Mississippi Medicaid Provider Manual

Prepared by: Telligen

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I. About Division of Mississippi Medicaid (DOM)

The Mississippi Division of Medicaid is a state and federal program created by the Social Security Amendments of 1965 (PL 89-97), authorized by Title XIX of the Social Security Act to provide health coverage for eligible, low-income populations. In 1969, Medicaid was enacted by the Mississippi Legislature. The Mississippi Division of Medicaid, in the Office of the Governor, is designated by state statute as the single state agency responsible for administering Medicaid in Mississippi.

For additional information, please visit Home - Mississippi Division of Medicaid (ms.gov).

A. Utilization Mississippi Medicaid Program

Medicaid is a federal and state program created to provide medical assistance to eligible, low-income populations. This service is in place to provide access to quality health care coverage for vulnerable Mississippians. Mississippi Medicaid health benefits are available for populations including children, low-income families, aged, blind, or disabled, and pregnant women. Individuals must meet certain requirements to receive benefits and services.

Eligible members do not directly receive money from Medicaid for health benefits. Enrolled and qualified Medicaid providers are reimbursed for health services.

B. Utilization Management (UM)/Quality Improvement Organization (QIO) Vendor

Beginning January 16, 2024, Telligen Inc. will begin performing prior authorization (PA) reviews. Telligen was awarded the new UM/QIO contract in 2023 by DOM to serve as its UM/QIO, to review Fee-For-Service (FFS) services provided to Medicaid beneficiaries in the State of Mississippi. Under this contract, Telligen ensures that all Medicaid services meet medical guidelines for medical necessity, appropriateness, and length of service.

PA for beneficiaries enrolled in MississippiCAN are handled by the respective coordinated care organizations.

For additional information on service authorization processes and provider education opportunities, please visit Telligen's DOM portal at Home | MS DOM (telligen.com).

If you have any questions, please contact the Office of Medical Services at 601-359-6150.

C. UM/QIO Requirements

Telligen has developed written policies and procedures, approved by DOM, for Utilization Management (UM) services, which comply with Federal and State laws and regulations, the Mississippi Administrative Code, the Mississippi Division of Medicaid State Plan, formal memorandums, and policies promulgated by DOM when conducting reviews.

All UM written policies and procedures are available and accessible to all Mississippi FFS contracted providers on Telligen's Provider Portal. For additional information, please visit Home | MS DOM (telligen.com)

Fee schedules are provided on DOM's public website Fee Schedules and Rates - Mississippi Division of Medicaid (Home - Mississippi Division of Medicaid (ms.gov)). Refer to DOM's Comprehensive Fee Schedule and individual fee schedules to identify procedure codes that currently have prior authorization requirements.

For additional information on Mississippi Medicaid Prior Authorization requirements, please visit Procedure Code PA Requirement- Mississippi Division of Medicaid (ms.gov)

II. Telligen, an employee-owned company, is the federally designated QIO for Iowa, Illinois, Colorado, and Oklahoma. We perform Utilization Management (UM), Case Management (CM) and Population Health Management (formerly Disease Management) activities tailored for FFS Medicaid beneficiaries, including members in the private sector (e.g., Group Health Insurance companies, Self-Insured Employer Groups, Managed Care Plans, etc.). Telligen's long-established, national Utilization Management (UM) program began as a Medicare Peer Review Organization (PRO) focusing on case review in Iowa (1984 to 2014) and in Illinois (1996 to 2014) – each of which involved *medical necessity* and *quality of care reviews* for the *Medicare Beneficiary Protection Program*. Similar to today's UM work, our first and second level clinical reviewers evaluate utilization management (PA requests) requests to ensure clinical documentation supports medical necessity decisions.

As a Medicaid UM and a Medicare QIO contractor for more than 50 years, Telligen's goal is to continue to improve the quality of care deliver to our customers and through our review process provide appropriate utilization of medically necessary services and resources.

Our Mission

Our mission is to transform lives and economies by improving health.

Our Vision

The vision of Telligen is to be one of the most sought-after companies to transform the health of populations.

Our Core Values

- Ownership
- Integrity
- Ingenuity
- Community.

Office Location

Telligen is headquartered in West Des Moines, Iowa, with offices also in Mississippi, Maryland, Massachusetts, Oklahoma, Colorado, Idaho, Minnesota, and Virginia. Telligen features diverse products and services, working with millions of people nationwide.

Program Goals

Telligen aims to establish a relationship with Mississippi Medicaid FFS providers to develop a UM/QIO coordinated, integrated, and comprehensive approach to the delivery of care and services, to meet or exceed Medicaid beneficiaries' expectations.

Program Objectives:

- Evaluate requests for services by determining the medical necessity, efficiency, appropriateness and consistency with beneficiary's diagnosis and level of care required.
- Optimize resource utilization, promote appropriate care, and improve beneficiary safety and appropriateness of care by fostering safe practices through peer review, concurrent review, risk management, and medical record review.
- Support delivery of the highest quality and continuity of care and improve continuity and coordination of care through ongoing activities performed by UM clinical staff.
- Achieve high satisfaction among beneficiaries and providers by reducing provider burden in improving patient access and improve accessibility to and timeliness of care and services.
- Monitor delivery and access to care, and the quality and appropriateness of services rendered to FFS beneficiaries.
- Improve provider education and communication through feedback via quality and improvement committees, newsletters, surveys, provider portal, and ongoing provider trainings.
- Promote health care delivery in accordance with Mississippi government, Utilization Review and Accreditation Committee (URAC) & National Committee for Quality Assurance (NCQA) accreditation standards, evidence-based practice guidelines, industry standards, and Telligen policies & procedures.

II. Web-Based PA Electronic Review System

Telligen's Web-Based PA system *Qualitrac* is our proprietary, MITA-aligned, mobile friendly, Population Health Management application for DOM's UM program. Reporting, which is a Software as a Service

(SaaS) solution that consists of four defined modules: UM, CM, *Care Management*, and *Quality Measurement* and *Reporting*, is available 24 hours, 365 days per year. The electronic review request system offers providers an easy way to enter, update, and track authorization requests for their patients. Once an authorization request is submitted, and/or updated providers immediately receive an email notification that the system has updated the status of their request, ensuring timely and transparent access to the review process. Outcomes and all correspondence are easily accessible in the portal in real-time to ensure that authorized provider users can access information as they need it to provide the best quality care for Medicaid beneficiaries.

DOM FFS Providers have 24/7 access to *Qualitrac*, and training is provided periodically via webinars by Telligen Education Manager/Provider Relations staff. Telligen's dedicated Mississippi Provider Portal also includes education and training materials to assist providers with understanding the different functions of *Qualitrac*. A provider portal user guide is also available on our website, Home | MS DOM (telligen.com). This guide provides step-by-step instructions for use in completing responsibilities within the Qualitrac health management system.

All authorized users can access our web based (Qualitrac), electronic review system via secured logon. As an authorized user, providers have the ability to view and securely download all data, analytics, or reports that are specific to each provider (e.g., Office Manager) as defined by the user's profile and security access.

For additional questions about *Qualitrac*, user logons, and passwords, please contact our Education Manager, Katrina Merriwether, at 769-366-1602, or by email at kmerriwether@telligen.com.

III. Accessibility & Contact Information

This section provides information about accessing UM/QIO and provides important contact information. At the end of the section, we provide a quick reference guide of web site links and toll-free telephone and facsimile (fax) numbers.

A. Submitting PA Requests

Methods of Submission

All PA requests should be submitted to Telligen through our proprietary, HIPAA-compliant web-based electronic review system, *Qualitrac*, which is accessible via our Mississippi Provider Portal Home | MS DOM (telligen.com) seven (7) days a week – See Figure 1 below.

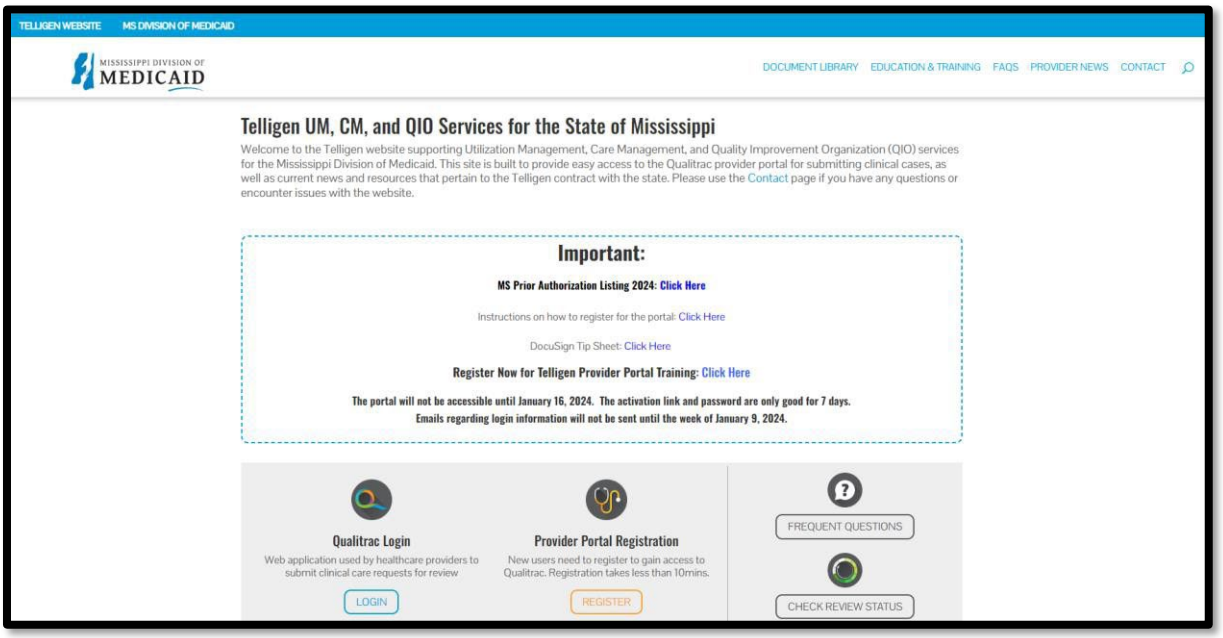


Figure 1 – Telligen Website – Provider Portal

In addition, PA requests and supporting documentation submitted through web portals other than the one established by Telligen (Qualitrac) are also accepted in accordance with DOM requirements. Telligen may also accept supporting documentation for prior authorization requests via facsimile transmission, via electronic upload through the web-based system (Qualitrac) or via a secure email solution: msauthorizations@telligen.com.

Both submission methods are available twenty-four (24) hours a day, seven (7) days a week, including our secure email solution.

B. When you Need Information or Assistance

DOM and Telligen are committed to delivering exceptional services to our customers. We offer a variety of ways for Providers to efficiently obtain the information or assistance you need. In the following sections we identify, by topic or type of assistance needed, useful resources.

C. Questions about UM/QIO

Providers who have questions or want to learn more about DOM UM/QIO program, please refer to the following resources:

A. Resources available on our website: Home | MS DOM (telligen.com)
   a. Frequently Asked Questions (FAQ's): Available under the FAQ's tab.
   b. Education & Training Materials: Copies of training and education presentations are available under *"Education & Training"* tab.
   c. This Provider Manual: Telligen Provider Manual is available under the "Document Library" tab.

B. Mississippi DOM portal: https://medicaid.ms.gov/ MESA Portal for Providers - Mississippi Division of Medicaid (ms.gov)

C. Telligen customer service staff: Our Toll-free number is 1-855-625-7709.

D. Questions about Submitting PA Requests or about Using Qualitrac

Providers can use one of the following resources:

1. *Qualitrac Provider Portal User Guide* for how to submit a PA request is available on our website: Home | MS DOM (telligen.com)
2. Telligen's Website: Home | MS DOM (telligen.com) for PA helpful resources.

E. Checking the Status of a PA Request or Submitting an Inquiry about a Request

Providers can choose one of the following options:

1. Check the status of a previously submitted PA request: Use your secure *Qualitrac* login and check the information on the "Check Review Status" tab.
2. Contact Customer Service during normal business hours.

Qualitrac is available 24 hours a day, seven (7) days a week. Using *Qualitrac* is the most efficient way to obtain information about PA requests. You may also contact our customer service staff, please see "Telligen Customer Service" below for additional information.

F. Telligen Customer Service

Providers also have the option to contact our customer service call center. For general inquiries, inquiries that cannot be addressed through *Qualitrac*, or if you have a complaint, contact our customer service staff. The toll-free number for medical services authorization (Inpatient Hospital /Surgical) inquiries is 855-625-7709. Telligen customer service staff is available Monday through Friday, 8:00am - 5:00pm Central Standard Time (CST), including state holidays except for the following observed holidays:

- New Year's
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day

- Christmas Day

If you call our customer service unit during non-business hours, you have the option of leaving a message. Calls received after non-business hours are answered by customer staff the following business day. If you have a complaint and would prefer to submit a written inquiry, please mail your inquiry to the following address:

Telligen, Inc
Attention: Complaints
715 S. Pear Orchard Rd, Suite 400
Ridgeland, MS 39157

G. Submitting Supporting Documentation

It sometimes will be necessary to submit supporting information for authorization requests. We provide two methods for submitting supporting documentation. You may:

1. Upload additional supporting documentation via Qualitrac), or
2. Fax additional supporting documentation to our toll-free fax number, 1-800-524-5710.

H. Requesting a Reconsideration of a Medical Necessity Adverse Decision

Telligen has a process for conducting reconsiderations. When Telligen renders an adverse medical necessity decision (denial determination) for all or a portion of the requested services, the provider, attending physician, beneficiary/representative responsible party may request a reconsideration. Requests for reconsideration may be submitted using any of the methods described below:

1. Through Qualitrac, or
2. Phone: toll-free number 1-855-625-7709 (option TBD for reconsiderations)
3. Fax: toll-free number 1-800-524-5710
4. U.S. mail, sent to:

Telligen, Inc
Attention: Reconsiderations
715 S. Pear Orchard Rd, Suite 400
Ridgeland, MS 39157

Regardless of the method used for requesting a reconsideration review, Telligen will send written notification to confirm that a reconsideration request was received and allow for additional information to be submitted within ten (10) business days from the date on Telligen's notification letter.

When a request for reconsideration is completed, the reviewing peer reviewer may render one of the following determinations:

1. Uphold the original adverse decision (denial determination).
2. Modify original decision, approving a portion of the services (e.g., authorization of a portion of the services).
3. Reverse the original decision, approving all services (e.g., authorization of all services).

A reconsideration form is available on the provider portal, please see section XII – Applicable forms to see an example of the form.

Providers also have the option of requesting a physician consultation, please see below for additional information.

Physician Consultation

Telligen also has established a process for verbal consultation by the physician reviewer (e.g., Peer Reviewer) with the provider (e.g., Ordering Provider) to obtain additional information when the documentation submitted does not clearly support medical necessity for the service or days requested. Telligen will have peer-to-peer physician reviewers available, as appropriate, for consultation.

All providers can request a physician consultation (peer-to-peer consultation) through the Qualitrac portal or by contacting our customer service call center at 855-625-7709.

Clinical reviewers conducting specialized physician consultation in their area of specialty are currently licensed or certified by the Mississippi state licensing agency or hold a multi-state license with Mississippi privilege and of the same specialty pursuant to Miss. Code Ann. § 41-83-31.

V. Overview of Medical Services

A. Scope of Services

Telligen, Inc in accordance with a contract agreement between the *Office of the Governor*, an administrative agency of the *State of Mississippi,* the *Division of Medicaid* is responsible for the performance of UM/QIO professional services. Under this contract agreement, Telligen is responsible for providing UM & QIO to Medicaid FFS population for the following services:

1. Medical Services
2. Behavioral Health Services (Behavioral Health Services are covered in a separate Provider Manual)
3. Dental Services (Dental Services are covered in a separate Provider Manual)
4. Level of Care Review

Additionally, at the request of DOM, Telligen may conduct reviews of *adverse benefit* determinations (e.g., denials, suspensions, terminations) issued by a Coordinated Care organization (COO) participating in MississippiCAN.

Telligen also provides the following services to support DOM's UM/QIO goals:

1. Peer Review Services
2. Clinical/Medical Consultation
3. Quality Improvement Services

B. Program Components – Medical Services

UM/QIO program includes the following medical services provided by Telligen:

1. Inpatient Hospital Medical/Surgical
2. Outpatient Services and Surgical Procedures
3. Organ Transplant Services
4. Hospice Services
5. Durable Medical Equipment, Appliances, Medical Supplies, and Orthotics and Prosthetics
6. Vision Services
7. Hearing Services
8. Outpatient Physical Therapy, Occupational Therapy and Speech Therapy
9. EPSDT
10. Expanded Physician Services/Office Visits
11. Expanded Home Health Services
12. Private Duty Nursing
13. Prescribed Pediatric Extended Care
14. Physician Administered Drugs and Implantable Drug System Devices
15. Molecular (Genetic) Testing
16. Continuous Glucose Monitoring Service and Remote Patient Monitoring Services
17. Diabetes Self-Management Training
18. Cardiac Rehabilitation Services
19. Innovative programs, Services, or Items
20. Non-Emergency Outpatient Advanced Imaging Services

C. PA Review Requirements

As part of the PA review requirements, Telligen is responsible for determining the medical necessity for inpatient medical/surgical services to eligible Mississippi Medicaid beneficiaries. As a condition for reimbursement, DOM requires that all inpatient hospital admissions receive authorization. Failure to obtain the authorization may result in denial of payment to all providers billing for services, including the hospital and the attending physician.

The general review process is the same for all types of authorization requests. However, the type of authorization request may influence administrative requirements such as the review submission timeframe. Please refer to Table 1 – below provides a detailed of all review areas.

Review Area	Authorization of Inpatient Hospital Medical/Surgical Services
Review Type (s)	• Authorization • Pre-Payment • Retrospective (Urgent)
Submission Method	• Web Portal - Qualitrac • Secure Fax

	• U.S. Mail • Telephone • Email
Description	Telligen to process authorizations for: • All urgent and non-emergency inpatient hospital admissions, as well as inpatient medical/surgical services
Completion Timeframe	Telligen completes authorization requests: • Within one (1) business day of receipt (non-emergency admissions) *Requests received after business hours or during the weekend and holiday are completed the next business day. • Retrospective review requests: Within twenty (20) business days of receipt of a complete request
Who Receives Notification	• Provider & beneficiaries or legal guardian/representative For Approved Services: • Hospital Provider • Attending Physician For Adverse Decisions (Denials, Modification, & reductions) • Hospital Provider • Attending Physician
Review Area	Authorization of Outpatient Services & Surgical Procedures
Review Type(s)	• PA • Authorization • Pre-Payment • Retrospective (Urgent)
Submission Method	• Web Portal - Qualitrac • Secure Fax • U.S. Mail • Telephone • Email
Description	Telligen to process authorizations for: • Elective Surgical Procedures that require PA • Outpatient observation services (72-hour observation stay)
Completion Timeframe	Telligen completes authorization requests: • PA requests: Within two (2) business days of receipt of a complete request • Retrospective review requests: Within ten (10) business days of receipt of a complete request
Who Receives Notification	Beneficiary, and/or legal guardian representative and Providers
Review Types	Maternity Admissions for Delivery/Early Elective Delivery and Reporting

Review Type(s)	• Authorization • PA • Pre-Payment
Submission Method	• Web Portal - Qualitrac • Secure Fax • U.S. Mail • Telephone • Email
Description	Telligen to complete, process, and: • Maintain Maternity Reports for delivery and early elective delivery • Continued Stays • Inpatient Medical/Surgical Services Authorization
Completion Timeframes	Telligen completes authorization requests: • Within one (1) business day from receipt of completed report
Who Receives Notification	Hospital Provider and Attending Physician
Review Types	Authorization of Organ Transplant Services
Review Type(s)	• Authorization • PA • Extensions of Benefits and/or Retrospective Reviews
Submission Method	• Web Portal - Qualitrac • Secure Fax • U.S. Mail • Telephone • Email
Description	Telligen to process authorizations for: • Single organs: Heart, Intestines, Liver, Single Lung, Bilateral Lung,
Completion Timeframes	Telligen completes authorization requests: • PA review requests: Within three (3) business days of receipt of a complete request • Authorization review requests: Within three (3) business days of receipt of a complete request • Extension review requests: Within three (3) business days of receipt of a complete request • Retrospective review requests: Within ten (10) business days of receipt of a complete request • Within one (1) business day (Transplant approval to DOM)
Who Receives Notification	• Requesting Providers (Denial Determinations) • DOM (for transplant approvals) – DOM provides notification to either requesting physician or transplant facility
Review Type	Authorization of Hospice Services
Review Type(s)	• PA review for the initiation of hospice enrollment period (Medicaid beneficiaries only) • PA review for the initiation of hospice enrollment for dual eligible • Hospice Admission review: Medicare & Medicaid

Submission Method	• Continued Stay review: Recertification for continuation of the hospice benefit period (Medicaid beneficiaries only)
Description	Telligen to process authorizations for: • Hospice services: Applicable when beneficiary /legal representative receive Palliative care of the Hospice services rather than active treatment of the terminal condition • Subsequent- continued stay (following the initial ninety (90) day enrollment period) Hospice services: Applicable when beneficiary/legal representative elects to receive palliative care of the hospice services rather than active treatment of the terminal condition
Completion Timeframes	Telligen completes authorization requests: • Within three (3) business days of receipt of a complete review
Who Receives Notification	• Providers and beneficiaries or legal guardian/representative within one (1) day
Review Type	Authorization of Durable Medical Equipment, Medical Supplies, Appliances and Orthotics & Prosthetic Supplies
Review Type(s)	• Authorization • PA • Pre-Payment
Submission Method	• Web Portal - Qualitrac • Secure Fax • U.S. Mail • Telephone • Email
Description	Telligen to process authorizations for: • Supplies • Appliances • Orthotics • Prosthetics
Completion Timeframes	Telligen completes authorization requests: • PA review requests: Within two (2) business days of receipt of a complete review • Retrospective: Within ten (10) business days of receipt of a complete review
Who Receives Notification	• Approved requests: Ordering provider • Denials, modifications, or reductions: Ordering provider, beneficiary, and/or legal guardian representative
Review Type	Authorization of Vision Services (optional benefit under state's Medicaid Program)
Review Type(s)	• Authorization • PA • Pre-Payment
Submission Method	• Web Portal - Qualitrac • Secure Fax

	• U.S. Mail • Telephone • Email
Description	Telligen to process authorizations for: • Certain vision services, such as glasses for beneficiaries who have had eye surgery • One (1) pair of glasses every five (5) years • Eye exams
Completion Timeframes	Telligen completes authorization requests: • PA review requests: Within two (2) business days of receipt of a complete review • Retrospective review requests: Within ten (10) business days of receipt of a complete review
Who Receives Notification	• Approvals: Vision Services Providers • Denials, modifications, or reductions: Vision Services Provider, and beneficiary, or legal guardian/representative (if child)
Review Type	Authorization of Innovative Programs, Services, or Items
Review Type(s)	• Authorization • PA • Pre-Payment • Retrospective
Submission Method	• Web Portal - Qualitrac • Secure Fax • U.S. Mail • Telephone • Email
Description	Telligen to process authorizations for: • UM of programs, services or items that could result from CMS State Plan Amendments (SPA's), federal, state laws, and regulations, DOM administrative code, and policy revisions, including program exceptions
Completion Timeframes	Telligen completes authorization requests: • PA review requests: Within three (3) business days of receipt of a complete review • Retrospective review requests: Within ten (10) business days of receipt of a complete review
Who Receives Notification	• Approvals: Ordering and requesting provider • Denials, modifications, or reductions: Ordering and requesting provider, and beneficiary, or legal guardian/representative (if child)
Review Type	Authorization of Hearing Services
Review Type(s)	• Authorization • PA • Pre-Payment
Submission Method	• Web Portal - Qualitrac • Secure Fax • U.S. Mail • Telephone

	• Email
Description	Telligen will: • Follow regulations covering hearing services in Title 23, Part 218 of the administrative code. • Reviews are for beneficiaries under 20 and includes codes approved by DOM and covered by EPSDT Program • Beneficiaries who meet the age requirement and when medical necessity may get one hearing aid per fiscal year (July 1 through June 30)
Completion Timeframes	Telligen completes authorization requests: • PA review requests: Within two (2) business days of receipt of a complete review • Retrospective review requests: Within ten (10) business days of receipt of a complete review
Who Receives Notification	• Approvals: Ordering Provider & Requesting Provider • Denials, modifications, or reductions: Requesting and ordering provider, and beneficiary, or legal guardian/representative (if child)
Review Area	Expanded Early and Periodic Screening
Review Type(s)	• Authorization • PA • Pre-Payment
Submission Method	• Web Portal - Qualitrac • Secure Fax • U.S. Mail • Telephone • Email
Description	Telligen to process authorizations to ensure: • Approved diagnostic and treatment services are required to correct or ameliorate physical, mental, psychosocial, and/or behavioral health conditions discovered by a screening.
Completion Timeframes	Telligen completes authorization requests: • PA review requests: Within two (2) business days of receipt of a complete review • Retrospective review requests: Within ten (10) business days of receipt of a complete review
Who Receives Notification	• Approvals: Ordering Provider & Requesting Provider • Denials, modifications, or reductions: Requesting and ordering provider, and beneficiary, or legal guardian/representative (if child)
Review Type	Authorization for Expanded Physician Services/Office Visits
Review Type(s)	• Authorization • PA • Pre-Payment
Submission Method	• Web Portal - Qualitrac • Secure Fax • U.S. Mail

	• Telephone • Email
Description	Telligen to process authorizations to ensure: • Approve diagnostic and treatment services are required to correct or ameliorate physical, mental, psychosocial, and/or behavioral health conditions discovered by screening.
Completion Timeframes	Telligen completes authorization requests: • PA review requests: Within two (2) business days of receipt of a complete review • Retrospective review requests: Within ten (10) business days of receipt of a complete review
Who Receives Notification	• Approvals: Attending Physician • Denials, modifications, or reductions: Attending Physician and beneficiary, or legal guardian/representative (if child)
Review Type	Authorizations for Expanded Home Health Services
Review Type(s)	• PA (initial certification) • Continued Saty (conduct at 60-day intervals) • Retrospective: Applicable to beneficiaries who receive retroactive eligibility
Submission Method	• Web Portal - Qualitrac • Secure Fax • U.S. Mail • Telephone • Email
Description	Telligen to process authorizations for: • PA services delivered in the home beyond the 25th visit; EPSDT diagnostic and treatment services required to correct or ameliorate physical, mental, psychosocial, and/or behavioral health conditions discovered by screening. • Continued Stay: Re-Certify services delivered in the home beyond the 25th visit • Retrospective: Re-Certify services delivered in the home beyond the 25th visit
Completion Timeframes	Telligen completes authorization requests: • PA review requests: Within two (2) business days of receipt of a complete review • Continued Stay review requests: Within two (2) business days of receipt of a complete review • Retrospective review requests: Within ten (10) business days of receipt of a complete review
Who Receives Notification	• Approvals: HHA & Attending Physician • Denials, modifications, or reductions: HHA, Attending Physician and beneficiary, or legal guardian/representative (if child)
Review Type	Authorizations for Private Duty Nursing
Review Type(s)	• PA (initial certification) • Continued Stay (conduct at 60-day intervals)

	• Retrospective: Applicable to beneficiaries who receive retroactive eligibility
Submission Method	• Web Portal - Qualitrac • Secure Fax • U.S. Mail • Telephone • Email
Description	Telligen to process authorizations for: • PA & Retrospective reviews: Authorize services through EPSDT expanded program for EPSDT eligible beneficiaries who require more individual and continuous care than is available under the home and health benefit • Re-Certify services through the EPSDT expanded program for EPSDT eligible beneficiaries who require more individual and continuous care than is available under the home health benefit
Completion Timeframes	Telligen completes authorization requests: • PA: Within ten (10) days of receipt of a complete review • Continued Stay: Within ten (10) days of receipt of a complete review • Retrospective: Within ten (10) days of receipt of a complete review
Who Receives Notification	• Approval: PDN Agency & Attending Physician • Denials, modifications, or reductions: PDN, Attending Physician and beneficiary, or legal guardian/representative (if child)
Review Type	Authorizations for Prescribed Pediatric Extended Care Services
Review Type(s)	• PA (admission review) • Continued Stay • Retrospective: Applicable to beneficiaries who receive retroactive eligibility
Submission Method	• Web Portal - Qualitrac • Secure Fax • U.S. Mail • Telephone • Email
Description	Telligen to process authorizations to ensure: • Authorize services through EPSDT expanded program for EPSDT eligible beneficiaries who require more individual and continuous care than is available under the home and health benefit
Completion Timeframes	Telligen completes authorization requests: • PA: Within ten (10) days of receipt of a complete review • Continued Stay: Within ten (10) days of receipt of a complete review

	• Retrospective: Within ten (10) days of receipt of a complete review
Who Receives Notification	• Approval: PPEC Agency & Attending Physician • Denials, modifications, or reductions: PDN, Attending Physician and beneficiary, or legal guardian/representative (if child)
Review Type	Disabled Children Living at Home or "Katie Beckett" Group Level of Care Determinations
Review Type(s)	Hospital LOC ICF/IID LOC
Submission Method	Web Portal - Qualitrac
Description	Telligen will evaluate cost-effectiveness of care at home (for children aged 18 or under) compared to care provided in a medical institution, as determined by DOM
Completion Timeframes	Within twenty (20) calendar days of receipt
Who Receives Notification	Providers and beneficiaries or legal guardian/representative
Review Type	Long-Term Care Clinical Eligibility Determinations
Review Type(s)	PAS Level of Care
Submission Method	Electronic or Mail
Description	Clinical eligibility for elderly and physically disabled applicants applying for or being recertified for DOM's long-term care services
Completion Timeframes	Within two (2) business days or receipt
Who Receives Notification	DOM
Review Type	Authorization for Physician Administered Drugs (PAD) & Implantable Drug System Devices
Review Type(s)	• PA • Authorization • Retrospective
Submission Method	• Web Portal - Qualitrac • Secure Fax • U.S. Mail • Telephone • Email
Description	Components of the three distinct areas of physician-administered drugs and implantable drug system devises
Completion Timeframes	Telligen completes authorization requests: • PA: Within three (3) days of receipt of a complete review of a complete review • Retrospective: Within ten (10) days of receipt of a complete review
Who Receives Notification	• Approval: Requesting Provider • Denials, modifications, or reductions: Requesting provider and beneficiary, or legal guardian/representative (if child)
Review Type	Molecular Genetic Testing
Review Type(s)	• Authorization • PA • Pre-Payment

	• Retrospective
Submission Method	• Web Portal - Qualitrac • Secure Fax • U.S. Mail • Telephone • Email
Description	Testing that identifies changes in the chromosomes, genes or proteins that confirms or rules out a genetic condition
Completion Timeframes	Telligen completes authorization requests: • PA: Within three (3) days of receipt of a complete review of a complete review • Authorization & Pre-Payment: Within ten (10) days of receipt of a complete review
Who Receives Notification	• Approval: Requesting Provider • Denials, modifications, or reductions: Provider and Requesting provider and beneficiary, or legal guardian/representative (if child)
Review Type	Authorization for Continuous Glucose Monitoring and Remote Patient Monitoring Services
Review Type(s)	• PA • Authorization • Pre-Payment • Retrospective
Submission Method	• Web Portal - Qualitrac • Secure Fax • U.S. Mail • Telephone • Email
Description	Telligen to process authorizations to ensure: • Authorize rental of blood glucose monitor up to amount of purchase when beneficiary has these diagnosis: insulin-dependent diabetes mellitus, non-insulin dependent diabetes mellitus • Authorize remote patient monitoring for implantable pacemakers, defibrillators, cardiac monitors, loop recorders and external mobile cardiovascular telemetry (beneficiary must meet chronic conditions outlined in Title 23)
Completion Timeframes	Telligen completes authorization requests: • PA: Within three (3) days of receipt of a complete review of a complete review • Retrospective: Within ten (10) days of receipt of a complete review
Who Receives Notification	• Approval: Provider and Requesting Provider • Denials, modifications, or reductions: Provider and Requesting provider and beneficiary, or legal guardian/representative (if child)
Review Type	Diabetes Self-Management Training (DSMT) Services

Review Type(s)	• PA • Authorization • Pre-Payment • Retrospective
Submission Method	• Web Portal - Qualitrac • Secure Fax • U.S. Mail • Telephone • Email
Description	Telligen to process authorizations to ensure: • Authorize DSMT when medically necessary, and approved by a Physician, PA, or NP Includes one initial training per lifetime and follow-up training as outlined by Title 23
Completion Timeframes	Telligen completes authorization requests: • PA: Within three (3) days of receipt of a complete review of a complete review • Retrospective: Within ten (10) days of receipt of a complete review
Who Receives Notification	• Approval: Provider and Requesting Provider • Denials, modifications, or reductions: Provider and Requesting provider and beneficiary, or legal guardian/representative (if child)
Review Type	Cardiac Rehabilitation Services
Review Type(s)	• PA • Authorization • Pre-Payment • Retrospective
Submission Method	• Web Portal - Qualitrac • Secure Fax • U.S. Mail • Telephone • Email
Description	Telligen to process authorizations to ensure: • Authorize services for phase II cardiac rehab services for beneficiaries 18 and over for one of the six qualifying episodes as outlined in Title 23 • Authorize up to 36 phase II cardiac rehab sessions per 12 months • Services are furnished in outpatient hospital setting with physician supervision
Completion Timeframes	Telligen completes authorization requests: • PA: Within three (3) days of receipt of a complete review of a complete review • Retrospective: Within ten (10) days of receipt of a complete review
Who Receives Notification	• Approval: Provider and Requesting Provider

	• Denials, modifications, or reductions: Provider and Requesting provider and beneficiary, or legal guardian/representative (if child)

In the following sections we explain the review process for:

1. Prospective Review Requests – PA or Precertification
2. Concurrent Review Requests (Continued Stay)
3. Reconsideration Review Requests

Telligen PA Review Process

Auto-Authorization

When a PA request is initially entered in Qualitrac the system applies a series of business rules or clinical algorithms to ensure review meets medical necessity criteria for certain diagnosis and clinical conditions. This process is integrated with InterQual clinical decision support guidelines, allowing the provider to enter and upload applicable clinical information resulting in an immediate approval or referral to a nurse reviewer (see VI - First Level Review) if submitted request is complete (e.g., Provider submits all required supporting information).

There are two outcomes of the auto-authorization process (for which providers receive immediate notification of decisions):

1. Approval of the service or procedure via the clinical algorithm.
2. Failure to meet auto-authorization results in an automatic referral to a nurse for a manual review.

Telligen first level reviewer (nurse reviewer) will manually review each PA and prepayment review request received that is not certified by DOM approved rules-based system (auto-authorization), along with any required supporting documentation to support the need for services.

First Level Medical Necessity Review

Upon receiving a PA request, Telligen will confirm Provider and Medicaid member eligibility through Qualitrac or DOM's Medicaid Management Information System (MMIS). Once eligibility is confirmed, our nurse reviewers will conduct a review of the clinical information against approved clinical criteria (e.g., InterQual) to determine the medical necessity of the services under review. The nurse review process is described in section VII – First & Second Level Review Process.

When applicable policies are satisfied the nurse approves the services as proposed and approval notifications are generated in accordance with DOM requirements. For information on our review processing and notification process, please see section VI – Review Processing (Completion) Timeframes. Telligen generates notifications as follow:

1. Electronic notifications are generated to providers who submit requests through Qualitrac. When a review determination is rendered, Qualitrac immediately generates an email notification to the provider who requested the PA review.
2. If a provider submits the PA request by fax, the approval notification is mailed to the provider.

Referral to a Peer Reviewer

As explained in section VII - First & Second Level Review Process, Telligen first level reviewers may not render an adverse determination. They refer to a peer reviewer any PA request they cannot approve.

Second Level (Peer Review) Review Process

When we schedule a peer review every effort is made to match the case being reviewed to a physician of the same specialty. During the review process, the peer reviewer uses his/her clinical experience and judgment, see section VII – First & Second Level Review Process for additional information.

D. Review Determinations

In accordance with 42 C.F.R. Subpart E, Telligen's PA process includes a mechanism to ensure all ordering and referring physicians or other professionals providing services under the State plan are enrolled as a participating Medicaid provider, prior to authorizing review requests.

Telligen nurses, physicians, and other licensed health professionals conducting reviews of medical services, and other clinical reviewers conducting specialized reviews in their area of specialty are licensed or certified by the Mississippi state licensing agency or hold a multi-state license with Mississippi privilege.

Approvals

Telligen's PA process includes the issuance of medical necessity approvals. For approved PA requests, Qualitrac will generate an approval (e.g., Treatment Authorization Number (TAN)) if requested service meets all policy and medical criteria necessary for authorization of the services requested.

Pending Additional Information

Telligen reviews all PA requests to ensure supporting information is received, which allows review staff to determine if services meet DOM medical necessity requirements. PA requests are placed in a "pause" status (e.g., "Pending Additional Information") if the provider submits a request for authorization with incomplete, inadequate, or ambiguous information. When a PA request cannot be completed with submitted information, Telligen *support staff* may attempt to contact requesting provider to seek clarification or request that the provider submit all required information, including additional supporting clinical information, as necessary.

When PA requests are on "pause" providers will receive written notices via *Qualitrac* or via facsimile notification. In the event a provider is unable to access *Qualitrac* or receive written facsimiles, Telligen support staff will make every effort to contact the ordering provider to verbally notify them of any pended reviews.

All PA requests may remain on "pause" (pending) for up to ten (10) business days until additional information has been received. If additional supporting information is not received within ten (10) business days, Telligen may issue a technical denial.

Technical Denials

PA requests are technically denied when additional information is not received by the tenth (10th) business day of the review's "pause" status (pending status) and Telligen is unable to complete the review.

Telligen will issue a technical denial for services when the case does not meet Federal and State laws and regulations, DOM policies and/or formal memorandums or is technically insufficient.

Denials

In accordance with DOM contract requirements, Telligen complies with 42 C.F.R. § 438.210 (b)(3), which requires that any decision to deny a service request (e.g., PA request) or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the Member's medical, behavioral health, and/or long-term services and supports needs.

All denials, modifications, or reductions in services by the second level reviewer are made by a physician reviewer or appropriate health care professional (dentist, orthodontist, etc.) licensed in

the State of Mississippi and of the same specialty as a result of the second level review pursuant to Miss. Code Ann. § 41-83-31.

Reconsiderations

In accordance with DOM requirements, Telligen conducts reconsiderations and make determinations upholding, modifying, or reversing the review outcome by taking into consideration all pertinent information, including any additional or new information that may be presented during the reconsideration.

Telligen will provide, at a minimum, a reconsideration process for reviews in which the decision is a:

1. Denial, modification, or reduction of services/items based on medical necessity.
2. Denial based on Federal and State laws and regulations, DOM policies, and/or formal memoranda that excludes coverage.
3. Other adverse decisions as defined by DOM.

Providers may submit a reconsideration request via Qualitrac, telephone, facsimile, or mail. For reconsideration contact information, please see section IV – Accessibility & Contac Information above.

All PA review determinations are issued by Telligen in accordance with DOM requirements and within review timeframes.

E. Clinical Criteria for UM Decisions

When conducting medical necessity determinations (UM decisions), our Mississippi licensed clinicians apply InterQual® criteria (IQ) in accordance with DOM policy. When InterQual® criteria is not available, then Telligen contracted licensed clinicians apply nationally recognized standards for the clinical criteria in all review types, as previously approved by DOM.

All PA (e.g., UM) determinations are made by Mississippi licensed clinicians in accordance with 42 C.F.R. Subpart E, and the review process includes an administrative verification to ensure all ordering and referring physicians or other professionals providing services under the State plan are enrolled as a participating Medicaid provider, prior to authorizing review requests.

Once review determinations are completed by Telligen, written notices are made available to providers through Qualitrac or via facsimile notification if applicable. Telligen may also provide verbal notification of any reviews that are on "pause" status (e.g., pended) to those providers that are unable to use Qualitrac or receive written facsimile notifications. All written notices are provided in accordance with DOM *Notification Timeframe* requirements.

Please be aware that Telligen's determination does not guarantee Medicaid payment for services or the amount of payment for Medicaid services. Eligibility for and payment of Medicaid services are subject to all terms, conditions, and limitations of the Medicaid program.

Additionally, Telligen may be disclosed criteria to providers or beneficiaries as legally required by DOM.

For information on how to go about requesting a copy of the criteria, please visit Telligen's DOM portal at Home | MS DOM (telligen.com).

F. Types of Review

In this section we summarize the various types of review. For information about review completion timeframes, please see section VII- Review Processing Timeframes.

1. Prospective Review - Includes the review of medical necessity for the performance of services or scheduled procedures before the service is rendered or before admission. Also referred to as prior authorization or precertification.
2. Concurrent Review - Includes a review of medical necessity decisions made while the patient is currently in an acute or post-acute setting or when an episode of care needs to continue beyond the initial authorization period. Also referred to as a continued stay review or continuing authorizations, which may include Member authorizations obtained from a Coordinated Care Organization (CCO).
3. Retrospective Review - Reserved for medical emergent conditions or situations where the provider has insufficient information required to submit a prospective review. Retrospective reviews shall include review of service documentation to confirm medical emergent condition or situation along with medical necessity.
4. Reviews related to Retroactive Eligibility - Includes a review for a beneficiary that was not eligible for Medicaid benefits at the time of service in which the authorization request is submitted within ninety (90) days of the system add date of the eligibility determination, in accordance with Administrative Code Part 200, Rule 3.3.
5. Prepayment Review - Includes review of documentation of the services rendered that is conducted prior to the provider receiving reimbursement. This is a distinct and separate review process from prospective reviews.
6. Post-Payment Review - Includes review of medical documentation to ensure medical necessity. May also be referred to as post-utilization review. Refer to Article II.G.1.a. All Patient Refined Diagnosis Related Groups (APR-DRG) Validation.
7. Level of Care Review - A determination made by factoring in an individual's physical, functional, mental, social, and/or emotional capacity to meet his or her own needs and is not solely based on diagnosis. Level of care review requirements will be discussed on Telligen's Behavioral Health Manual.

VI. Review Processing (Completion) Timeframes

The review processing timeframe for completing a medical service PA request depends on the type of review. The completion timeframe also may depend on whether a physician peer reviewer (PR) must review the request. The completion time is measured from the date we receive all required supporting documentation. Review processing timeframes are noted in table below.

Medical Services Review Processing Timeframes			
General Services	Prospective	Concurrent	Retrospective
Inpatient Hospital/Surgical	1	1	20
Outpatient Services/Surgical Procedures	2	N/A	10
Organ Transplant Services	3	3	10
Hospice Services	3	3	N/A
Durable Medical Equipment, Appliances, Medical Supplies, and Orthotics and Prosthetics	2	N/A	10
Vision Services	2	N/A	10
Hearing Services	2	N/A	10
Outpatient Physical Therapy, Occupational Therapy and Speech Therapy	2	2	10
EPSDT	2	N/A	10
Expanded Physician Services/Office Visits	2	N/A	10
Expanded Home Health Services	2	2	10
Private Duty Nursing	3	10	10
Prescribed Pediatric Extended Care	3	10	10
Physician Administered Drugs and Implantable Drug System Devices	2	N/A	10
Molecular (Genetic) Testing	3	N/A	10
Continuous Glucose Monitoring Service and Remote Patient Monitoring Services	3	N/A	10
Diabetes Self-Management Training	3	N/A	10
Cardiac Rehabilitation Services	3	N/A	10
Non-Emergency Outpatient Advanced Imaging Services	2	N/A	5

Innovative Programs, Services, or Items	3	N/A	10

Notification Timeframes

Telligen notifies providers and beneficiaries or legal guardians/representatives of review determinations within one (1) business day from the date the determination is completed. Notification timeframes are noted in the table below.

Notification Timeframes			
General Services	Prospective	Concurrent	Retrospective
Inpatient Hospital/Surgical	1	1	1
Outpatient Services/Surgical Procedures	1	N/A	1
Organ Transplant Services	1	1	1
Hospice Services	1	1	N/A
Durable Medical Equipment, Appliances, Medical Supplies, and Orthotics and Prosthetics	1	N/A	1
Vision Services	1	N/A	1
Hearing Services	2	N/A	10
Outpatient Physical Therapy, Occupational Therapy and Speech Therapy	1	1	1
EPSDT	1	N/A	1
Expanded Physician Services/Office Visits	1	N/A	1
Expanded Home Health Services	1	1	1
Private Duty Nursing	1	1	1
Prescribed Pediatric Extended Care	1	1	1
Physician Administered Drugs and Implantable Drug System Devices	1	N/A	1
Molecular (Genetic) Testing	1	N/A	1
Continuous Glucose Monitoring Service and Remote Patient Monitoring Services	1	N/A	1
Diabetes Self-Management Training	1	N/A	1
Cardiac Rehabilitation Services	1	N/A	1
Non-Emergency Outpatient Advanced Imaging Services	1	N/A	1
Innovative Programs, Services, or Items	1	N/A	1

VII. First & Second Level of Review Process

Telligen conducts authorization reviews that include two (2) levels of review for all services as described below:

1. Medical Services
2. Behavioral Health Services
3. Dental Reviews, and
4. Level of care Determinations

The levels of review are distinguished by their:

- Clinical credentials
- Determinations/decisions they may render and how they render those decisions.

With the exception of reconsideration reviews, all PA review requests not approved through our clinical rules-based system (auto-authorization) are processed by first level reviewers (e.g., Nurse or other licensed health professional). All review determinations are entitled to a reconsideration review, which are addressed by Telligen second level reviewers.

A. First Level Review – Nurse Initial Screening

Telligen First Level Reviewers (Nurse Reviewers) are Mississippi licensed registered nurses with clinical knowledge and experience in utilization review. During the review of PA requests, first level reviewers apply Federal and State laws and regulations, DOM policies and/or formal memorandums, and DOM approved criteria (e.g., InterQual) to determine if proposed service is appropriate and medically necessary.

First level reviewers may render one of the following determinations:

1. Authorization of services by the first level reviewer.
2. Authorization through the automated rules system (auto-authorization), when appropriate.
3. Pending of the review based on incomplete, inadequate, or with ambiguous information that results in a request for additional information from the provider.
4. Technical denial of the request due to Federal and State laws and regulations, DOM policies and/or formal memorandums.
5. Referral to second level review.

Telligen nurse reviewers may not deny, reduce, or modify a service authorization request. Requests that cannot be approved on the basis of complete clinical information are referred to second level review, physician peer reviewer (see below).

B. Second Level Review – Peer Review

Physician Peer Reviewers review all:

1. PA requests that cannot be approved by a first level reviewer.
2. Requests for reconsideration of an adverse decision (denial determination).

All requests that cannot be approved at the first level of review are referred for a second level review. Second Level Reviews (e.g., Physician Peer Reviewer) are conducted by a licensed physician or appropriate health care professional (dentist, orthodontist, etc.) licensed in the state of Mississippi, in accordance with MS Code 41-83-31.

All peer review determinations are based on:

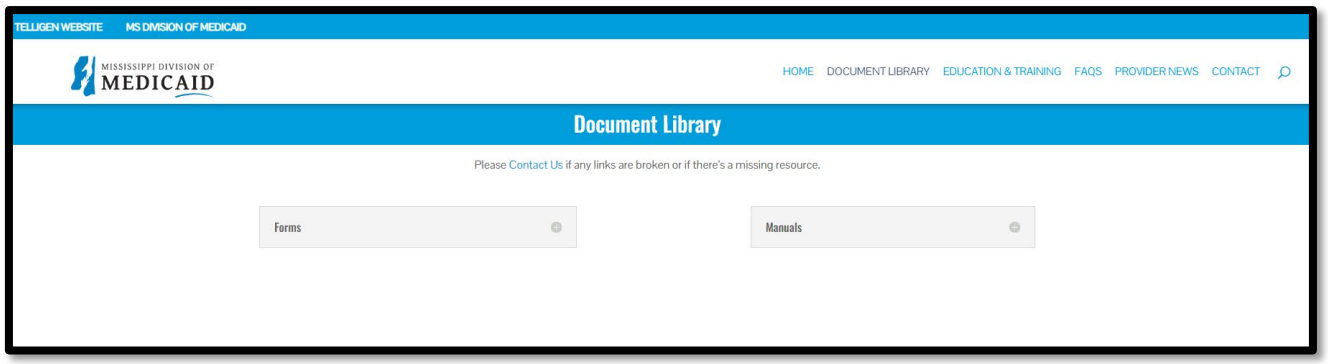
1. Documentation that supports the prognosis and medical appropriateness for the setting;
2. Evidence-based guidelines;
3. Consideration of unique factors associated with a patient's episode of care;
4. Local healthcare delivery system infrastructure; and
5. Clinical experience, judgement, and accepted standards of healthcare.

Second Level Reviewers may render one of the following determinations:

1. Authorization of services by the second level reviewer.
2. Denial, modification, or reductions of services by the second level reviewer.
3. Pending of the review based on incomplete, inadequate, or with ambiguous information that results in a request for additional information from the provider.
4. Technical denial of the request due to Federal and State laws and regulations, DOM policies and/or formal memorandums.

VIII. Applicable Forms

Please visit the Document Library on our website to access applicable forms needed to accompany your authorization submissions. https://msmedicaid.telligen.com/document-library/ - See Figure 2 below.



IX. Definitions

Glossary

1. Continued Stay Reviews - Continued stays reviews are subsequent reviews performed to determine if continuation of services is medically necessary and appropriate. The Contractor shall have the capability and established procedures to receive continued stay review requests for additional inpatient days of care for admissions previously approved and conduct prior authorizations on or before the next review point (i.e., the last approved day).
2. Early and Periodic Screening and Diagnostic Screening - The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is a federally mandated service which provides preventive and comprehensive health services for children under 21 years of age. It provides critical services to improve the health of infants, children, and adolescents.
3. Fee-for-Service - is a system of health insurance payment in which a doctor or other health care provider is paid a fee for each particular service rendered, rewarding medical providers for volume and quantity of services provided, regardless of the outcome.
4. Non-Emergency Admission Reviews - Non-emergency admissions are for planned or elective admissions and the beneficiary has not been hospitalized.
5. Urgent Admission Reviews - Urgent admissions are defined as admissions to an inpatient hospital setting resulting from the sudden onset of a medical condition or injury requiring acute care and manifesting itself by acute symptoms of sufficient severity that the absence of immediate inpatient hospital care could result in:
   - Permanently placing the beneficiary's health in jeopardy;
   - Serious impairment to bodily function; or
   - Serious and permanent dysfunction of any bodily organ or part, or other serious medical consequence.
6. Retrospective Reviews - Retrospective review is defined as a review performed when a service has been provided and no authorization had been given. DOM reserves retrospective reviews for medical emergent conditions or situations where the provider has insufficient information required to submit a prospective review. Retrospective reviews shall include a review of service documentation to confirm medical emergent condition or situation along with medical necessity.
7. Weekend and Holiday Admission Reviews - Weekend admissions are when the beneficiary was admitted on a weekend. Holiday admissions are defined as those admissions where a beneficiary is admitted on a state-observed holiday.