

Frequently Asked Questions (FAQs) for Children’s Habilitation Intervention Service (CHIS) Reviews Submitted in Qualitrac

How do I set up my account to use the Qualitrac Portal?

Please navigate to the Telligen Medicaid Services website to download the Security Admin Registration Form. Complete the form and return to the address indicated. You may also refer to the following link: http://idmedicaid.telligen.com/sites/default/files/documents/documentlibrary/ProviderPortal_SecurityAdminRegistrationForm.docx. If you need assistance with completing the form, please contact CHIS@telligen.com.

How do I update my address, phone number, or other provider information with Telligen?

Telligen receives updated provider data from DXC daily. Please ensure your provider enrollment information is updated with DXC in order to ensure Telligen has the correct information. Contact information for Provider Relations Consultants (PRCs) with DXC in your region can be found at: <https://www.idmedicaid.com/Lists/Provider%20Relations%20Consultants%20PRC/AllItems.aspx>

How can I submit my review if I’m having issues with my Qualitrac account or in the process of setting it up?

Fax is the alternate way to submit documents to Telligen. You may fax to 1-866-539-0365. It is recommended you then contact Telligen at CHIS@telligen.com or 208-433-7500 to ensure your fax was received. Using the Qualitrac portal is the recommended method because it is faster, more efficient, and more secure.

What are the review timeframes for PA requests and Crisis PA requests?

Regular PA requests are subject to a 10-business day/14-calendar day turnaround time. Crisis requests have a 3-business day turnaround time. If the request submitted does not include all the required documentation or not enough documentation to make a decision, Telligen will reach out to request the needed information via a Request for Information letter. This pauses the review time. Once the needed information is received, the review timeframe does not start over, but continues with the remaining days left in the 10-business day or 3-day time period.

What days are non-business days for Telligen?

Telligen’s offices are closed New Year’s Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day and the day after, and Christmas Day.

What is a “Request for Information” letter?

During Telligen’s review of your service request, if any required documentation is missing or additional information is needed to finalize the request, you will receive a notification and “Request for Information” or “RFI” letter. The letter will detail what you need to submit to Telligen and requests that you include a copy of the RFI letter with your submission. If you have questions about the needed information or how to submit it, you may contact Telligen at CHIS@telligen.com or at 866-538-9510. Once an RFI is issued, the time clock for Telligen’s 10-business day review period pauses until the information is received.

How do I add additional documentation in response to a Request of Information (RFI)?

To respond to an RFI, you will need to upload the additional or corrected documentation requested. To do this, open the appropriate Case ID, scroll down to the documentation panel, and click the orange “+

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Add” button on the right-hand side. If your response to the RFI doesn’t include an additional document to upload, you may email CHIS@telligen.com to discuss your response with Telligen.

What categories do I select when I submit my requests in Qualitrac?

For prior authorized services (Behavioral Intervention, Interdisciplinary Training, Habilitative Skill Building, Prior Authorization Amendments, and the annual ACTP), select “Outpatient Therapy Intervention” as the Review Type, “Community” as the Place of Service, and “Prospective” as Timing. For “Type of Service” select the option that applies to your request. If it is an annual request, select “Children’s Habilitation Intervention Services – Initial/Annual”, if it is a 4-month review, select “Children’s Habilitation Intervention Services – 4 Month Review”, if it is a PA Amendment, select “Children’s Habilitation Intervention Services – Amendment”, and so on.

For retrospective authorizations (Initial ACTP, Screening, and Crisis Intervention), select “Outpatient Therapy Intervention” as the Review Type, “Community” as the Place of Service, and “Retrospective” as Timing. For “Type of Service” select the option that applies to your request. If you are submitting an Initial ACTP and/or Screening, select “Children’s Habilitation Intervention Services – Initial/Annual”. If you are submitting a Crisis Intervention request, please select “Children’s Habilitation Intervention Services – Crisis” as your Service Type to ensure the review turnaround time is 3 business days instead of 10.



What is the “Eligibility Comment” box in the “Coverage Panel” section for?

The Eligibility Comment box in the Coverage section refers to the member’s Medicaid eligibility, not their eligibility for Intervention Services. You do not need to type anything here unless the member’s Medicaid is not active. For example, if you know their eligibility will be active in the next few days, you could still submit the request explaining that situation.

Should I submit my ACTP, Screening, and services all on one request?

Requests for different date ranges should be on their own request. Initial ACTPs and Screenings should be on their own requests because they are retrospective and for the date range that they were completed. Requests for 96 units/24 hours in 30 days prior to your services starting should also be on their own request. Crisis Intervention is also only for up to 30 days and should be its own request. Behavioral Intervention, Habilitative Skill Building, Interdisciplinary Training and annual ACTPs are all for 4-month timespans, so they should have their own request. Please remember to include all required supporting documentation for your initial services request including the ACTP, even though you will have also submitted separately. Prospective annual ACTPs should be requested on the same case as your 8-month service request.

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What documentation do I submit with my prospective annual ACTP request?

It is recommended this be submitted with your 8-month service request. You will upload the required documentation for that request, enter the codes for your services (such as H0004 and associated modifier if applicable), and enter H0032 (and associated modifier) for the annual ACTP. If you submit your annual ACTP request separately from your 8-month service request, please remember that it **must** still be submitted as a prior authorization, prior to starting the work. You can attach a document stating that you are requesting your annual ACTP prior authorization, the code and modifier, the units needed, and the dates requested.

How do I submit a request for 96 units (24 hours) for 30 days and when is it allowable?

The 96 units in 30 days can be requested for members that are coming off a transitional PA or have not received services in the past year, or 365 days. If these requirements are met, the 96 units can start the same day you submit your ACTP.

These will also be submitted as a separate case because they are for a separate date range as other requests for ACTPs and/or screenings and 4-month service authorization. The “Service Start Date” will be the date you submitted your ACTP and the end date would be either 30 days later or the date you intend the 4-month of services to start, whichever is sooner. For example, if you submitted the ACTP on March 1, 2020 and your services are going to start March 30, 2020, your service start and end dates for the 96 units will be March 1, 2020 through March 30, 2020. If you submit your ACTP on March 1, 2020 and your services are going to start March 20, 2020, then your service start and end dates will be March 1, 2020 through March 19, 2020.

How do I submit a request that allows for multiple providers with different qualifications to provide the approved hours per week interchangeably?

Please follow the standard process for submitting the prior authorization request and documentation to Telligen for review and approval. Providers must clearly indicate that they are only asking for “x” hours per week to be used interchangeably between multiple provider qualification types from week to week and ARE NOT requesting “x” hours per week each for both provider qualification types. Example:

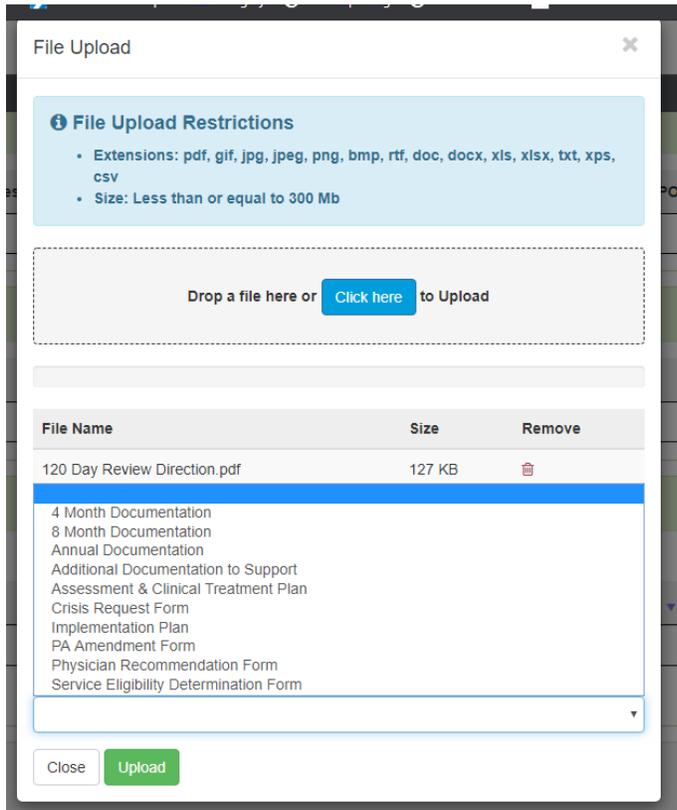
- H0004 (no modifier) 10 hours per week
- H0004 (HN) 10 hours per week
- Justification must be clear in the Clinical Recommendations section of the participant’s ACTP to justify the need for the additional provider qualifications and make it clear that **only** 10 hours per week are being requested, not a total of 20.

If this is approved, providers **may not** seek reimbursement for more than the TOTAL number of clinically recommended units/hours of CHIS authorized per week. This will be monitored and reviewed during QA/QI reviews. For example, in the above example, the provider MAY ONLY BILL for a maximum total of 10 hours per week of CHIS but may use either modifier for the authorized provider qualification, depending on the provider qualification of the staff who actually rendered the service.

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What documentation type do I select in the ‘Documentation’ panel?

There are many documentation types available in Qualitrac. Please select the type that best fits the document you are uploading. If you are unsure what type the document you are uploading fits into, you may select “Additional Documentation to Support”.



How do I request more than 21 units for an ACTP?

To request over 21 units for the ACTP, enter the service code H0032 and appropriate modifier and enter the total number of units, including the 21, in your request. For example, if you need an extra 10 units, please enter a total of 31 units.

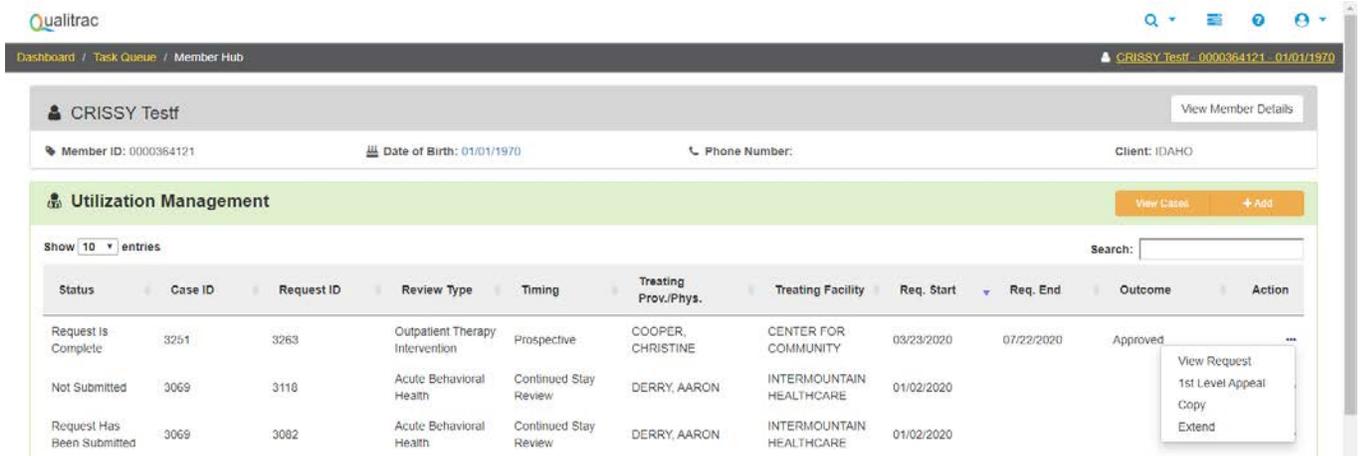
Can I copy demographic information onto a new case when I’m submitting multiple requests for the same Medicaid member at the same time, so I don’t have to retype everything?

Yes. Telligen has a “Copy” feature that allows you to copy a previous request and start a new one. Please be sure to update sections as necessary to reflect your current request accurately. **Please also note that this feature is only available once the previous case’s review has been completed by Telligen.** For example, if you submit a case today and want to submit an additional case for that member right away, that feature will not be available. The Panels starting with Dates of Service and below, can be edited/updated to reflect the current request. Updated documentation will need to be added to the case. Continue through the standard process to complete the review. **Please note that the “Type of Service” cannot be changed from the request you copied. Best practice would be to use the copy feature starting your annual request so that you can copy your initial request and the new request will**

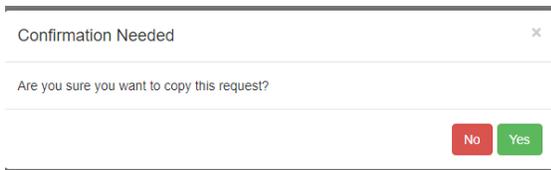
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have the correct service type, you can copy your 4-month request and it will have the correct service type, etc. If you copy your initial request to submit your 4-month request, it will have a service type of “Children’s Habilitation Intervention – Initial/Annual”.

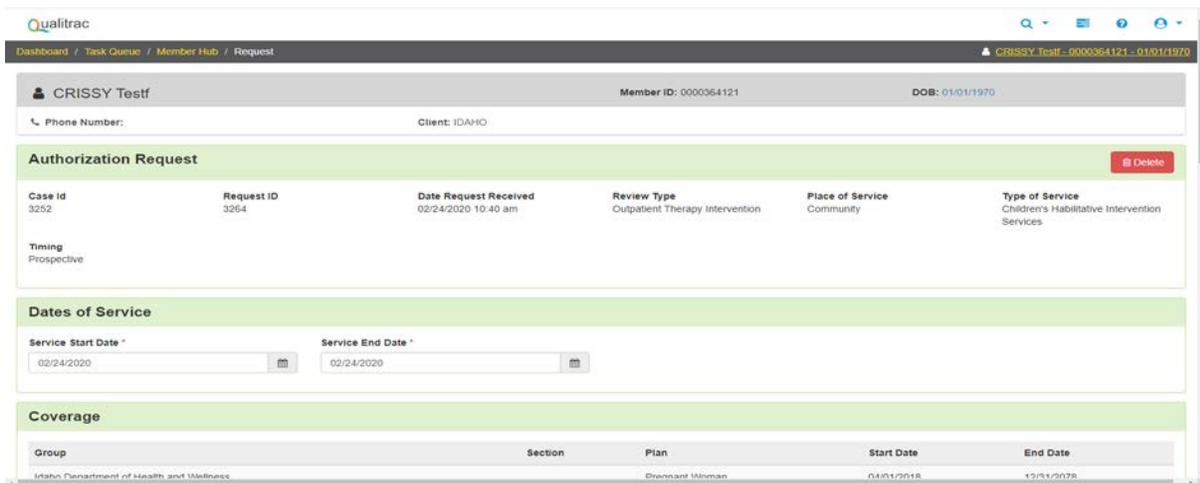
From the Member Hub, identify the Case ID number to be copied. Click on the blue ellipsis (three blue dots) found to the right of the case. A list of options appears. Click on the work “Copy”.



A Confirmation will pop up. Click “Yes” to proceed with the copy.



A new case is created with the same information as the copied case and it is assigned a new Case ID.



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What are Milliman Care Guidelines (MCG)?

Milliman Care Guidelines are nationally accepted guidelines for care which Telligen is required by contract to use and help guide Telligen’s reviewers in making medical necessity determinations during the review. The guidelines related to Children’s Habilitation Intervention Services that you will see when requesting services have been modified to align with Idaho Medicaid’s rules regarding these services.

How do I navigate the Milliman Care Guidelines (MCG) portion of submitting my review through Qualitrac?

When creating a review, you will be taken to the MCG authorization Request page. The first step is to choose “Document Clinical” in the screen shot below:



Choose the most appropriate Guideline based upon your request by clicking “add” on the right side.

Procedure Code: 96152 (CPT/HCPCS)
 Requested Units: 786
 Description : INTERVENE HLTHBEHAVE INDIV

Guideline Title	Product	Code	Action
ID_DDA_Telligen Habilitative Skill	BHG	ID_DDA_Telligen Habilitative Skill	add
ID_DDA_Telligen Behavioral Intervention	BHG	ID_DDA_Telligen Behavioral Intervention	add
ID_DDA_Telligen Crisis Intervention	BHG	ID_DDA_Telligen Crisis Intervention	add

Acknowledge you have read and understand the criteria by checking the boxes on the left and then click “Save”. You can select any boxes that you feel apply to your client.

(continued on next page)

Procedure Code: 96152 (CPT/HCPCS)
 Requested Units: 786
 Description : INTERVENE HLTHBEHAVE INDIV

ID_DDA_Telligen Habilitative Skill - ID_DDA_Telligen Habilitative Skill - (BHG)

Acute outpatient level of care is/was needed for appropriate care of the patient because ...

- Child or adolescent has a demonstrated functional need or a combination of functional and behavioral needs that require intervention services, or requires intervention to correct or ameliorate their condition in accordance with Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT). [🔗](#)
- The child or adolescent has a functional and behavioral need identified as one point five (1.5) or more standard deviations below the mean for functional areas or above the mean for maladaptive behavior in three (3) or more of the following areas: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency, or maladaptive behavior. [🔗](#)
- Situation and expectations are appropriate for habilitative skill as indicated by ...
 - Recommended treatment is necessary [🔗](#)
 - Child or adolescent is requiring remediation of one or more documented developmental functional deficits [🔗](#)
 - Treatment is to be administered in setting (eg, home, community, developmental disability agency) and by team (eg, multidisciplinary) that is specifically designed and compatible with child's or adolescents needs and abilities. [🔗](#)
 - Functional abilities and daily living skills related to functional deficits have been identified as appropriate for habilitative skill [🔗](#)
 - Treatment plan includes coordination of care with other providers and community-based resources, as appropriate [🔗](#)
 - Treatment plan includes explicit and measurable goals that will define child or adolescent improvement with regular assessment that progress toward goals is occurring or that condition would deteriorate in absence of continued habilitative skill [🔗](#)
 - Treatment plan engages family, caregivers, and other people impacted by and in position to affect the child or adolescent needs, as appropriate [🔗](#)
 - Treatment intensity (ie, number of hours per week) and duration (ie, length of service intervention) is individualized and designed to meet needs of child or adolescent and adjusted as is clinically appropriate [🔗](#)

[✔ Save](#) [✖ Cancel](#)

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Complete this portion by clicking the “Submit Request” button. For more information, please refer to training materials regarding Milliman Care Guidelines which can be found at <http://idmedicaid.telligen.com/document-library>.

In Qualitrac, what does it mean by “date requested” and does it affect the start date of my client’s services?

The date requested box in Qualitrac is the date that you submitted the request for services. It does not affect the date that the services are approved or the start date of approved services, unless you submit your services request after the date you are requesting the services to start. All services except the initial ACTP and crisis must be requested prospectively. If they are not, the services can only be approved starting the day after the date requested.

In Qualitrac, what should I enter for the start and end dates of services?

For your requests for Behavioral Intervention, Habilitative Skill Building, and Interdisciplinary Training, the start date and end date should be for 4 months. The start date will be the date you want the intervention services to start and should be a future date because these services are to be prior authorized. For example, if the services should start on 1/1/2020, you would enter the end date as 4/30/2020 because this is 4 months. This is the same for your 4-month and 8-month reviews as it is for your initial or annual request. Please see the example below for a prospective request.

Dates of Service	
Service Start Date *	Service End Date *
<input type="text" value="01/01/2020"/>	<input type="text" value="04/30/2020"/>

If you are requesting retrospective authorization for an initial ACTP or a screening, you will enter the start date as the day you began the ACTP and/or screening and the end date as the day it was completed. For example, 1/1/2020 through 1/31/2020. If you are requesting an annual ACTP, please include it on the same case as your 8-month services request as it will be approved for the same 4-month timeframe. If you submit your annual ACTP separately from the 8-month service request, please ensure it is still a prospective request and enter the end date as the last day of your approved 8-month service request.

If the date entered in “services start date” does not align with the dates on the ACTP, what date will be used for the start of service?

The start date used will always be what is entered in Qualitrac.

Will approved services start the day they are authorized, or for the date entered in the “services start date” box?

Approved services will be authorized to start on the date entered in the “services start date” box. The exception to this is if you do not submit your service request prior to the date you are asking the services to start. **All services, except the initial ACTP, Screening, and Crisis Intervention, must be prior**

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authorized. For example, if your request is for services to start 1/15/2020, but you do not submit the request until 1/30/2020, any approved services will be authorized to start the day after the request was submitted, 1/31/2020. Please see the next question for how an ACTP and screening would be authorized.

What will the ACTP and Screening authorization start dates and end dates be?

Both an approved initial ACTP and an approved Screening will be authorized for the date range in which they were completed, which should be demonstrated by the dates on the ACTP and supporting documentation. In the “services start date” and “end date” boxes, you will enter the date you started and ended/completed the ACTP and/or screening.

For an annual ACTP, if the prior authorization request is submitted at the same time as the 8-month service request, the start and end dates will be the same as the 8-month service request. If it is submitted separately from the 8-month service request, it must still be submitted prospectively as a prior authorization. The start date would be the date in the future you intend to start the ACTP and the end date will be the same date as your 8-month service request.

What do I put in the “Total Cost” section when I am submitting a request?

This field is not a required field. It does not affect the outcome of the review. Only those Qualitrac fields marked with a red asterisk are required. You may leave others blank.

Why do I need to put a diagnosis when requesting services when a specific diagnosis is not required for these services?

The field is required, but it does not affect the outcome of the review. Please put a diagnosis relevant to the member.

What do I put in the “Treating Provider”, “Treating Facility”, and “Ordering Provider” boxes?

If you are an agency, you will add your NPI in both the “Treating Provider” and “Treating Facility” sections. If you are an independent provider, you will add your NPI in the “Treating Provider” section and leave the “Treating Facility” section blank. The “Ordering Provider” section may also be the agency or independent provider providing intervention services (all sections could be the same provider), or it could be the member’s primary care provider if it is more appropriate for the situation. It is **important to put the independent provider or agency in the “Treating Provider”** section to ensure accurate transmission of information to the Department for billing purposes. This is because whoever is entered in the “Treating Provider” section is the entity that will receive the authorization number to bill with. If the primary care physician is listed under the “Treating Provider” section, the primary care physician will receive the authorization number. Since the primary care physician is not the intervention provider, the request will have to be resubmitted to correctly list the agency or independent provider as the “Treating Provider” for the services. Please see the example on the next page.

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Providers								
Type	Name	NPI	Address	Phone	Primary Taxonomy	PPO Redirect Reason	Comments	Action
Treating Provider					Early Intervention Provider Agency	Valid PPO provider		Remove
Ordering Provider					Pediatrics			Remove

If I worked on the ACP with another provider and we need to split the request for the ACP and/or requested hours, how do we enter the request?

If you completed the ACP with another provider, both providers must submit a request to Telligen separately requesting authorization for the number of units each provider used on completing the ACP. For example, one of you may request 10 units and the other request 11 units, etc. You each must submit the ACP, the screening documentation, and the physician recommendation in your separate requests. You cannot request services for both of you in the same request. If you do this, only the provider who submitted the request will get the authorization for all the units.

If another provider is also providing services to my client, how do we request services?

If this is occurring at the initial, 4-month, 8-month or annual request, then you each will need to submit your own request including all required supporting documentation. Please be sure to only request the units each of you are using, not the full units on the child's ACP, so that each of you receive your own authorization number with the appropriate units on it. You cannot request services for both of you in the same request. If you do this, only the provider who submitted the request will get the authorization for all the units. If another provider is going to start providing some of the services you currently provide part of the way through your 4-month authorization period, the other provider will need to submit a PA Amendment Request form that is signed by them, yourself/your agency, and the parent/guardian.

How are monthly Interdisciplinary Training (IT) hours calculated?

Hours approved for IT are multiplied by the months approved. For example, if you are approved one (1) hour of IT per month for the full 4 months, it would be calculated as 1 hour x 4 units x 4 months for a total of 16 units. If you request IT weekly, it will be 1 hour x 4 units x 18 weeks for a total of 72 units.

How are Behavioral Intervention and Habilitative Skill Building hours calculated?

Hours per week are multiplied by 4 units per hour and 18 weeks (4 months). If the child will receive 10 hours per week, then the calculation would be: 10 hours x 4 units x 18 weeks for a total of 720 units.

If a child needs more hours than initially approved, how do I request these?

Additional hours that need to be added to an authorization for Behavioral Intervention, Interdisciplinary Training or Habilitative Skill Building must be prospectively requested through Telligen. **If this need is identified at the 4-month or 8-month service request, please include an updated ACP that justifies the need for additional hours in your request to Telligen. If this is needed mid-cycle, the request should also include a completed PA Amendment Form in addition to the updated ACP. Please ensure these are**

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submitted prospectively (prior to the change taking place) as all Behavioral Intervention, Interdisciplinary Training, and Habilitative Skill Building services must be prior authorized.

If I am updating the ACTP because the child needs more hours or services initially anticipated, what do I enter in the "services start date" and "services end date" boxes?

The start date would be the date you want the change to go into effect (this should be a future date because all services must be prior authorized) and the end date would be the same end date as your current 4-month authorization period.

Where do I submit my PA Amendment Request Form?

As of March 4, 2020, all PA Amendment Forms should be submitted to Telligen via the Qualitrac Portal. More information on this can be found in the most recent PA Amendment Instructions at the link below under "Provider Forms/Templates" and "State Plan Intervention". Please also ensure you are using the most up to date PA Amendment Form from the website.

<https://healthandwelfare.idaho.gov/Medical/DevelopmentalDisabilities/ChildrensDDServices/ChildrensDDInformationforProviders/tabid/2362/Default.aspx>

When a PA Amendment is reviewed and approved, what date will the change take effect?

Any approved changes requested on a PA Amendment form will be approved for the date indicated in the "services start date" box in Qualitrac. This date should match the date written in the "Date of Requested Amendment" box in the "Prior Authorization Amendment Request" section of the PA Amendment Request form. The PA Amendment Form should also include the dates of the current authorization. You should enter the end date of the current authorization in the "services end date" box in Qualitrac. Please note these also should be done as prior authorizations, not after the change in services has already occurred. **If you submit your PA Amendment after the date you are asking to start the change, it will not be approved for the date requested. It will be approved for the day following your submission.**

What is the review timeframe for PA Amendment requests?

All PA Amendment requests are subject to the same review time as other non-crisis requests, 10-business days/14-calendar days. If the request submitted does not include the required justification to make a decision, Telligen will reach out to request the needed information. This pauses the review time. You will need to attach documentation supporting your amendment such as an updated PA Amendment Form with the justification required. Once the needed information is received, the review timeframe does not start over, but continues with the remaining days left in the 10-business day period.

How long does it take for me to get an authorization number once my request is approved by Telligen?

As of March 4, 2020, cases in Qualitrac that are reviewed will generate an authorization number as soon as the review is complete. The authorization numbers are 7 digits long and generally start with an "8". They do not have "AUTH" in front of them as the manually entered authorization numbers do. If you bill with "AUTH" in front of the number, the billing will be denied. These authorization numbers are transmitted electronically overnight to DXC and should be visible and billable the next day in DXC. You

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will see these authorization numbers under "View and Submit Referrals" in DXC's portal rather than "View Authorizations." Currently, when these authorizations transfer to DXC, they do not show the provider all details included in the authorization such as codes, modifiers, and total units. This information is available in Qualitrac under "Outcomes" as well as in the approval letters sent to providers, which are downloadable from Qualitrac as well.

If the request is a PA Amendment to an already established authorization, these authorizations are updated manually. The Department is working to update all PA Amendments on the original authorization numbers as quickly as possible. This is generally within 48 hours. Please reach out to medicaidqio@dhw.idaho.gov if you have any questions or concerns.

How do I edit a case that I submitted that has not yet been reviewed?

If you need to add or delete documentation in a case that has not been reviewed yet, open the appropriate Case ID and scroll down to the document panel. Here you can click the orange "+ Add" button on the right-hand side. If you wish to delete a document, click the red trashcan icon under "Action" on the right-hand side. This is the same process if you wish to add or delete a service in a case.

Who do I contact if I see an error with the approved codes, units, etc. with my authorization number?

Please contact medicaidqio@dhw.idaho.gov as Telligen does not have the ability to change information already loaded in the DXC system.

How do I submit a 4-month, 8-month or annual review?

To request authorization for the next 4-month period, please submit a new prospective request for prior authorization of the member's services. The Service Start Date will be the first day of the new 4-month period and the Service End Date will be the end date of the 4-month period. For example, March 1, 2020 through June 30, 2020. This will ensure you are provided an accurate authorization with a unique authorization number for claims payment purposes. A request for the prior authorization of the annual ACTP must be prospective and is recommended to be included on your 8-month service request. For more details on what needs to be included when you submit a 4-month, 8-month, or annual review, please reference the Provider Handbook which can be found here:

<https://healthandwelfare.idaho.gov/Medical/DevelopmentalDisabilities/ChildrensDDServices/ChildrensDDInformationforProviders/tabid/2362/Default.aspx>

When should we submit our documents for the initial, 4-month, 8-month, and annual reviews?

Requests for services should be submitted **30 days prior to the start date of services**. This allows ample time for review and potential requests for information if a review request is incomplete. Best practice would be to not submit the information more than 60 days prior to the start date of services to ensure the most accurate and up-to-date information is submitted with your review. Please also note that Telligen's review turnaround time is up to 10 business days/14 calendar days if no Request for Information is needed.

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For additional guidance please visit or contact the following:

Department of Health and Welfare's Children's Developmental Disability (DD) Services website for the most up-to-date forms, the Intervention Provider Handbook, and other program information:
<https://healthandwelfare.idaho.gov/Medical/DevelopmentalDisabilities/ChildrensDDServices/tabid/1017/Default.aspx>

Telligen's Provider Manual under "Manuals and User Guides":
<http://idmedicaid.telligen.com/document-library>

Telligen's Intervention trainings:
<http://idmedicaid.telligen.com/education-training>

If you have questions regarding authorization numbers already loaded in DXC's system, please reach out to Medicaid at medicaidqio@dhw.idaho.gov.

If you have questions regarding building a case in the Telligen portal or uploading additional documents to an existing case, please email CHIS@telligen.com or contact Brandi Lavarello at 208-433-7500.

If you need assistance in obtaining credentials for the Telligen portal or need Telligen portal training, please visit <https://telligen.qualitrac.com/home>, or contact CHIS@telligen.com.

If you have questions regarding the status of your review, please reach out to Telligen Customer Service at 866-538-9510.

For policy questions regarding Children's Habilitation Intervention Services (CHIS) through Medicaid, please contact ChildrensDDServices@dhw.idaho.gov.

For operational questions regarding Children's Habilitation Intervention Services (CHIS) through Family and Community Services (FACS), please contact FACSChildrensDD@dhw.idaho.gov.

For questions regarding Children's Developmental Disability Support Services through Family and Community Services (FACS), please contact FACSChildrensDD@dhw.idaho.gov.