When should I submit a retrospective request?

Retro requests should be submitted when there is an eligibility change or a managed care recoupment affecting prior authorization.

What documentation is required for a retro request?

- A formal authorization approval (e.g., approved CCO authorization or formal approval letter)
- Proof of eligibility change (e.g., enrollment updates or CCO confirmation)
- Proof of recoupments/denials (e.g., remittance advice or denied claim documentation)
- Clinical documentation submitted with the original request

What is the purpose of the PRTF Monthly Census Report?

The report tracks new admissions, current census, and discharges to ensure accurate reporting of patient status and compliance with administrative code guidelines.

What information should be included in the Monthly Census Report?

Providers must report:

- Patient Name
- Medicaid Number
- Admission Date
- Number of Seclusions and if reported to Telligen
- Number of Restraints and if reported to Telligen
- Discharge Location and Date (for discharged patients)

When is the Monthly Census Report due?

The report must be submitted by the last day of each month.

How do I submit the Monthly Census Report?

Reports should be emailed to MSPRTF@telligen.com

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What happens if my report is incomplete or late?

Late or incomplete reports may result in follow-up requests from Telligen. Ensure timely and accurate submissions to avoid compliance issues.

How do I submit an appeal or peer-to-peer (P2P) review?

Appeals must be submitted within 30 calendar days of a denial outcome letter. Providers can request:

- **Reconsideration (1st Level Appeal) –** Submit reconsideration through Qualitrac.
  - The provider should:
    - Search for the case
    - Click the blue three ellipsis menu and select 1st level of appeal
    - Upload additional supporting documents and submit the reconsideration
    - The review will be assigned to a new Review Coordinator for an outcome
- **Peer-to-Peer Review – Discuss the case with a Telligen Medical Director.**
  - Provider should contact Telligen Provider Help Desk – Email: msmedicaidum@telligen.com Phone: 855-625-7709 or Fax: 800-524-5710
  - The provider should provide the Physician Name, Contact Information, Best Available Dates. The ticket will be escalated to schedule a P2P Review with a Telligen Medical Director
- **Administrative Appeal –** A written request through the Mississippi Division of Medicaid.
  - The provider must submit in writing a request for an appeal
  - Mailing address: Division of Medicaid Attn: Appeals 550 High Street, Suite 1000, Jackson, MS 39201
  - The appeals department will reach out to schedule the Appeal

When should I submit a Continued Stay Review?

- If an inpatient stay **exceeds the original approval period**, a CSR is required.
- Submit a **CSR before the initial authorization expires** to avoid disruptions in patient care.

How do I know if my Continued Stay Review was approved?

- Providers will receive an **email notification** when a decision is made.
- You can also check the status in the **Utilization Management (UM) panel** in the **Provider Portal**.

What documentation is required for a Continued Stay Review?

- **Physician orders**
- **Clinical progress notes** supporting the need for an extended stay
- **Medication administration records**
- **Diagnostic test results** (if applicable)
- **Discharge planning notes**

Is there a change request option to add additional services to an existing approved request?

Providers must submit a NEW request for additional services. There is a change request form available for updates to date changes, modifying quantities, or updating information. Updated form [MS-Change-Request-Fill-In-Form.pdf (telligen.com)]

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