Telligen®

MISSISSIPPI MEDICAID UM/QIO

Telligen Provider Review Training
Psychiatric Residential Treatment Facility (PRTF)



Housekeeping

- **Questions**
  - Enter all questions into the chat during the presentation
  - Live Q&A at the end of the presentation (mics can be unmuted)

- **Survey**
  - Registrants will be sent a survey via email following today's training
  - Telligen welcomes your feedback and suggestions on future training opportunities

- **Feedback**
  - Send complaints, grievances and feedback to the Provider Help Desk via Email: msmedicaidum@telligen.com or Toll-Free Phone: 855-625-7709

Agenda

- Welcome & Introduction
  - DOM Mental Health Team (Casey Dittus)
- Compliance & Reporting
- Foundation & Key Terms
- Building the Authorization Request (in Qualitrac)
- Review Process
- Provider Actions & Next Steps
- Resources & Support

Contact & Support

Education Manager – Primary Point of Contact
Charity A Jones, MOL,BA
chjones@telligen.com

Book 1 on 1: Book with Charity

Website: https://msmedicaid.telligen.com/

Mississippi Call Center & Provider Help Desk

- Email: msmedicaidum@telligen.com
- Toll-Free Phone: 855-625-7709
- Fax: 800-524-5710

Portal Registration Questions

- Email: qtregistration@telligen.com
- Toll-Free Phone: 855-625-7709

Program Manager
Claudia Collins, MSN, RN, CCM, CHCQM, CMCN

Assistant Program Manager
Cassandra Bullock, DHA, MHA, CEHRS

Quality Program Director
Roxanne Coulter, BSN,RN,CPM

DOM Mental Health Team

Casey Dittus & Camille introduction
Mental Health Services contact information
Brief overview of DOM support role

Quality of Care Concerns and Issues

Roxanne Coulter, BSN,RN
Quality Director

Overview

- What is Quality-of-Care (QOC)?
- What are Quality-of-Care concerns or issues?
- Quality of Care Quick Reference Guide
- Telligen's responsibilities
- PRTF's responsibilities

Quality of Care Concerns or Issues

What is **Quality-of-Care?**

- Providing health care that is safe, effective, patient-centered, timely, efficient, and equitable, while consistently achieving the best possible outcomes, respecting patient needs, values, preferences, and minimizing waste or harm.

A **Quality-of-Care** concern or issue arise when providers do not meet acceptable standards or care or negatively impact safety, effectiveness, patient-centeredness, timelines, equity, or does not respect patient needs, values, preferences, or does not minimizing waste or harm.

Quality of Care Concerns or Issues

Examples of **Quality-of-Care** concerns or issues

- Sentinel Events
  - Death by self-inflected injurious behavior
  - Sexual abuse/assault of a beneficiary, staff member, visitor, or vendor
  - Physical assault of a beneficiary, staff member, visitor, or vendor
  - Elopement
  - Fall resulting in fracture, surgery, casting or traction, neurological injury, death or permanent harm
- Hospital Acquired Conditions
  - Fractures, dislocations, intracranial injured, crushing injuries, burns, other injuries, poor glycemic control
- Medication Errors

Quality of Care Concerns or Issues

- Incomplete, inaccurate or missing documentation
- Delay in treatment
- Aggression/violence peer to peer or toward a staff member
- Harm to self
- Contraband/Illegal substance found
- Allegations of abuse or mistreatment
- Injury from restraint or seclusion

Quality of Care Quick Reference Guide

Telligen's Quick Reference Guide provides definitions and examples related to **Quality-of-Care**

To request a copy of the Quick Reference Guide, contact Roxanne Coulter via email at rcoulter@telligen.com

Quality-of-Care Telligen Responsibilities

Telligen is responsible for monitoring the **Quality-of-Care** rendered DOM beneficiaries

All prior authorization requests and concurrent stay review requests are monitored

Telligen's Quality Director is responsible for the following:

- Reviewing PRTF incident reports
- Conducting investigations
- Requesting medical records (providers have 30 days to submit records from the date of the request)
- Reviewing investigation reports, final incident reports, and actions taken
- Notifying the provider of findings
- Issuing corrective action plans (CAP) if indicated
- Notifying provider when CAP is accepted and case closed
- Referring to DOM if immediate jeopardy of beneficiary
- Referring suspected fraud, waste or abuse to DOM's Office of Program Integrity

Quality-of-Care PRTF Responsibilities

Psychiatric Residential Treatment Facility's (PRTF) are responsible for the following:

- Completing the DOM required PRTF Incident Report Form
- Submitting the Incident Report Form, timely
- Submitting another Incident Report Form with the results of the final incident investigation
  - Only if the initial submission Incident Report Form did not include the final results
- Submitting documentation/records to the Telligen Quality Director upon request
  - Providers have 30 days to submit records
  - Provider may request a submission extension in writing
- Complete the corrective action plan (CAP) within the required timeframes, if indicated
- Notify Quality Director if issues arise related to CAP
- Collaborate with the Quality Director on completion of CAP if indicated or necessary

Contact Information

- Telligen Quality Director
  - Roxanne Coulter at rcoulter@telligen.com

- Telligen Sr. Program Manager
  - Claudia Collins at ccollins@telligen.com

- Telligen Assistant Program Manager
  - Cassandra Bullock at cbullock@tellligen.com

Compliance & Reporting

Monthly Census Report

In accordance with MS Administrative Code Part 207, Chapter 4, Rule 4.12: Special Procedures, G., 3.

*Information regarding the number of times **seclusion** or **restraint** have been employed by a facility must be included each month as part of the facility's **census report** to the UM/QIO.*

Submission Requirements:

- Due by the **5th business day of the following month**
- Submit via email to: **MSPRTF@Telligen.com**
- **Monthly Census Report**

Monthly Census Report

Psychiatric Residential Treatment Facility Medicaid Monthly Census Report

PRTFs must submit monthly census reports to Telligen, the designated UM/QIO for Mississippi Division of Medicaid. The census indicates any Medicaid beneficiary at the facility for any amount of time during that month, Medicaid ID, admit date, seclusions/restraints used for that beneficiary during that month, anticipated d/c date, and actual d/c date (as applicable). The report for the preceding month should be submitted to Telligen no later than the 5th of the following month. Submit Report to: **MSPRTF@TELLIGEN.COM**. If no Medicaid beneficiaries are present in the facility during the reporting month, please submit with "None" indicated in the Medicaid Beneficiary field

PRTF Name:		Provider #:	
Phone Number:		Fax #:	
Census Month:		Report Date:	

Patient Information for Month

Medicaid Beneficiary Name	Medicaid ID	Admit Date	# of Seclusions	# of Restraints	Anticipated D/C Date	Actual D/C Date	Form 317 Submission Date

Page 1

Serious Incident Reporting

In accordance with MS Administrative Code Part 207, Rule 4.15: Reporting Requirement B.

Serious incidents *must also be reported to the appropriate agencies or entities according to applicable state and federal regulations. These include but are not limited to: 6. Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid.*

Submission Requirements:

- Initial Incident Report due **within 24-48 hours of the incident**
- Follow-up Updates due **every 10 business days** until the investigation is completed
- Submit via email to: **MSPRTF@Telligen.com**
- **Serious Incident Reports**

Serious Incident Reporting

MISSISSIPPI DIVISION OF MEDICAID

Office of Mental Health Programs
550 High Street, Suite 1000
Jackson, MS 30201
601-359-9545
FAX: 601-359-6294

Psychiatric Residential Treatment Facility (PRTF)
Incident Report Form – Confidential

Please submit completed form via EMAIL to MSPRTF@TELLIGEN.COM

SECTION I – REPORTING FACILITY AND REPORTING PERSON	
PRTF Name: Address: City, State, ZIP: Risk Manager: Phone Number:	Form Completed By: Title: Investigator Phone Number: Case # (if applicable): Date faxed to DOM:

SECTION II – RESIDENT INFORMATION

Indicate if the resident/s involved are MS Medicaid beneficiaries and list their name/s below. List only the initials of any non-MS Medicaid residents.

☐ MS Medicaid Beneficiary ☐ Non-MS Medicaid Beneficiary

Resident Name/Initials:
VICTIM:
SUSPECT:

This information has been disclosed to you from records whose confidentiality has been protected. Statutes/regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug patient (42 CFR Part 2).

Serious Incident Reporting

SECTION III – INCIDENT INFORMATION	
Date Incident Occurred:	Date Resident Reported to Staff:
Day of Week Incident Occurred: __M __T __W __TH __F __S __SU	
Type of incident (Check all that apply): ☐Serious Injury/illness requiring attention by in-house medical staff ☐ Serious Injury/illness requiring outside medical attention ☐ Injury resulting from physical restraint/seclusion ☐ Harm to self ☐ Physical assault by resident ☐ Sexual contact by residents ☐ Sexual assault ☐ Contraband found that could cause harm (illegal substances, lighter, etc.) ☐ Substance use on facility grounds/supervised trip ☐ Elopement ☐ Medication error requiring medical attention ☐ Suicide Attempt ☐ Suicide ☐ Mistreatment or allegations of mistreatment including but not limited to abuse, neglect, emotional harm, or sexual exploitation by staff ☐ Death ☐Other (Explain):	Staff Involved: Name: Name: Name: Name: Name: Witnesses: Name: Name: Name: Name: Name: Where Incident Occurred: ☐ PRTF ☐ School ☐ Community ☐ Home ☐ Other (Explain):

Serious Incident Reporting

SECTION IV- NARRATIVE DETAILS
Describe the injury, condition or circumstance of the incident and the activities taking place immediately prior to the incident. Identify all participants (resident, staff, etc.) and their involvement in the incident. Please be comprehensive but concise in explaining who, when, where, why, how, and what was heard and/or observed:
SECTION V- PLAN TO RESOLVE (IMMEDIATE AND LONG TERM)
At the time of the report, is the facility conducting an internal investigation? Yes No Updated reports should be submitted every 10 business days until the investigation is complete using the **Incident Report Update Form** Describe any corrective action taken to prevent future incidents (including changes to behavior care plan, treatment plan, or medication regimen, etc.): If mistreatment or allegations of mistreatment by staff, actions taken (training, suspension, termination, etc.):

Serious Incident Reporting

SECTION VI- INDICATE WHCH OF THE FOLLOWING AGENCIES AND INDIVIDUALS HAVE BEEN INFORMED		
Check all that apply and provide: ☐ Parent/Legal Guardian ☐ MS Department of Human Services (DHS) ☐ MS Department of Health (MDH) ☐ Disability Rights Mississippi (DRM) ☐ Medicaid Fraud Control Unit, Attorney General (MFCU) ☐ Center for Medicare/Medicaid Services (CMS) ☐ DMH Office of Incident Management	Name: Name: Name: Name: Name: Name: Name: Name:	Date: Date: Date: Date: Date: Date: Date: Date:
SECTION VII – ATTACHMENTS		
Are there attachments included with this report? ___Yes _ _No		

Serious Incident Reporting

Compliance & Record Maintenance -

- Reports must be complete, accurate, and timely
- Providers must maintain supporting documentation and records
- Failure to comply may result in compliance review, Corrective action, Additional oversight

Eligibility Verification

Eligibility Verification

Why Eligibility Verification Matters

- Confirms active Medicaid coverage for the date of service
- Helps avoid denials by ineligibility or coverage lapses
- Provides important details on benefit plans, managed care assignments, and any limitations.

Verify Eligibility

Always verify eligibility before submitting an authorization request

Always verify eligibility before providing services

Resources

Eligibility Verification

MESA Portal for Providers

Eligibility, Benefit Usage, and Retro Job Aid

Eligibility Verification

Medicaid Provider Portal



Eligibility Verification

Enter the Member ID or enter two of the following:

- SSN
- DOB
- Member's Full Name

Enter the Begin Date and the End Date



Beneficiary Record Summary



Eligibility Verification Information for [redacted] for 5/13/2024 to 5/13/2024

Member ID [redacted] Birth Date [redacted] Gender Female

Head of Household [redacted] Authorized Rep No

Authorized Rep Name N/A Authorized Rep Phone # N/A

Verification Response ID 2413400008

Expand All | Collapse All

Demographic Details

Street Address [redacted]

City PONTOTOC State Mississippi Zip Code 38863-8158

Benefit Details

Coverage	Effective Date	End Date	Add Date	Last Update Date
073 - Children age 6-19 with income at/below the MAGI	05/01/2022	12/31/9999	03/25/2022	09/30/2022

Other Insurance Detail Information

Medicare Coverage Detail

Coverage	Effective Date	End Date	Last Update Date
None			

Managed Care Assignment Details

Managed Care Plan	Managed Care Plan Phone	Primary Care Provider	Provider Phone	Benefit Plan	Effective Date	End Date
MOLINA HEALTHCARE OF MISSISSIPPI IN	1-844-809-8438			MississippiCAN	6/1/2022	12/31/9999

Lock-In Details

Lock-in Provider	Lock-in Provider Phone	Benefit Plan	Effective Date	End Date
None				

Living Arrangement Details

Level of Care Plan	Provider NPI	Provider Name	Effective Date	End Date
None				

EPSDT Well Child Service Details

Service	Last Exam	Next Exam
EPSDT- Medical	05/20/2021	05/20/2022
EPSDT- Dental	11/04/2021	05/04/2022
EPSDT- Hearing	05/20/2021	
EPSDT- Vision	05/20/2021	
EPSDT- Other		

The Medicaid Provider Portal returns eligibility verification information for the member including the following:

- Head of Household
- Authorized Rep Name
- Authorized Rep Phone #
- Demographic Details,
- Benefit Details
- Managed Care Details
- Lock-In Details
- Living Arrangement Details, and EPSTD details.

Review Timings

Review Timing

Review Timing	Definition	When It's Used	Examples	Key Considerations
Prospective	Review conducted **before** services are provided or patient is admitted	When seeking **prior authorization** for scheduled or planned services	▪ Therapy eval request ▪ Scheduled outpatient imaging ▪ Elective surgeries	Must be approved **before** service begins to avoid denial
Concurrent	Review conducted **during** ongoing care	For **ongoing medical necessity** during an active admission or treatment episode	▪ Inpatient hospital stay ▪ Rehab requiring extended length of stay	Submit clinical updates **before current auth ends**
Retrospective	Review conducted **after** the service has been provided	When prior or concurrent review due to eligibility coverage change	▪ Recoupment from MCO or other Insurance notification	Requires **justification** and documentation to avoid denial

Provider & Facility Information

Providers Panel: Provider and Facility Information

The Provider's Panel is used to identify all required provider and facility information associated with the requested services.

This information tells us:

- Who ordered the service
- Who is responsible for the member's treatment
- Where the service is being rendered

All required fields must be completed accurately to avoid processing delays or a technical denial.

6.1 Providers Panel: Provider and Facility Information

Treating Physician: The Treating Physician is the provider who is clinically responsible for the member's treatment during the admission or course of care and oversees treatment decisions. For best results, search using the active Gainwell Provider ID number and select the active record.

Treating Facility: The Treating Facility is where the services are being rendered. This should reflect the physical location providing care. For best results, search using the active Gainwell Provider ID number and select the active record.

Ordering Provider: The Ordering Provider is who ordered, prescribed, or certified the requested service. This is the provider authorizing the need for services. Must match supporting clinical documentation. For best results, search using the active Gainwell Provider ID number and select the active record.

Medical Director (Hospice Review Only): The Medical Director, can be the Treating Physician, at the facility. For best results, search using the active Gainwell Provider ID number and select the active record.

Key Reminder: All Treating Physician, Treating Facility, Ordering Provider and/or Medical Director must be an **enrolled and active Mississippi Medicaid Provider**. All required provider fields must be completed accurately. Missing or incorrect provider information may delay processing or result in a technical denial.

Federal Regulation 42 CFR § 455.410

All Provider and Facilities entered into the Providers Panel MUST be active and enrolled Medicaid Providers.

In accordance with Federal Regulation 42 CFR § 455.410, "The State Medicaid agency must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers."



Documentation

Documentation

Clinical documentation tells the clinical story of the member.

Documentation must clearly describe the following.

- Diagnosis,
- Onset of symptoms
- Current clinical presentation
- Progression of the condition

Documentation must directly support medical necessity criteria.

Clinical Documentation-Acceptable Documents

Acceptable: The following methods are acceptable when corrections or updates are needed.

- Original clinical documentation directly from the provider
- Single line through the error with initials and date noted
- A new version clearly labeled "Corrected" with a new signature and date
- Clinical information must be documented in office visit notes or other medical record documentation.

Required Identifiers
All clinical documentation must include at least two member identifiers

Clinical Documentation- Not acceptable

Not acceptable: The following documentation practices are not acceptable and may result in a Request for Information (RFI) or denial.

- White-out or scribbled corrections
- Overwritten or scanned changes without proper signatures
- Word documents submitted without official company letterhead or identifying information
- Handwritten notes on cover sheets, telephone calls, or other fax pages that are not reflected in office visit notes will not constitute actionable information for clinical decision making

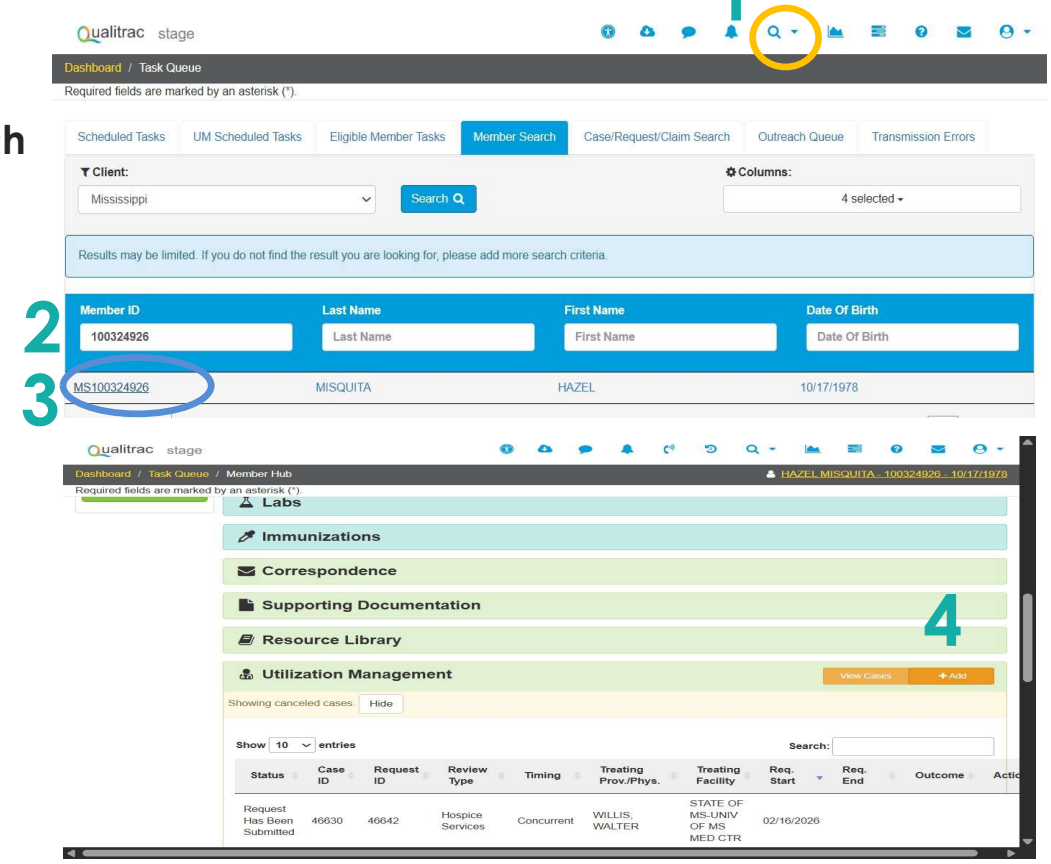
Building the Authorization Request (in Qualitrac)

Telligen Provider Portal – Required sections

1. Member Search/Member Hub
2. Authorization Request Section
3. Dates of Service Panel
4. Eligibility
5. Supporting Information
6. Providers & Provider Organization Visibility
7. Diagnosis, Procedures & Modifiers
8. Assessments (GAF, Seclusion & Restraints)
9. Documentation

1. Member Search/Member Hub

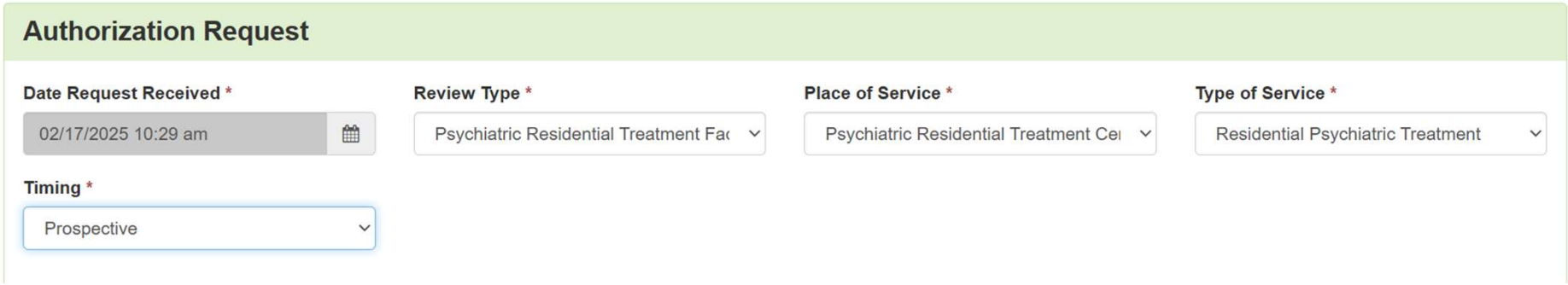
1. From the Dashboard, click on Member Search
2. Search for the Member using Medicaid ID, or by Name and Date of Birth
3. Click on the Member File to access the Member's Hub
4. Under Utilization Management Section Click on "Add" to start a new request



2. Authorization Request Section

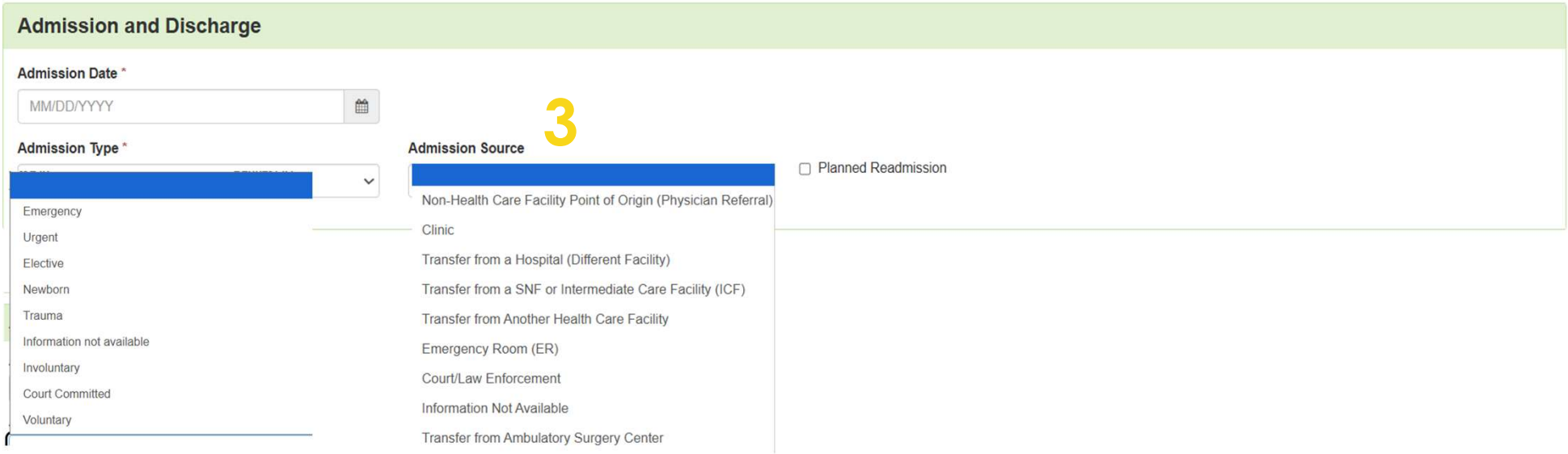
Start building your request by completing the following fields:

- **Date Request Received:** This date is the date you are submitting the request.
- **Review Type:** PRTF
- **Place of Service:** PRTF
- **Type of Service:** Residential Treatment
- **Timing:** Select the appropriate timing for the request (prospective, concurrent, or retrospective)



3. Admission & Discharge Section

1. Admission Date must align with: Review Timing selected (Prospective, Concurrent, Retrospective) and Clinical documentation submitted
2. Admission Type: must reflect actual level of care and scenario
3. Admission Source: must accurately reflect where the member is coming from

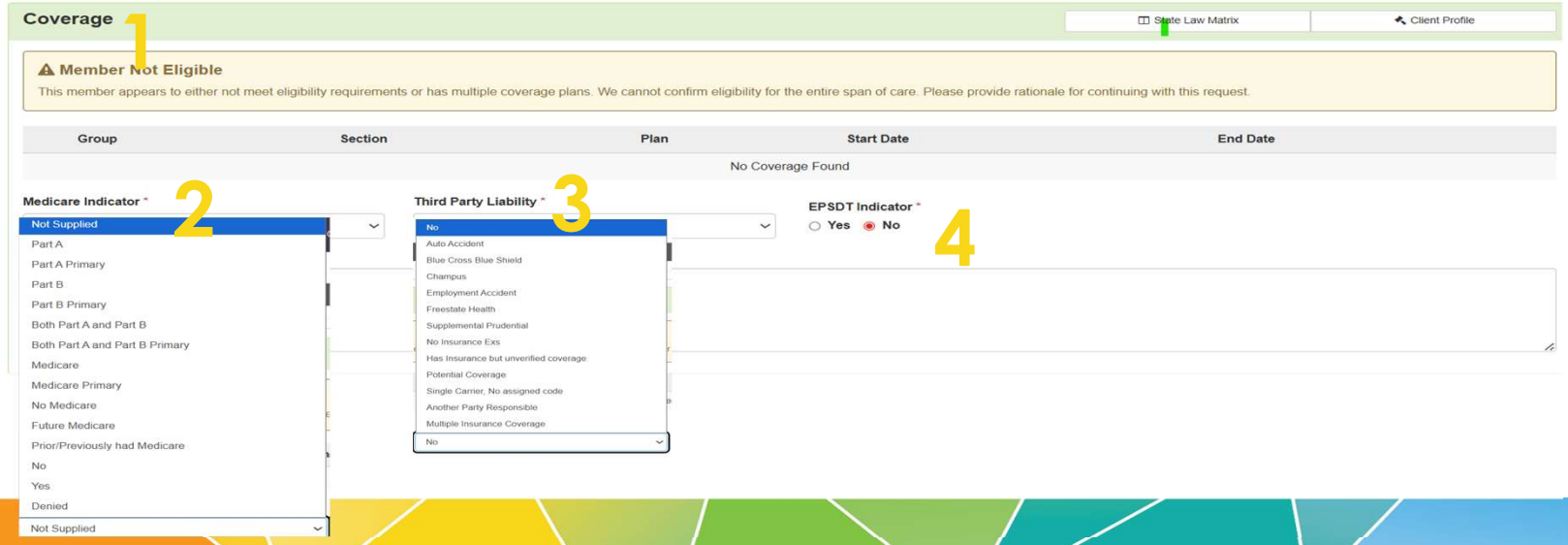


4. Eligibility Coverage

Providers must verify eligibility **prior to submission and prior to services.**
The coverage panel should align with their beneficiary record.

1. Confirm active Medicaid coverage for dates of service
2. Review benefit plan and service limitations
3. Identify Third Party Liability (TPL), if applicable
4. Identify EPSDT Indicator, if applicable (toggle yes or no)

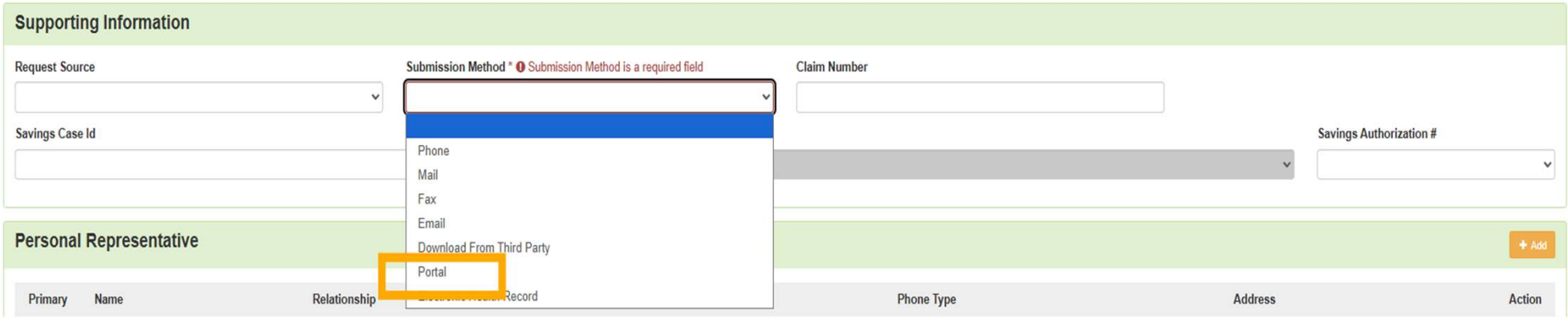




5. Supporting Information

Requests submitted through Qualitrac must be identified as **PORTAL** submissions.

- Select **PORTAL** from the dropdown menu.

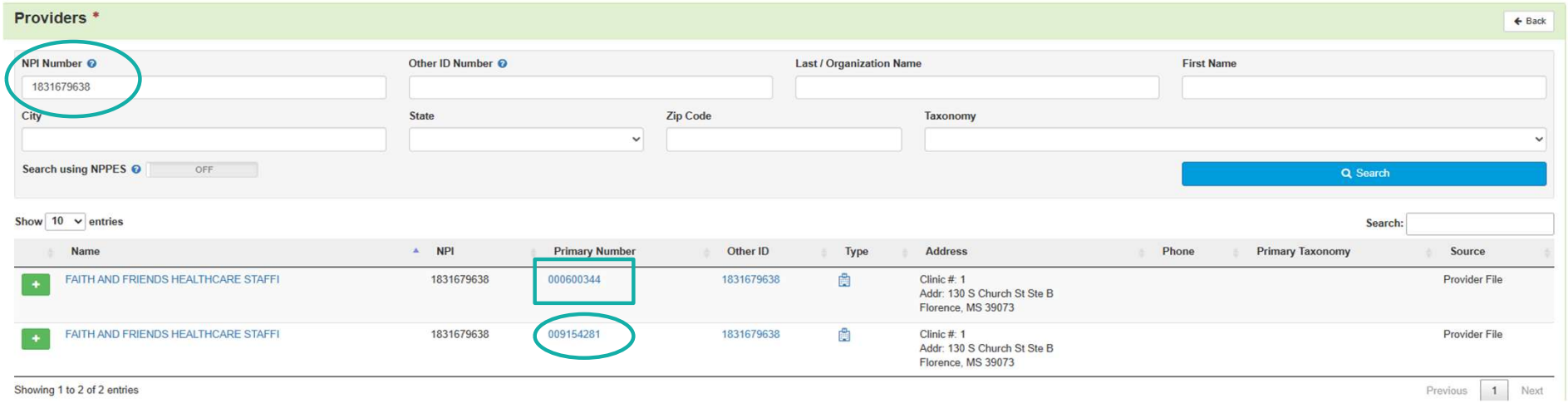


6. Entering Physician and Facility Information by NPI

Select **Add** to open the provider search window

Search for the provider or facility by entering one of the following:

- NPI number, or Medicaid Provider ID (entered in the Other ID Number field)
- Select **Search** to display matching results.



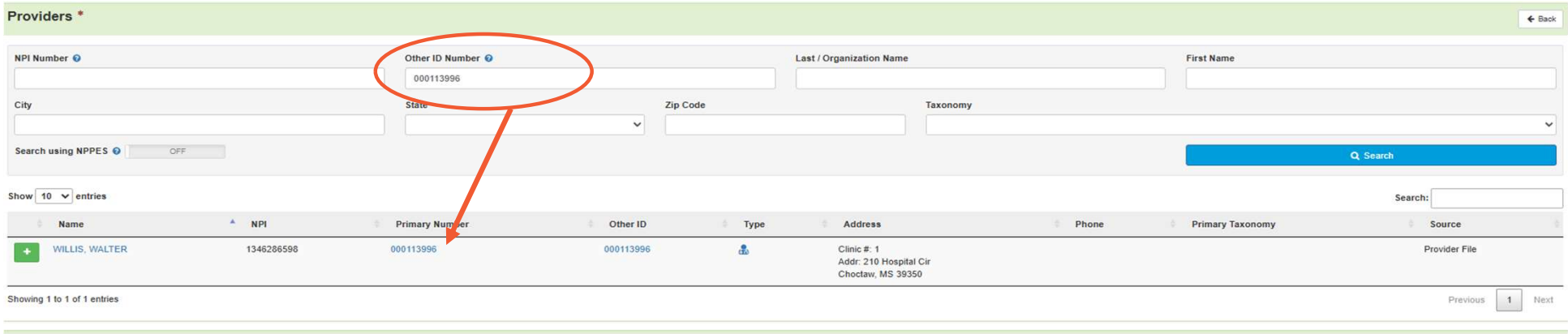
Best Practice: Providers **MUST** verify that the provider's name, address, and Medicaid Provider ID is correct before selecting the provider from the list.

Failure to verify may result in an authorization applied to the **WRONG** Provider

Entering Physician and Facility Information by Medicaid Provider ID

Select **Add** to open the provider search window.

- Enter **Medicaid Provider ID** in the "Other ID" number search field
- After entering the information, select **Search** to locate the correct physician or facility.
- Click the Primary Number to add appropriate provider from the list.



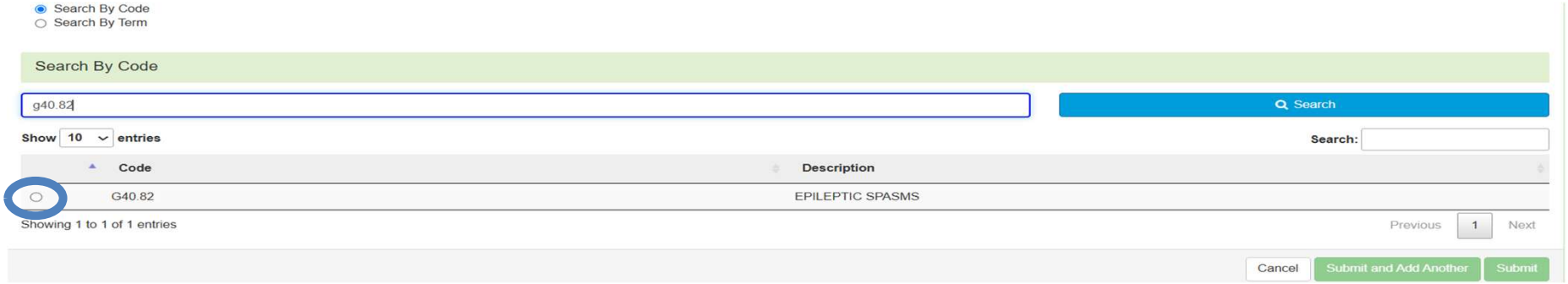
Best Practice: Providers **MUST** verify that the provider's name, address, and Medicaid Provider ID is correct before selecting the provider from the list.

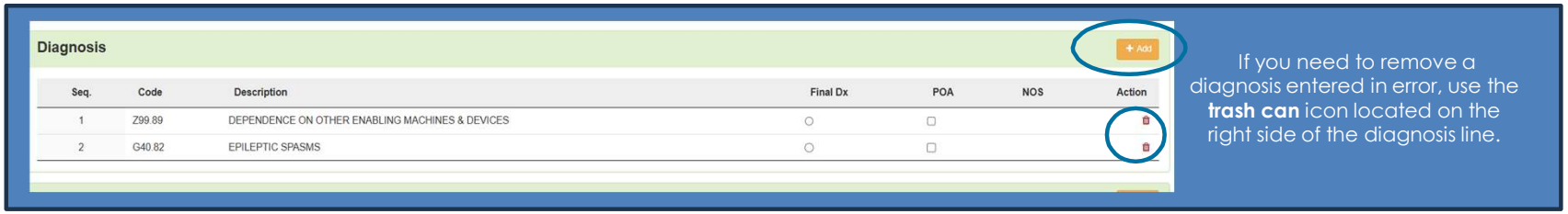
Failure to verify may result in an authorization applied to the **WRONG** Provider

7. Diagnosis Panel

Steps to Search

1. Select the search method (Code or Term) using the radio button.
2. Enter the diagnosis code or keyword in the search box.
3. Click **Search**.
   - Select the correct diagnosis by clicking the radio button to the left of the code.
   - Click **Submit** (or **Submit and Add Another** if multiple diagnoses must be entered).





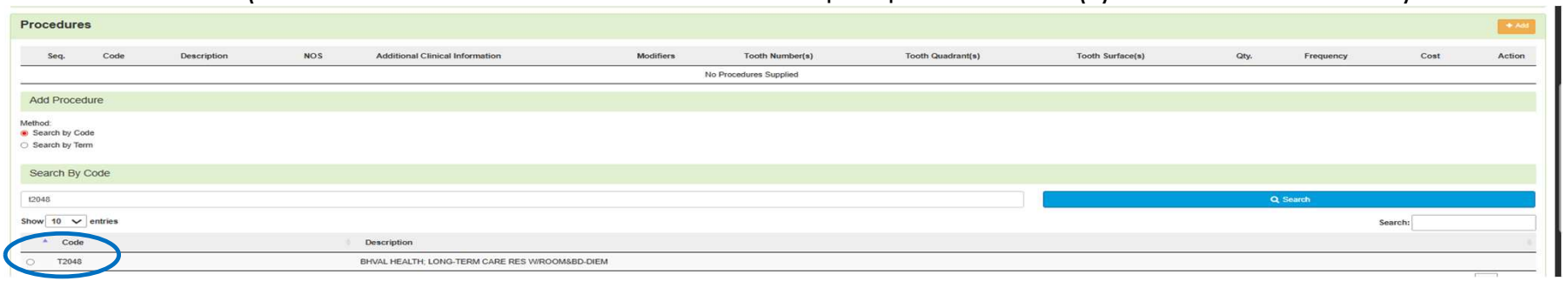
If you need to remove a diagnosis entered in error, use the **trash can** icon located on the right side of the diagnosis line.

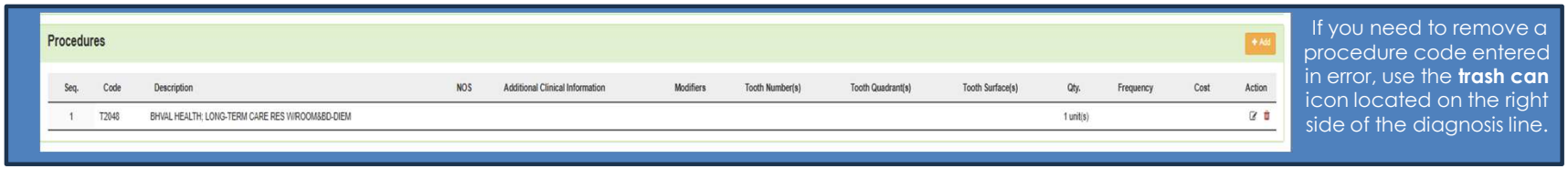
8. Procedure(s) Panel

The Procedures Panel is where you will enter the procedure code information required for this review. Select **Add** to open the procedure search window.

Steps to Search

1. Select the search method (Code or Term) using the radio button.
2. Enter the procedure code or keyword in the search box.
3. Click **Search**.
   - Select the correct procedure by clicking the radio button to the left of the code.
   - Click **Submit** (or **Submit and Add Another** if multiple procedure (s) must be entered).

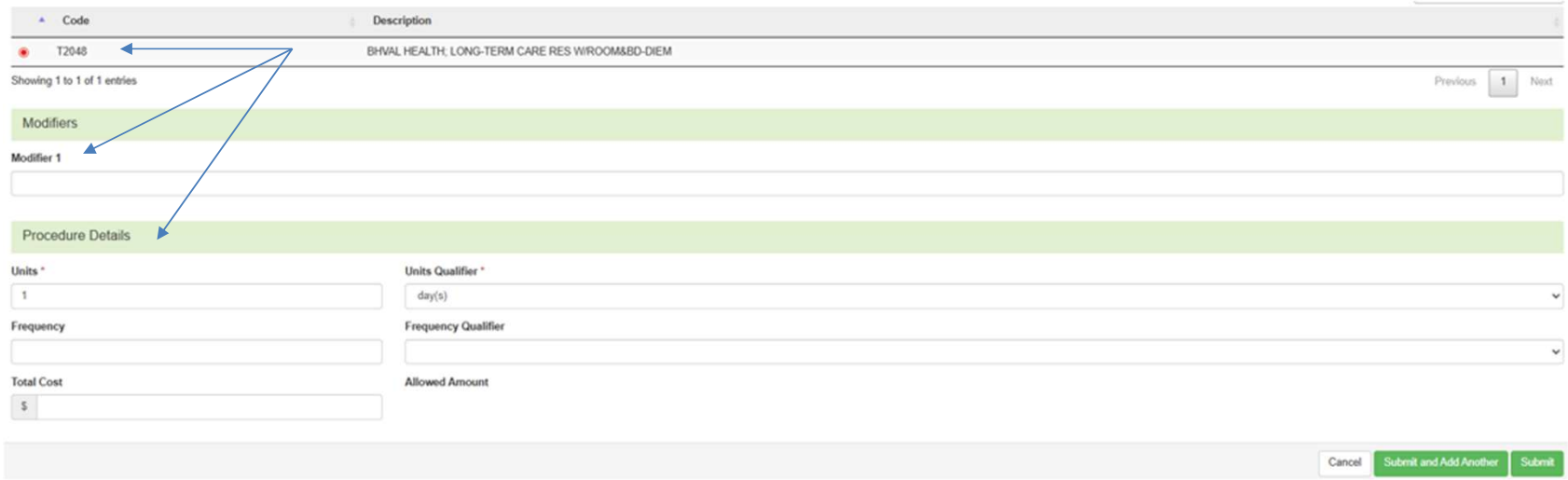




If you need to remove a procedure code entered in error, use the **trash can** icon located on the right side of the diagnosis line.

8. Procedure Panel- Modifier

Once the system populates the procedure code results, use the radio button to select the correct procedure. After selection, the Modifiers & Units section becomes available for completion.

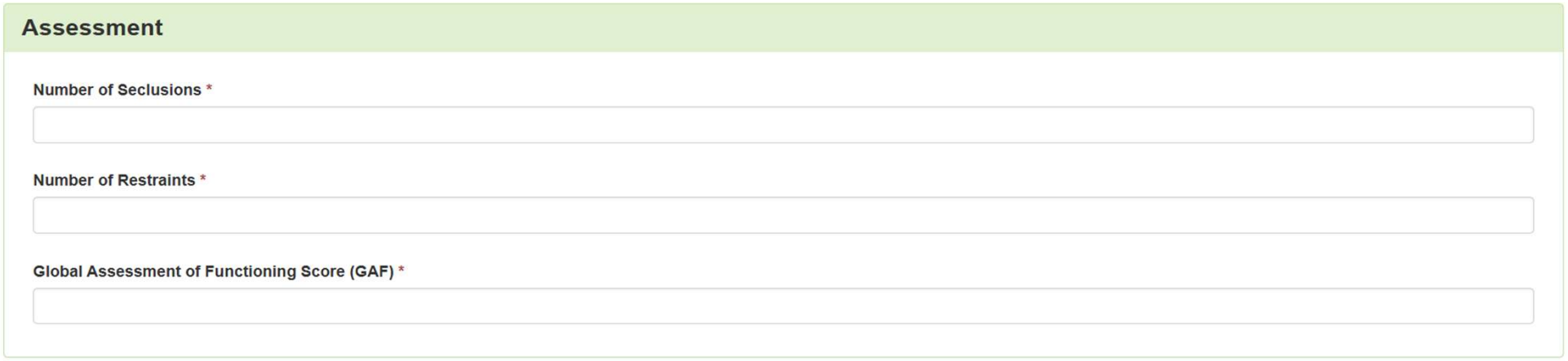


Modifiers are **not always required** in Qualitrac. However, if the claim will be billed with a modifier based on coding guidelines and/or billing practices, the authorization must reflect the **same modifier(s)**.

9. Assessment Requirements

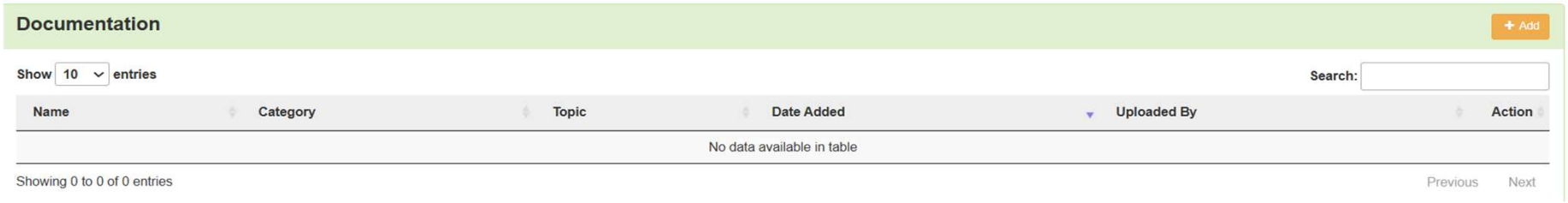
Per Mississippi Administrative Code Title 23, Part 207, Chapter 4:Rule 4.8 – Assessment and Evaluation; Rule 4.7 – Active Treatment, providers are required to document and report:

- Number of Seclusions
- Number of Restraints
- Member's functional status (GAF Score)



10. Documentation: Required Documentation

- Initial Treatment Plan within 24 hours of admission
- Signed Treatment Plan
- Signed ISP
- Psychological Diagnosis
- Psychological/Psychiatric Evaluation (within 30 days of admission)that includes:
  - Diagnostic evaluation (medical, psychological, social, behavioral, developmental)
  - Assessment of immediate and long-term therapeutic needs
  - Assessment of personal strengths and liabilities
  - Measurable goals and objectives with timelines
  - Integrated program of therapies and activities
- Signed Progress Notes (especially if patient has received prior PSR services)



Complete the Submission

Providers may add comments to the review prior to submission.

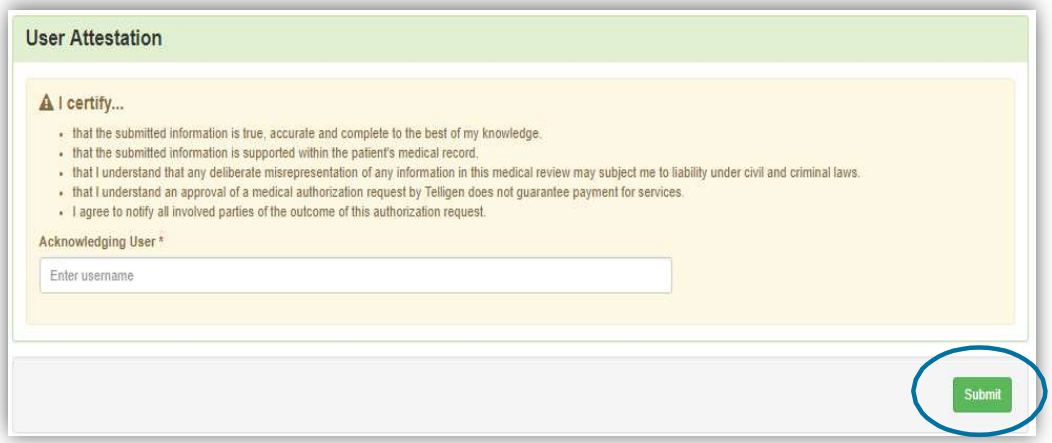
- Comments may be used to provide clarifications, explanations, or context that support the authorization request.
- **Comments are optional and are not required to submit or complete the review.**



Complete the Submission

Enter your **Username** in the attestation field to certify that the information submitted is accurate and complete to the best of your knowledge.

Select **Submit** to send the review to Telligen for processing.



Case Review Process

Review Process – What Happens After Submission

Case Review Process

- Case is assigned to a Review Coordinator (RC)
- Clinical documentation is reviewed for medical necessity aligned with PRTF requirements
- If all review criteria is complete, an outcome is rendered:
  - **Approved**
  - **Partial Denial- which is a limited approval**
  - **Clinical Denial**
  - **Administrative Denial**
  - **Tech Denied or**
  - **ONR**

Request for Information (RFI)

If documentation is incomplete: Case is **pended (paused)** and A **Request for Information (RFI)** is issued outlining what is needed.

Providers have **10 business days** to respond to a Request for Information (RFI).

Notification Methods (Portal Users)

- The submitter will receive an email notification indicating that additional information is required
- RFI task will populate in the Qualitrac system (Portal)

Notification Methods (Alternative Methods: Fax or Mail)

- Telligen will notify the Provider by original method received (Fax or Mail) indicating that additional information is required.

Request for Information (RFI)

You have **ONE opportunity** to submit all requested information.

Once submitted:

- The case returns for review
- The reviewer will render an outcome based on the information provided

Required Actions

- Do NOT submit a new case to provide additional information
- Always respond using the RFI task
- Upload ALL requested documentation at one time

Failure to respond to an RFI request will result in a Tech Denial.

- Technical Denial is an Administrative Denial for Missing Information

Review Outcomes

Review Outcome Definition

Outcome	What It Means	Common Reasons	Provider Next Steps	Reconsideration
Approved	medical & administrative requirements met	Documentation complete & criteria met	Proceed with services	Not applicable
Partial Denial	Limited approval; some denied	Units exceed criteria or limits	Review denied services carefully	Reconsideration (1st-level appeal)apply to denied portion
Clinical Denial	Denied based on medical necessity	Criteria not met per evidence-based guidelines	Review denial rationale	Reconsideration (1st-level appeal)
Administrative Denial	Denied for non-clinical reasons	• Eligibility • Untimely Submission • Duplicate Request • Service Not Covered	Review denial rationale and proceed appropriately	Reconsideration (1st-level appeal)
Tech Denied (Admin Denial)	System Generated denial due to no response to RFI	• Provide not respond to the RFI task by uploading a response	Submit a change request to reopen for reconsideration	Reconsideration (1st-level appeal)
Outcome Not Rendered (ONR)	No decision rendered	• Provider Request • Incorrect Review Type • Incorrect Review Timing	Submit a **new case**, if applicable	Not eligible for Reconsideration (1st-level appeal)

Reconsideration Process (After Technical Denial)

Reconsideration requests for Technical Denials can only be submitted through the via Fax, email or Provider Help Desk. Reconsideration requests will be processed once all necessary documentation is received, and providers will be notified of the outcome.

Providers must submit requests within **10 business days** using one of the following methods:

Email: msmedicaidum@telligen.com
Phone: 855-625-7709
Fax: 800-524-5710

Required Action:

- Submit a **Change Request Form**
- Enter **"Tech Denial"** as the Reconsideration Reopen Reason
- Include all required documentation from the original RFI

If the case is reprocessed, you will receive your Reconsideration outcome.
If it is untimely to submit a reconsideration request, the Provider will need submit a new case with correct documentation.

Outcome Not Rendered (ONR) Details

ONR - no determination made on the case

- No letter is generated
- Reconsideration (1st-level appeal) rights **DO NOT** apply

ONR reasons

- Provider Request –provider contacts Telligen and requests the review to be cancelled. **Action**: Provider will need to submit a change request form requesting cancelation and reason.
- Incorrect Review Type – provider submits a review under the incorrect review type. **Action**: Provider will need to submit a new case with the correct Review Type
- Incorrect Review Timing – provider submits a request with the incorrect review timing. **Action**: Provider will need to submit a new case with the correct Review Timing

Provider Actions & Next Steps

Appeal Rights Timely Submission

Providers and/or members have the right to appeal an adverse determination.

1st-Level Appeal: Reconsideration

- A reconsideration is the first-level appeal.
- Providers and/or members have **10 business days** from the date of the outcome letter to submit a reconsideration request.
- If the reconsideration is denied, the determination is **final for the provider**.
- Providers do not have additional appeal rights beyond reconsideration.

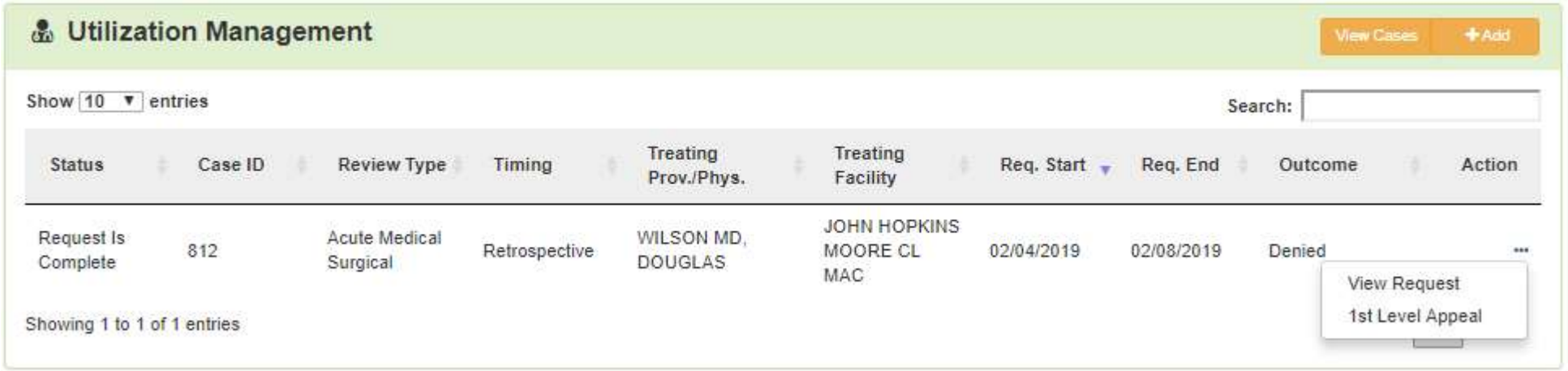
1st-Level Appeal: Reconsideration requests must be submitted using one of the following methods

- Qualitrac Portal (http://myqualitrac.com)
- Fax: 1-800-524-5710
- Mail: Telligen UM Department, 715 S Pear Orchard Rd, Ste 400, Ridgeland, MS 39157

Qualitrac (1st Level Appeal)

To submit a **1st-Level Appeal:** Reconsideration

- Go to the **Utilization Management** panel in the member hub
- Click on the blue ellipsis within the denied case to open the action menu
- Select **1st Level Appeal** from the menu



Appeal Rights Timely Submission

Beneficiary Appeal: State Fair Hearing - Division of Medicaid (DOM)

If a decision is made to reduce, deny, suspend, or terminate covered services provided to a Medicaid beneficiary, and the beneficiary disagrees with the decision, the beneficiary and/or the beneficiary's legal representative must request a hearing within thirty (30) days of the notice of adverse action. See Part 300, Chapter 2, Rule 2.7, All Hearing Requests, for more information.

Beneficiary Appeal: State Fair Hearing must be submitted to:

Division of Medicaid
Attn: Office of Appeals
c/o Director of Appeals
P.O. Box 2222
Jackson, MS 39225

Change Request

Submitting a Change Request Form

Change Request Form

- Must be submitted within 90 days of the approval date listed on the outcome letter
- Fax 800-524-5710 or email: MSMedicaidUM@Telligen.com

Change Request Form are used to request simple modifications to an approved authorization.

- Correct Date – a correction of less than a 2-day difference at the start or end of the approved certification period

- Minor Administrative Updates (with supporting documentation)
  - Correcting provider information
  - Adding appropriate modifiers
  - Cancelling an ONR or approved PA request to submit a new case with corrections

Submitting a Change Request Form

Change Requests **ARE NOT** for:

- Adding or removing CPT codes
- Extending services dates past the current authorization
- Reconsideration (1st-level appeal)
- Denied claims (including technical denials)
- Updates to claims that have already been paid

Resource: Change Request

Extension of Services

Submitting an Extension Request

Providers may request to extend a beneficiary's stay beyond the initially approved authorization period. A Continued Stay **must be submitted prior** to the current authorization end date.

Extension of Service:

- Ensures **continuity of care and quality of care**
- Provides **medical justification** based on **clinical criteria**
- Must be submitted **before** the current auth end date
- Maintains compliance with **Mississippi Medicaid** regulations and avoid **claim denials** due to lack of prior approval

Submitting a Continued Stay Review (extension request)

Step 1: Access Qualitrac
Log into your Qualitrac provider account.

Step 2: Select Patient Case
Locate and select the **existing** patient case requiring an extension.

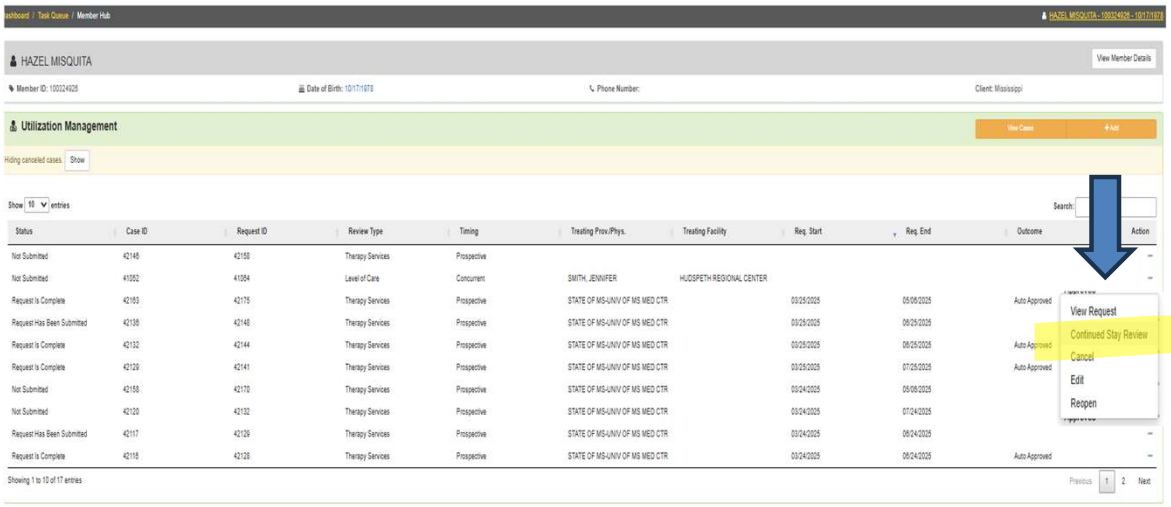
Step 3: Initiate Continued Stay
Click on the "Request Continued Stay Review.

Step 4: Upload Supporting Documentation

Step 5: Update your Assessment (seclusion, restraints and GAF score

Step 6:Complete InterQual process

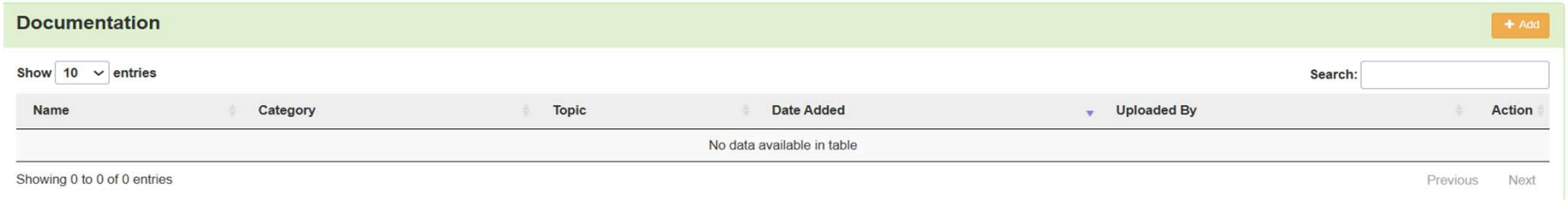
Step 7: Submit Request



Reminder: Submit extension requests **prior** to expiration of current authorization.

CSR Required Documentation

- Documentation from the physician stating why continuation is needed
- Three (3) most recent Progress Notes
- Updated signed treatment plan with goals
- D/C Plan



Discharge Tasks

Completing Discharge Task

Completing the discharge task ensures the case is properly closed, authorized dates align with the actual discharge date, and downstream systems and claims process accurately. Incomplete discharge tasks may result in system errors, overlapping authorizations, claim delays, or compliance issues.

1. **Discharge Documentation** - Complete discharge disposition that includes the date of discharge

2. **Upload Discharge Orders/Documentation** - Medications, treatments and procedures must be dated and signed

3. **Completing the Task**: Once all the information has been entered in the panels, the submitter can complete the process by clicking the "Close Case" button at the bottom of the page.

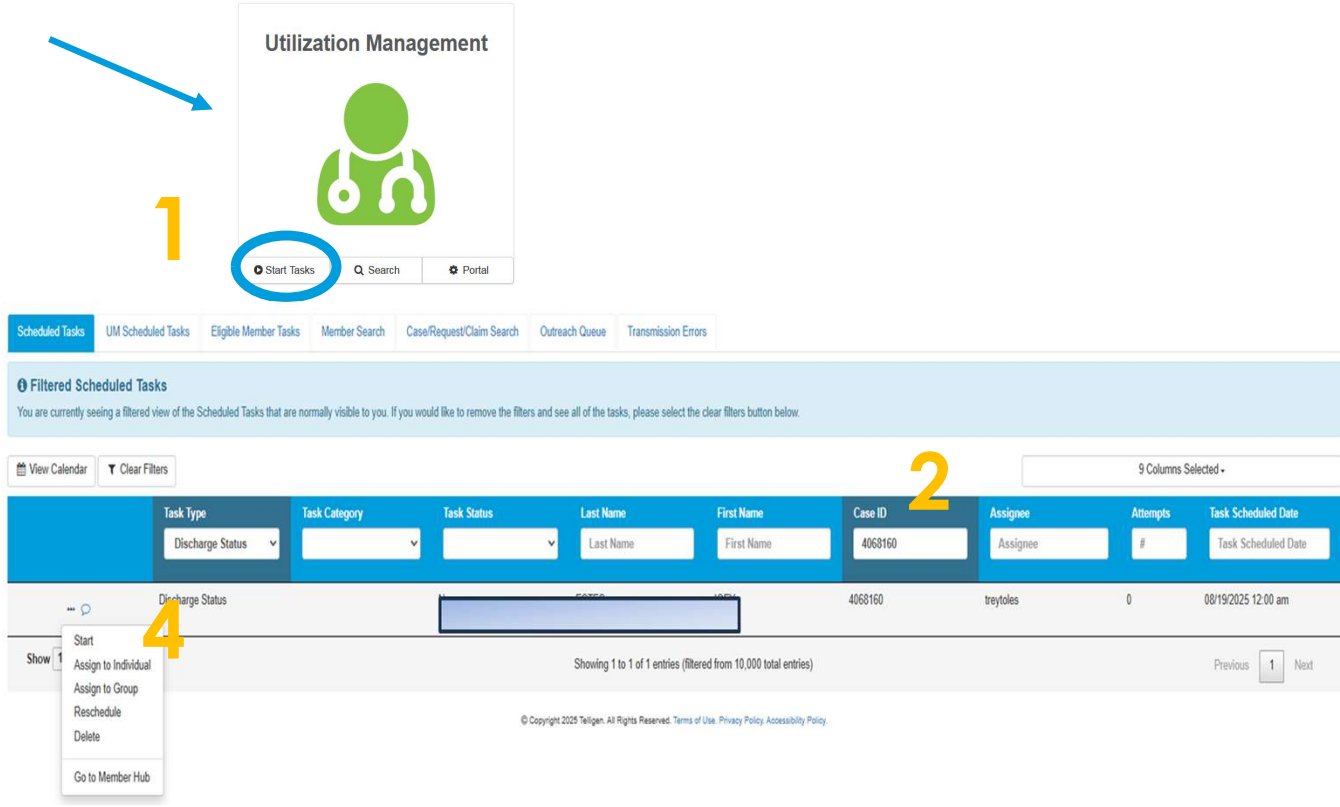
Completing Discharge Task

1. From the **Home Screen:**
   - ✓ Navigate to the **Utilization Management** section.
   - ✓ Click on **Start Task**.

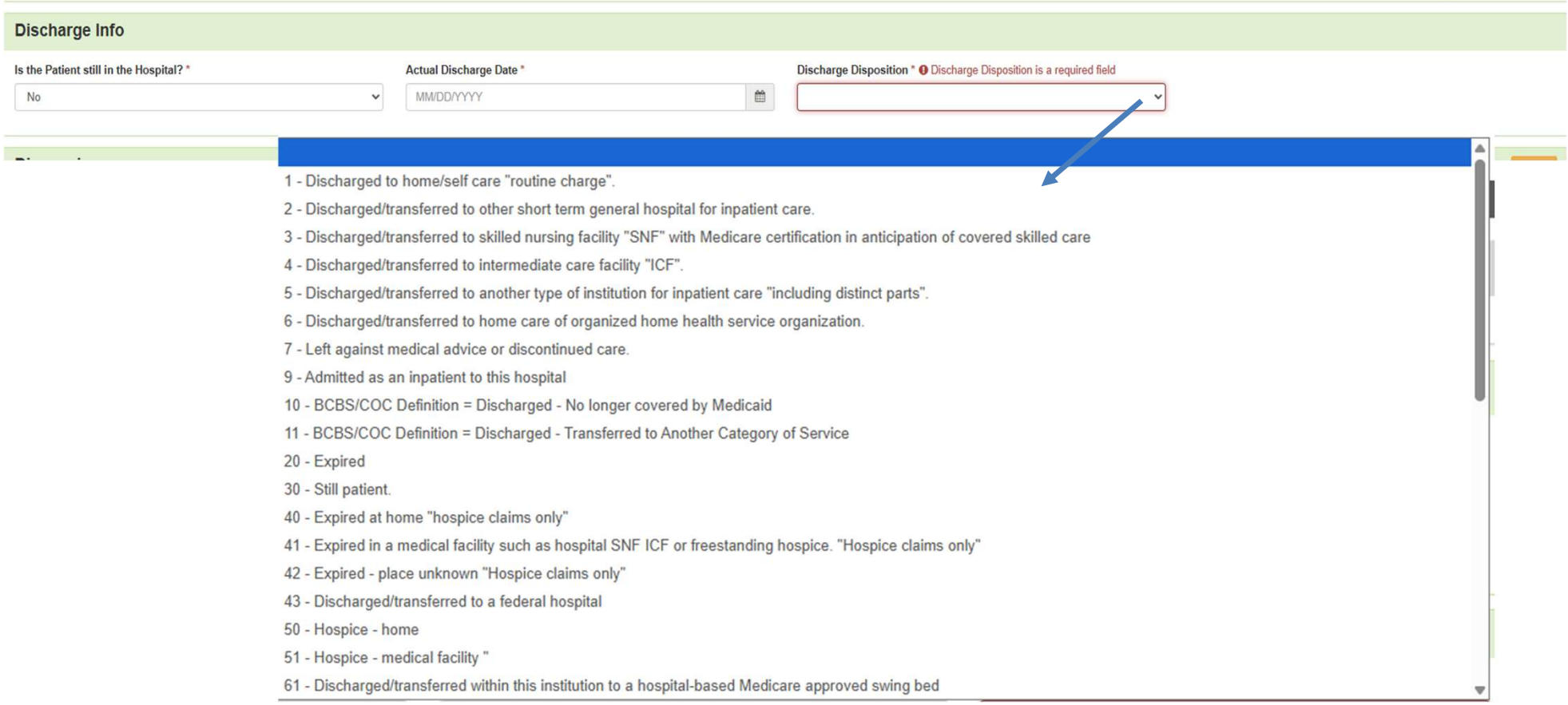
2. **Search for Your Case:**
   - ✓ Under **Case ID** column, enter your **Case Number** and press **Enter**.

3. **Open the Case:**
   1. Click the blue **ellipsis menu** (three dots) next to the case.

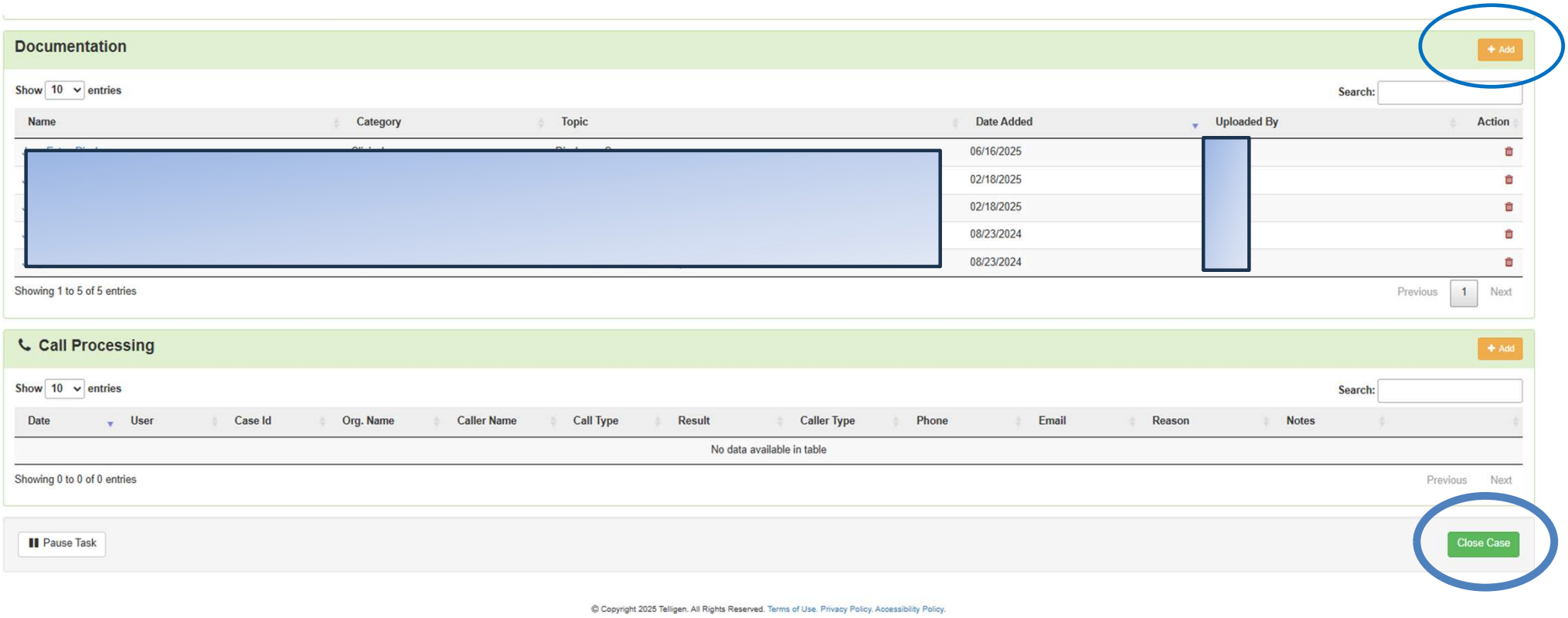
4. Select **Start** to open the case.



Discharge Details



Discharge Details



Website Tour Q&A

Questions

Contact & Support

Education Manager – Primary Point of Contact
Charity A Jones, MOL,BA
chjones@telligen.com

Book 1 on 1: Book with Charity

Website: https://msmedicaid.telligen.com/

Mississippi Call Center & Provider Help Desk

- Email: msmedicaidum@telligen.com
- Toll-Free Phone: 855-625-7709
- Fax: 800-524-5710

Portal Registration Questions

- Email: qtregistration@telligen.com
- Toll-Free Phone: 855-625-7709

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