If necessary, file a 'Reconsideration Appeal' within 30 calendar days.

Can providers update the service dates for an approved request?
Yes, a 'Change Request Form' can be submitted for date modifications, quantity adjustments, or corrections to provider information.

What happens if an authorization request is submitted incorrectly?
Providers should not submit a new review. Instead, they should follow the 'Request for Information (RFI)' process to update missing details.

How can providers contact Telligen for additional support?
- Email: msmedicaidum@telligen.com
- Call Center: 855-625-7709
- Fax: 800-524-5710

What happens if eligibility changes after submitting a request?
Providers should verify eligibility using the MESA Provider Portal before submitting a request. Coverage can change daily, so it is important to confirm that the beneficiary has Fee-for-Service coverage at the time of request submission.

How should providers ensure they are selecting the correct provider in the system?
When searching for a treating physician or facility, providers should use the most current Medicaid Provider ID instead of the NPI number to avoid incorrect selections. Gainwell reissued new provider ID numbers, so it is important to verify provider details before submitting a request.

What happens if the uploaded documentation is not legible?
All documentation must be legible and unaltered. Documents that have been faxed multiple times may become distorted. If the submitted documents are not readable, a Request for Information (RFI) will be issued, requiring the provider to resubmit clear documentation.

What are the requirements for submitting documentation in the InterQual process?
InterQual is integrated into Qualitrac, and all required documentation, including diagnosis and procedure codes, must be entered accurately. If there are no applicable clinical guidelines, providers should check the 'No Guidelines Applicable' box and provide a detailed explanation in the comment section.

What should providers do if they receive a Request for Information (RFI)?
Providers should not start a new review. Instead, they should log into Qualitrac, locate the case, and attach the additional requested documentation under the existing request. Responses to RFIs must be submitted within 10 business days to avoid denial of the request.

How should providers submit a reconsideration appeal?
A reconsideration appeal can be submitted through the Qualitrac platform within 30 calendar days of the outcome letter. Providers should include additional supporting documentation that was not part of the original submission.

How can providers request a Peer-to-Peer (P2P) review?

A P2P review can be requested through the Provider Help Desk via email or phone. Providers must provide the case ID number, the requesting physician's name, available time slots, and contact information for scheduling.

What is the process for submitting an administrative appeal?

If reconsideration and P2P reviews do not resolve the issue, providers may submit an administrative appeal in writing to the Mississippi Division of Medicaid at:

Office of Appeals
Mississippi Division of Medicaid
550 High Street, Suite 1000
Jackson, MS 39201

What happens if a provider fails to respond to an RFI within 10 business days?

If a provider does not respond to an RFI within the 10-day timeframe, the system will automatically deny the request, requiring the provider to start the process over.

Can additional personnel be given access to Qualitrac reviews?

Yes. When submitting a review, providers can add additional personnel under the 'Provider Visibility' section in Qualitrac to ensure they receive notifications and can complete tasks related to the review.

How does using the correct Medicaid Provider ID affect claim approval?

Using the correct Medicaid Provider ID is crucial to avoiding claim denials. Prior authorization (PA) requests must be submitted with the correct Medicaid Provider ID, as the PA is linked to the provider's ID for reimbursement purposes.