Telligen
Healthcare Intelligence
670 East Riverpark Lane, Suite 170
Boise, ID 83706

Utilization and Quality Review Manual
Idaho Medicaid
2019

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Telligen's Healthcare Intelligence

Telligen's Ability to Combine Extensive Clinical and Technical Expertise

To Intelligently Solve Our Clients' Complex Healthcare Challenges

Section 1: Introduction

Purpose of the Telligen's Utilization and Quality Management Program

The purpose of the Telligen's Utilization and Quality Management (UM and QM) program is to ensure that appropriate medical services are provided with medical necessity and Quality of Care in accordance with state and federal regulations, statutes and policies to Participants of Idaho Medicaid.

Corporate Background and Experience

As a Medicaid utilization management and Medicare Quality Improvement Organization (QIO) contractor for over 40 years, Telligen has developed contract specific UM plans for all elements of utilization review including admission, quality, invasive procedure, length of stay, outliers, coverage, discharge review and DRG validation. As a URAC accredited organization, we have corporate policies and procedures for utilization management that we will use as the foundation for the Idaho Medicaid contract.

Mission

Improve the quality and cost effectiveness of healthcare for consumers and providers

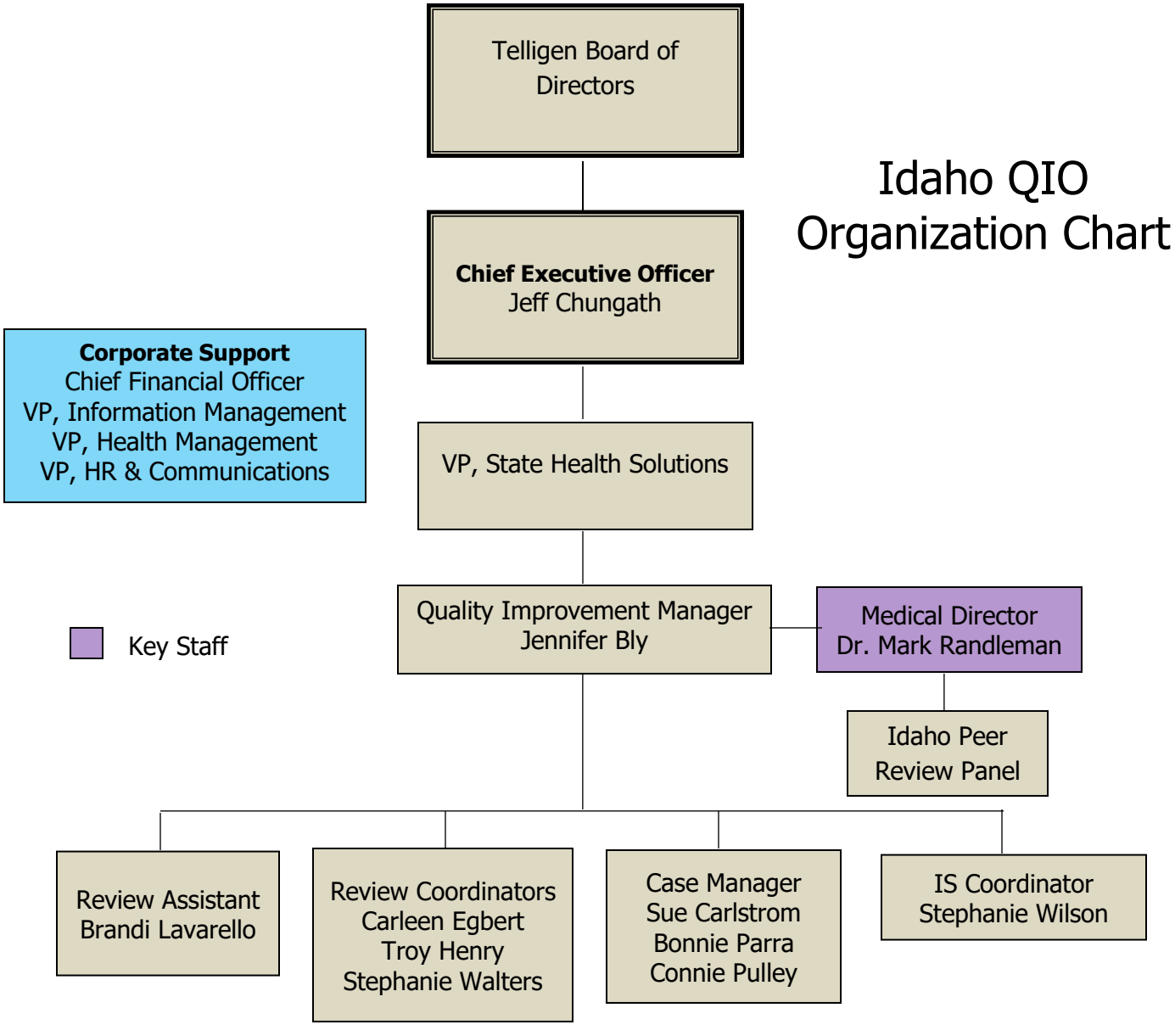
Vision

To be recognized for leadership, innovation and excellence in improving the health of individuals and populations.

Core Values

Dedication ~ Ingenuity ~ Community ~ Integrity

Section 2: Telligen's Idaho QIO Organization Chart



Section 3: Idaho Medicaid Review Team Positions

UM/QM Position	Responsibilities	Qualifications
Senior Review Coordinator / Review Coordinator	• Performs prospective, concurrent or retrospective utilization review/medical management for all services including appropriateness of Quality of Care based on contract, state, or URAC requirements. Screens individual cases according to specific criteria to determine if care is appropriate. • Refers cases that fail to meet criteria to peer review • Enters medical information into system(s)	• Registered nurse or other licensed healthcare professional directly relevant to the type of review performed • One to two years' experience in a healthcare setting • Valid Idaho license • Functional PC knowledge • Knowledge of medical coding, billing and/or utilization management preferred
Medical Coding Analyst (upon request)	• Performs coding validation to ensure submitted diagnoses/procedures on claim are supported by clinical record documentation and appropriate billing • Screens individual situations according to applicable coding guidelines to determine if coding is appropriate • Refers cases that fail to meet criteria to peer reviewer • Performs preliminary research on topics such as coverage determinations, coding guidelines or standards of care.	• Experience with ICD coding and concepts as well as CPT and HCPCS coding required • Two years minimum experience in inpatient and/or outpatient coding. • Certified Professional Coder or Certified Coding Specialist or Certified Coding Assistant or Registered Health Information Technician or Registered Health Information Administrator required
Review Assistant	• Support functions including scheduling • Assists in creating and editing documents including manuals, policies & procedures and reports • Prepares documentation for internal and external meetings (agenda, minutes, handouts, etc.)	• Two-year degree in business or related field • Three to four years' experience in project administrative support • Proficient with handling confidential information • Ability to multi-task and problem solve in a deadline driven environment

Section 4: Review Plan Overview

Authority

The Idaho Department of Health and Welfare contracts with Telligen to implement and manage the quality and utilization control program for hospital acute inpatient, outpatient, and prior authorization services provided to Idaho Medicaid Participants in the fee-for-services system.

Telligen will perform professional and technical services and other duties in accordance with, and subject to applicable Federal and State statutes and regulations, any Idaho departmental policies which may be contained in the Department Provider Bulletins, Department Provider Handbooks and any other law and regulation which may be issued or promulgated from time to time.

Purpose of Review Plan

The purpose of this document is to notify providers of the process that Telligen will follow for review of hospital acute inpatient, outpatient, and prior authorization for services provided to Idaho Medicaid Participants in the fee-for-services system.

Objectives

The Department contracts with Telligen to review services provided to Idaho Medicaid Participants to:

1. Evaluate the medical care that was provided for medical necessity, reasonableness and appropriate use of Medicaid funds.
2. Assess for the Quality of Care of those services so that they meet the professionally recognized standards of health care;
3. Assess the setting the care was delivered in was appropriate for the type of service provided by the standards of practice;
4. Determine if the level of care was appropriate for the services rendered; and
5. To provide a monitoring system to determine that medical services are delivered at the appropriate level of care in a timely, effective and cost-effective manner, to examine and improve the quality of medical care, and to evaluate practice patterns of healthcare delivery.

Section 5: Security

Regulation and Guidance

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 enacted by Congress, includes Administrative Simplification provisions that mandated the adoption of federal privacy protections for individually identifiable health information, national standards for electronic health care transactions and code sets, unique health identifiers, and security. Under terms of this contract and as a contracted partner with the Department, the contractor will be subject to the HIPAA Administrative Simplification Statue and Rules published by the U.S. Department of Health and Human Services (http://www.hhs.gov/ocr/privacy/hipaa/administrative). As defined in the Enforcement Rule provisions 45 CFR Part 160, Subparts C, D, and E, the contractor will be held accountable for criminal and civil money penalties imposed for violation of the HIPAA Administrative Simplification Rules.

Section 6: Telligen Utilization Review Process Overview

Utilization Review Procedures

All cases subject to review will be evaluated for medical necessity, appropriateness, timeliness of services, and level of care, as determined by the Medicaid services/benefits. Cases subject to review are dependent upon the Medicaid benefit plan but may include inpatient admissions, outpatient procedures, or other services, as the UM contract specifies. It is the policy of Telligen to perform the following reviews:

- Procedure Review for certain operations and diagnostic tests using clinical criteria. The review determines whether the requested service is medically necessary and delivered in the most appropriate setting;

- Prospective Review or Pre-Service Medical Necessity reviews prior to an admission or proposed service using clinical criteria. The review determines whether an admission or service is medically necessary and delivered in the most appropriate setting;
- Concurrent Medical Necessity Review after the Participant has been admitted to an inpatient facility using updated information required for continued stay and appropriate level of care. The review determines whether service is medically necessary and delivered in the most appropriate setting. Concurrent review is conducted when the patient is still receiving services in an inpatient setting. It may include admission and continued stay review. Admission medical necessity review is completed after the patient is admitted;
- Continued Stay Review after the initial admission certification is completed. Continued stay is conducted while the patient is still receiving services and is used to determine the medical necessity of continued acute level of care. This type of review assumes that the medical necessity for the admission has been approved; and
- Retrospective Medical Necessity Review (*also known as Post Service*) when the Participant has been discharged or the services have been completed. The review determines if the admission/continued stay or services were medically necessary and whether care was delivered in the most appropriate setting. In addition, review of outlier cases can be conducted. The outlier cases are reviewed to ensure provider treatment is consistent with practice guidelines.
- In the vast majority of circumstances, the most current set of Milliman Care Guidelines will be the clinical criteria used by Telligen to make appropriateness and medical necessity determinations. Occasionally circumstances may arise where the situation presented to Telligen to review does not correspond to a specific guideline published by Milliman. In these situations, Telligen staff will utilize their professional training and expertise to make a determination.

Medically Reasonable and Necessary

Health care services and supplies which are medically appropriate and:

1. Necessary to meet the basic health needs of the Participant;
2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
3. Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical research, or health care coverage organizations or governmental agencies;
4. Consistent with the diagnosis of the condition;
5. Required for means other than convenience of the Participant or his or her physician;
6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
7. Demonstrated value; and
8. No more intense level of service than can be safely provided.

The fact that the physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for an injury, sickness, or mental illness does not mean that it is covered by Medicaid.

Services and supplies that do not meet the definition of medical necessity set out above are not covered.

Approval by the federal Food and Drug Administration (FDA) or similar approval does not guarantee coverage by Idaho Medicaid. Licensure/certification of a particular provider type does not guarantee Idaho Medicaid coverage.

Section 7: Medical Requests

Overview

Providers may submit Medicaid authorizations by these methods:

1. Portal – (preferred method)
2. Fax
3. Mail
4. Telephone

Providers will continue to be responsible for the costs associated with copying and mailing medical records requested for review completion.

Providers are encouraged to submit clinical documentation, required forms and other medical records information through the Telligen web portal at http://idmedicaid.telligen.com/home. This results in a more efficient and more secure method for submitting sensitive medical information. Use of the portal will also reduce the administrative burden and lower the costs for the provider.

Authorization Requests via Portal

Telligen offers a secure HIPAA-compliant web portal for providers to submit requests for authorization and to supply clinical documentation to support the requested service. The portal is pre-loaded with request information for prior authorizations per Idaho Medicaid criteria. Providers may start a case with the Participant's Medicaid ID number and date of birth. The embedded workflow will move each provider through the request and at the completion allow for uploading the clinical documentation. Please see the Telligen's portal manual for more details or the Telligen's webpage for a webinar on the portal's use. The web portal is generally accessible to providers 24 hours per day, seven days per week.

Requests and supporting information received electronically are automatically processed and available to our review staff in Qualitrac™.

This method streamlines processes, saving Idaho Medicaid valuable dollars on contractor staff time. To access the Telligen Portal go to the web page at http://idmedicaid.telligen.com/home and the logon will be in the upper right-hand corner.

Authorization Requests via Fax

Providers will also be able to submit authorization requests to Telligen through a secure fax transmission. This option will be available 24 hours per day, seven days per week.

We process requests received by secure fax transmission within four business hours following receipt. Our fax system is integrated with Qualitrac™, so once a fax is received, it is automatically added into the queue for our operations team. This allows them to immediately begin review activities without any delays resulting from manual entry of the case into the system.

Secure Toll-Free Fax: 866-539-0365

Authorization Requests via Mail

Providers will be able to submit authorization requests through the mail, if they do not have access to Telligen's Portal system or fax services. The mailing address is:

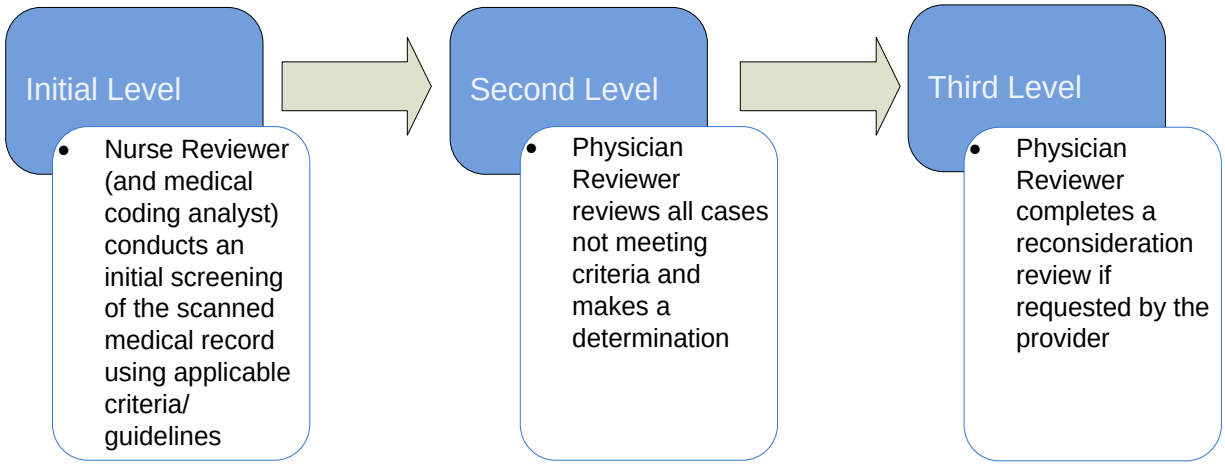
Telligen
670 East Riverpark Lane, Suite 170
Boise, ID 83706

Responsibility for Copying and Mailing Medical Records

Providers will continue to be responsible for the costs associated with copying and submitting medical records requested for review completion. Providers are encouraged to submit clinical documentation, required forms and other medical records information through the Telligen web portal. This results in a more efficient and a more secure method for submitting sensitive medical information. Use of the portal will also reduce the administrative burden and lower the costs for the provider.

Section 8: Review Description

The review process includes three levels:



Telligen Review Coordinators complete a detailed review of the submitted documentation including the plan of care to ensure services have been ordered in compliance with all coverage regulations identified.

Telligen encourages providers to use the web-based portal for all prior authorization requests.

Telligen's review system, Qualitrac™ will flag these authorization requests as a timed priority to ensure they receive immediate attention by the review coordinators and are completed within the time frame designated by the Department for completion of specific review areas.

Added features of the Qualitrac™ system include management tools to monitor authorization timeliness and staff productivity. Having these tools allows the contract manager to view the operations dashboard to assess the volume of pending reviews and corresponding due dates and times prompting action if indicated to ensure timely completion of all authorizations.

In situations where the review coordinator or the physician reviewer identifies additional information necessary to complete the review, Telligen will notify the provider and suspend the review until the additional information is received.

The final review and coverage decision will be completed and communicated to the provider within one business day of receipt of the additional information.

Auto Authorization (Tier One)

Telligen offers an Auto Authorization process that allows providers to submit their requests through Telligen's secure portal. Using the secure portal is a quick and efficient way to submit requests. Benefits of portal submission include:

- Secure means for submitting data
- Paperless submission, no papers to mail or fax
- Quicker turnaround times
- Automated notifications on case status and outcomes

Once the request has been submitted, it enters the auto authorization process. This process is integrated with MCG's Care Guidelines, allowing the provider to enter and upload applicable clinical information resulting in an approval or referral to a nurse reviewer.

Find a list of the Prior Authorization codes on the website at http://idmedicaid.telligen.com/document-library. Scroll down to the section titled "Manuals and User Guides" and click on the "Idaho Prior Authorization Codes" link.

Initial Review (Tier One)

For requests received via the portal, provider and Participant eligibility is confirmed through Qualitrac™.

For requests received via fax or mail, the Review Assistant verifies Participant eligibility, verifies the PA requested for the Participant is a service that requires authorization and builds the case in Qualitrac™.

The case is then referred to the Review Coordinator through the system scheduler.

The review coordinator reviews the information submitted by the provider including pertinent portions of the medical record if available to determine whether the requested service is medically necessary by applying the appropriate criteria set.

Our Review Coordinator may request additional information from providers to support the PA request.

Telligen records and tracks all information received from the provider and all requests for additional information in Qualitrac™. The information recorded includes supporting documentation from the provider and the date of all follow up requests for additional information. This enables us to respond immediately to a request from the Department regarding the status of any suspended review.

Upon receipt of the missing information, the Review Coordinator resumes the review process and completes the review within one (1) business day following receipt of the additional information. The review team has experience working collaboratively with providers offering education on the specific documentation needed to efficiently process authorization requests.

Criteria Application

All cases must meet Idaho Medicaid criteria before applying any other criteria. Telligen utilizes Milliman Care Guidelines® criteria. The criteria cover the healthcare continuum and can thus be applied to the vast majority of service types and can be used as Participants move from one setting to the next.

Milliman Care Guidelines criteria will be used by the Nurse Review Coordinators to conduct initial screening of the case. If criteria are met, the Review Coordinator approves the requested service(s) and the results are documented in the review system.

Review Coordinators may only approve cases based on application of criteria. Telligen ensures criteria are applied in a uniform manner through the inter-rater reliability process. If criteria are not met, the case is referred to the Medical Director or a Physician Reviewer licensed in Idaho to perform a physician review.

Peer Review Referral (Tier Two)

If the information provided for the review does not meet the criteria for approval, the Review Coordinator refers the case to our Medical Director or Physician Peer Reviewer. Using clinical knowledge and medical judgment, the peer reviewer determines the appropriateness of the requested service(s) and provides a medical rationale for the decision(s).

Approved Requests

Following review coordinator or peer reviewer approval of the requested services, Telligen will document the outcome in Qualitrac™. Notification of the approval will be sent electronically to the provider generated from Qualitrac™.

Denied Requests

If the peer reviewer determines the requested service is not medically necessary or appropriate, he/she will deny all or part of the service(s). The peer reviewer will document the outcome in Qualitrac™. Telligen will supply medical rationale for the denial decision in plain language that the Participant can understand. Letters approved by IDHW will be generated from Qualitrac™.

Section 9: Pre-Service Review

Review Type	Submission Method/ Review Components	Description	Time Frame to Completion & Notification
Pre-Service Review	Web portal Secure fax Telephone	conduct pre-service reviews for selected diagnosis and procedures that require prior authorization	Non-urgent; Fifteen calendar days Urgent; Three business days

Pre-service review is required for all inpatient admission and outpatient procedures included on the select diagnoses and procedures list. The list can be accessed at http://idmedicaid.telligen.com/home.

The physician or designated personnel may submit review requests to Telligen using one of four methods:

1. Secure Web Portal (preferred method)

2. Phone
3. Fax
4. Mail

For requests received via the portal, provider and Participant eligibility is confirmed through Qualitrac™.

For requests received via fax, telephone or mail, the Review Assistant verifies Participant eligibility, verifies the PA requested for the Participant is a service that requires authorization and builds the case in Qualitrac™.

The case is then referred to the review coordinator through the system scheduler.

The Review Coordinator reviews the information submitted by the provider including pertinent portions of the medical record if available to determine whether the requested service is medically necessary by applying the appropriate criteria set.

Our Review Coordinator may request additional information from providers to support the PA request. For example, during review of durable medical equipment PA requests, Telligen may request that providers submit medical clearance forms to justify DME or supplies.

Requests for Additional Information

If the information supplied by the provider is insufficient to complete the review, Telligen will suspend the case. Telligen will contact the provider for all suspended cases to request the additional information needed to complete the review. If the provider does not provide the additional information within ten (10) days following the initial contact, Telligen will administratively deny the requested service. The case will be reopened if the provider submits the additional information at a later time.

Telligen records and tracks all information received from the provider and all requests for additional information in Qualitrac™. The information recorded includes supporting documentation from the provider and the date of all follow up requests for additional information. This enables us to respond immediately to a request from the Department regarding the status of any suspended review.

Upon receipt of the missing information, the Review Coordinator resumes the review process and completes the review within one (1) business day following receipt of the additional information. The review team has experience working collaboratively with providers offering education on the specific documentation needed to efficiently process authorization requests.

Criteria Application

All cases must meet Idaho Medicaid criteria before applying any other criteria. Telligen utilizes Milliman Care Guidelines® criteria. The criteria cover the healthcare continuum and can thus be applied to the vast majority of service types and can be used as Participants move from one setting to the next.

Milliman Care Guidelines criteria will be used by the nurse review coordinators to conduct initial screening of the case. If criteria are met, the Review Coordinator approves the requested service(s) and the results are documented in the review system.

Review Coordinators may only approve prior authorization requests based on application of criteria. Telligen ensures criteria are applied in a uniform manner through the inter-rater reliability process. If

criteria are not met, the case is referred to the Medical Director or a Physician Reviewer licensed in Idaho to perform a physician review.

Peer Review Referral

If the information provided for the review does not meet the criteria for approval, the Review Coordinator refers the case to our Medical Director or Physician Peer Reviewer. Using clinical knowledge and medical judgment, the Peer Reviewer determines the appropriateness of the requested service(s) and provides a medical rationale for the decision(s).

Approved Requests

Following Review Coordinator or peer reviewer approval of the requested services, Telligen will document the outcome in Qualitrac™. Notification of the approval will be sent electronically to the provider generated from Qualitrac™.

Denied Requests

If the Peer Reviewer determines the requested service is not medically necessary or appropriate, he/she will deny or modify the service(s). The Peer Reviewer will document the outcome in Qualitrac™. Telligen will supply medical rationale for the denial or modified decision in plain language that the Participant can understand. Letters approved by DHW will be generated from Qualitrac™.

Section 10: Continued Stay Review

Review Type	Submission Method/ Review Components	Description	Time Frame to Completion & Notification
Continued Stay Review for stays exceeding previously authorized hospital stays	Web portal Secure fax Telephone	Conduct medical necessity review of services that received pre-service authorization when the stay reaches the scheduled discharge date and discharge is not anticipated	Concurrent Non-Urgent: Three business days Concurrent Urgent: Three business days
Continued Stay Reviews for all hospital admissions exceeding 3 days length of stay	Web portal Secure fax Telephone	Conduct review of medical necessity for diagnosis/procedures that do not require pre-service review when the length of stay exceeds three days	Concurrent Non-Urgent: Three business days Concurrent Urgent: Three business days
Continued Stay Review for Cesarean Section hospital stays	Web portal Secure fax Telephone	Conduct review for medical necessity when the length of stay exceeds four days (only if the primary diagnosis code is identified by the Department)	Concurrent Non-Urgent: Three business days Concurrent Urgent: Three business days
Psychiatric Hospital Continued Stay Review under 21 Psychiatric/Chemical Dependency Review: Participants 21 years of age or older	Web portal Secure fax Telephone	Conduct continued stay reviews of all admissions of Participants under the age of 21 with primary psychiatric diagnoses	Concurrent Non-Urgent: Three business days Concurrent Urgent: Three business days

Continued Stay Review takes place during the course of the Participants' treatment. The purpose is to determine if services are medically necessary and appropriate. Continued Stay Review of the following is required:

1. Stays exceeding previously authorized hospital days or stays associated with procedures requiring prior authorization by the Department.
2. All hospital admissions exceeding three (3) days length of stay.
3. Cesarean Section primary diagnosis code shall be reviewed for necessity of continued stay after four (4) days.

The physician or designated personnel may submit review requests to Telligen using one of four methods:

1. Secure Web Portal (preferred method)
2. Phone
3. Fax
4. Mail

For requests received via the portal, provider and Participant eligibility is confirmed through Qualitrac™.

For requests received via fax, telephone or mail, the Review Assistant verifies Participant eligibility, verifies the PA requested for the Participant is a service that requires authorization and builds the case in Qualitrac™.

The case is then referred to the Review Coordinator through the system scheduler.

The Review Coordinator reviews the information submitted by the provider including pertinent portions of the medical record if available to determine whether the requested service is medically necessary by applying the appropriate criteria set.

Our Review Coordinator may request additional information from providers to support the PA request. For example, during review of durable medical equipment PA requests, Telligen may request that providers submit medical clearance forms to justify DME or supplies.

Requests for Additional Information

If the information supplied by the provider is insufficient to complete the review, Telligen will suspend the case. Telligen will contact the provider for all suspended cases to request the additional information needed to complete the review. If the provider does not provide the additional information within ten (10) days following the initial contact, Telligen will administratively deny the requested service. The case will be reopened if the provider submits the additional information at a later time.

Telligen records and tracks all information received from the provider and all requests for additional information in Qualitrac™. The information recorded includes supporting documentation from the provider and the date of all follow up requests for additional information. This enables us to respond immediately to a request from the Department regarding the status of any suspended review.

Upon receipt of the missing information, the Review Coordinator resumes the review process and completes the review within one (1) business day following receipt of the additional information. The

review team has experience working collaboratively with providers offering education on the specific documentation needed to efficiently process authorization requests.

Criteria Application

All cases must meet Idaho Medicaid criteria before applying any other criteria. Telligen utilizes Milliman Care Guidelines® criteria. The criteria cover the healthcare continuum and can thus be applied to the vast majority of service types and can be used as Participants move from one setting to the next.

Milliman Care Guidelines criteria will be used by the Nurse Review Coordinators to conduct initial screening of the case. If criteria are met, the review coordinator approves the requested service(s) and the results are documented in the review system.

Review Coordinators may only approve prior authorization requests based on application of criteria. Telligen ensures criteria are applied in a uniform manner through the inter-rater reliability process. If criteria are not met, the case is referred to the Medical Director or a Physician Reviewer licensed in Idaho to perform a physician review.

Peer Review Referral

If the information provided for the review does not meet the criteria for approval, the Review Coordinator refers the case to our Medical Director or Physician Peer Reviewer. Using clinical knowledge and medical judgment, the Peer Reviewer determines the appropriateness of the requested service(s) and provides a medical rationale for the decision(s).

Approved Requests

Following Review Coordinator or Peer Reviewer approval of the requested services, Telligen will document the outcome in Qualitrac™. Notification of the approval will be sent electronically to the provider generated from Qualitrac™.

Denied Requests

If the Peer Reviewer determines the requested service is not medically necessary or appropriate, he/she will deny or modify the service(s). The Peer Reviewer will document the outcome in Qualitrac™. Telligen will supply medical rationale for the denial or modified decision in plain language that the Participant can understand. Letters approved by DHW will be generated from Qualitrac™.

Section 11: Psychiatric and Chemical Dependency Review

Review Type	Submission Method/ Review Components	Description	Time Frame to Completion & Notification
Psychiatric Hospital Admission Continued Stay Review under 21	Web portal Secure fax Telephone	Conduct reviews of all admissions with a length of stay exceeding three days of Participants under the age of 21 with primary psychiatric diagnoses	Concurrent Non-Urgent: Three business days Concurrent Urgent: Three business

Psychiatric/Chemical Dependency Review: Participants 21 years of age or older	Web portal Secure fax Telephone	Conduct reviews of all admissions with a length of stay exceeding three days of Participants 21 years of age and older with primary psychiatric diagnoses	Concurrent Non-Urgent: Three business days Concurrent Urgent: Three business days

Psychiatric Review: Participants 21 years and under

Telligen will complete Psychiatric Hospital Reviews for Participants twenty-one (21) years of age and younger in Institutions of Mental Disease (IMD) or freestanding psychiatric hospitals according to the appropriate Milliman Care Guidelines®. Concurrent stay reviews are required for inpatient psychiatric admissions that exceed three days.

The physician or designated personnel may submit review requests to Telligen using one of four methods:

1. Secure Web Portal (preferred method)
2. Phone
3. Fax
4. Mail

For requests received via the portal, provider and Participant eligibility is confirmed through Qualitrac™.

For requests received via fax, telephone or mail, the Review Assistant verifies Participant eligibility, verifies the PA requested for the Participant is a service that requires authorization and builds the case in Qualitrac™.

The case is then referred to the Review Coordinator through the system scheduler.

The Review Coordinator reviews the information submitted by the provider including pertinent portions of the medical record if available to determine whether the requested service is medically necessary by applying the appropriate criteria set.

Our Review Coordinator may request additional information from providers to support the PA request. For example, during review of durable medical equipment PA requests, Telligen may request that providers submit medical clearance forms to justify DME or supplies.

Requests for Additional Information

If the information supplied by the provider is insufficient to complete the review, Telligen will suspend the case. Telligen will contact the provider for all suspended cases to request the additional information needed to complete the review. If the provider does not provide the additional information within ten (10) days following the initial contact, Telligen will administratively deny the requested service. The case will be reopened if the provider submits the additional information at a later time.

Telligen records and tracks all information received from the provider and all requests for additional information in Qualitrac™. The information recorded includes supporting documentation from the provider and the date of all follow up requests for additional information. This enables us to respond immediately to a request from the Department regarding the status of any suspended review.

Upon receipt of the missing information, the Review Coordinator resumes the review process and completes the review within one (1) business day following receipt of the additional information. The review team has experience working collaboratively with providers offering education on the specific documentation needed to efficiently process authorization requests.

Criteria Application

All cases must meet Idaho Medicaid criteria before applying any other criteria. Telligen utilizes Milliman Care Guidelines® criteria. The criteria cover the healthcare continuum and can thus be applied to the vast majority of service types and can be used as Participants move from one setting to the next.

Milliman Care Guidelines criteria will be used by the Nurse Review Coordinators to conduct initial screening of the case. If criteria are met, the review coordinator approves the requested service(s) and the results are documented in the review system.

Review Coordinators may only approve prior authorization requests based on application of criteria. Telligen ensures criteria are applied in a uniform manner through the inter-rater reliability process. If criteria are not met, the case is referred to the Medical Director or a Physician Reviewer licensed in Idaho to perform a physician review.

Peer Review Referral

If the information provided for the review does not meet the criteria for approval, the Review Coordinator refers the case to our Medical Director or Physician Peer Reviewer. Using clinical knowledge and medical judgment, the Peer Reviewer determines the appropriateness of the requested service(s) and provides a medical rationale for the decision(s).

Approved Requests

Following Review Coordinator or Peer Reviewer approval of the requested services, Telligen will document the outcome in Qualitrac™, the length of stay will be assigned, and notification of the approval will be sent electronically to the provider generated from Qualitrac™.

Denied Requests

If the Peer Reviewer determines the requested service is not medically necessary or appropriate, he/she will deny or modify the service(s). The Peer Reviewer will document the outcome in Qualitrac™. Telligen will supply medical rationale for the denial or modified decision in plain language that the Participant can understand. Letters approved by DHW will be generated from Qualitrac™.

Psychiatric Review: Participants 21 years and older

Concurrent stay reviews are required for inpatient psychiatric admissions that exceed three days.

The physician or designated personnel may submit review requests to Telligen using one of four methods:

1. Secure Web Portal (preferred method)
2. Phone
3. Fax

4. Mail

For requests received via the portal, provider and Participant eligibility is confirmed through Qualitrac™.

For requests received via fax, telephone or mail, the Review Assistant verifies Participant eligibility, verifies the PA requested for the Participant is a service that requires authorization and builds the case in Qualitrac™.

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Our Review Coordinator may request additional information from providers to support the PA request. For example, during review of durable medical equipment PA requests, Telligen may request that providers submit medical clearance forms to justify DME or supplies.

Requests for Additional Information

If the information supplied by the provider is insufficient to complete the review, Telligen will suspend the case. Telligen will contact the provider for all suspended cases to request the additional information needed to complete the review. If the provider does not provide the additional information within ten (10) days following the initial contact, Telligen will administratively deny the requested service. The case will be reopened if the provider submits the additional information at a later time.

Telligen records and tracks all information received from the provider and all requests for additional information in Qualitrac™. The information recorded includes supporting documentation from the provider and the date of all follow up requests for additional information. This enables us to respond immediately to a request from the Department regarding the status of any suspended review.

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Peer Review Referral

If the information provided for the review does not meet the criteria for approval, the Review Coordinator refers the case to our medical director or physician peer reviewer. Using clinical knowledge and medical judgment, the Peer Reviewer determines the appropriateness of the requested service(s) and provides a medical rationale for the decision(s).

Approved Requests

Following Review Coordinator or Peer Reviewer approval of the requested services, Telligen will document the outcome in Qualitrac™, the length of stay will be assigned, and notification of the approval will be sent electronically to the provider generated from Qualitrac™.

Denied Requests

If the Peer Reviewer determines the requested service is not medically necessary or appropriate, he/she will deny or modify the service(s). The Peer Reviewer will document the outcome in Qualitrac™. Telligen will supply medical rationale for the denial or modified decision in plain language that the Participant can understand. Letters approved by DHW will be generated from Qualitrac™.

Section 12: Physical Rehabilitation Review

Review Type	Submission Method/ Review Components	Description	Time Frame to Completion & Notification
Physical Rehabilitation Review	Web portal Secure fax Telephone	Conduct pre-service reviews for physical rehabilitation services provided in State certified or Medicare approved rehabilitation units	Non-urgent; Ten business days Urgent; Three business days

Telligen will conduct pre-service review of all physical rehabilitation services provided in State certified or Medicare approved rehabilitation units.
The physician or designated personnel may submit review requests to Telligen using one of four methods:

1. Secure Web Portal (preferred method)
2. Phone
3. Fax
4. Mail

For requests received via the portal, provider and Participant eligibility is confirmed through Qualitrac™.

For requests received via fax, telephone or mail, the review assistant verifies Participant eligibility, verifies the PA requested for the Participant is a service that requires authorization and builds the case in Qualitrac™.

The case is then referred to the review coordinator through the system scheduler.

The review coordinator reviews the information submitted by the provider including pertinent portions of the medical record if available to determine whether the requested service is medically necessary by applying the appropriate criteria set.

Our review coordinator may request additional information from providers to support the PA request. For example, during review of durable medical equipment PA requests, Telligen may request that providers submit medical clearance forms to justify DME or supplies.

Requests for Additional Information

If the information supplied by the provider is insufficient to complete the review, Telligen will suspend the case. Telligen will contact the provider for all suspended cases to request the additional information needed to complete the review. If the provider does not provide the additional information within ten (10) days following the initial contact, Telligen will administratively deny the requested service. The case will be reopened if the provider submits the additional information at a later time.

Telligen records and tracks all information received from the provider and all requests for additional information in Qualitrac™. The information recorded includes supporting documentation from the provider and the date of all follow up requests for additional information. This enables us to respond immediately to a request from the Department regarding the status of any suspended review.

Upon receipt of the missing information, the review coordinator resumes the review process and completes the review within one (1) business day following receipt of the additional information. The review team has experience working collaboratively with providers offering education on the specific documentation needed to efficiently process authorization requests.

Criteria Application

All cases must meet Idaho Medicaid criteria before applying any other criteria. Telligen utilizes Milliman Care Guidelines® criteria. The criteria cover the healthcare continuum and can thus be applied to all service types and can be used as Participants move from one setting to the next.

Milliman Care Guidelines criteria will be used by the nurse review coordinators to conduct initial screening of the case. If criteria are met, the review coordinator approves the requested service(s) and the results are documented in the review system.

Review coordinators may only approve prior authorization requests based on application of criteria. Telligen ensures criteria are applied in a uniform manner through the inter-rater reliability process. If criteria are not met, the case is referred to the medical director or a physician reviewer licensed in Idaho to perform a physician review.

Peer Review Referral

If the information provided for the review does not meet the criteria for approval, the review coordinator refers the case to our medical director or physician peer reviewer. Using clinical knowledge and medical judgment, the peer reviewer determines the appropriateness of the requested service(s) and provides a medical rationale for the decision(s).

Approved Requests

Following review coordinator or peer reviewer approval of the requested services, Telligen will document the outcome in Qualitrac™. Notification of the approval will be sent electronically to the provider generated from Qualitrac™.

Denied Requests

If the peer reviewer determines the requested service is not medically necessary or appropriate, he/she will deny or modify the service(s). The peer reviewer will document the outcome in Qualitrac™. Telligen will supply medical rationale for the denial or modified decision in plain language that the Participant can understand. Letters approved by DHW will be generated from Qualitrac™.

Section 13: Retrospective Review/Retroactive Eligibility

Review Type	Submission Method/ Review Components	Description	Time Frame to Completion & Notification
Retrospective Pre-Payment Reviews	Web portal Secure fax Telephone	Conduct review for outpatient or inpatient hospitalizations where the primary diagnosis or procedure would have required pre-service review or when the hospitalization exceeded three days	Within thirty calendar days from receipt of all necessary documentation

Retrospective reviews are required for Medicaid Participants when eligibility is established retroactively. For any retrospective review of an inpatient stay, the provider must provide the required clinical information for the retrospective review submitted to Telligen.

Retroactive eligibility review is required only for those outpatient or inpatient hospitalizations where the primary diagnosis or procedure would have required pre-service review or when the hospitalization exceeded three days.

The physician or designated personnel may submit review requests to Telligen using one of four methods:

1. Secure Web Portal (preferred method)
2. Phone
3. Fax
4. Mail

For requests received via the portal, provider and Participant eligibility is confirmed through Qualitrac™.

For requests received via fax or mail, the Review Assistant verifies Participant eligibility, verifies the PA requested for the Participant is a service that requires authorization and builds the case in Qualitrac™.

The case is then referred to the Review Coordinator through the system scheduler.

The Review Coordinator reviews the information submitted by the provider including pertinent portions of the medical record if available to determine whether the requested service is medically necessary by applying the appropriate criteria set.

Our Review Coordinator may request additional information from providers to support the PA request. For example, during review of durable medical equipment PA requests, Telligen may request that providers submit medical clearance forms to justify DME or supplies.

Requests for Additional Information

If the information supplied by the provider is insufficient to complete the review, Telligen will suspend the case. Telligen will contact the provider for all suspended cases to request the additional information needed to complete the review. If the provider does not provide the additional information within ten (10) days following the initial contact, Telligen will administratively deny the requested service. The case will be reopened if the provider submits the additional information at a later time.

Telligen records and tracks all information received from the provider and all requests for additional information in Qualitrac™. The information recorded includes supporting documentation from the provider and the date of all follow up requests for additional information. This enables us to respond immediately to a request from the Department regarding the status of any suspended review.

Upon receipt of the missing information, the Review Coordinator resumes the review process and completes the review within one (1) business day following receipt of the additional information. The review team has experience working collaboratively with providers offering education on the specific documentation needed to efficiently process authorization requests.

Criteria Application

All cases must meet Idaho Medicaid criteria before applying any other criteria. Telligen utilizes Milliman Care Guidelines® criteria. The criteria cover the healthcare continuum and can thus be applied to the vast majority of service types and can be used as Participants move from one setting to the next.

Milliman Care Guidelines criteria will be used by the Nurse Review Coordinators to conduct initial screening of the case. If criteria are met, the Review Coordinator approves the requested service(s) and the results are documented in the review system.

Review Coordinators may only approve prior authorization requests based on application of criteria. Telligen ensures criteria are applied in a uniform manner through the inter-rater reliability process. If criteria are not met, the case is referred to the Medical Director or a Physician Reviewer licensed in Idaho to perform a physician review.

Peer Review Referral

If the information provided for the review does not meet the criteria for approval, the Review Coordinator refers the case to our Medical Director or Physician Peer Reviewer. Using clinical knowledge

and medical judgment, the Peer Reviewer determines the appropriateness of the requested service(s) and provides a medical rationale for the decision(s).

Approved Requests

Following Review Coordinator or Peer Reviewer approval of the requested services, Telligen will document the outcome in Qualitrac™. Notification of the approval will be sent electronically to the provider generated from Qualitrac™.

Denied Requests

If the Peer Reviewer determines the requested service is not medically necessary or appropriate, he/she will deny or modify the service(s). The Peer Reviewer will document the outcome in Qualitrac™. Telligen will supply medical rationale for the denial or modified decision in plain language that the Participant can understand. Letters approved by DHW will be generated from Qualitrac™.

Section 14: Focused Case Reviews

Review Type	Submission Method/ Review Components	Description	Time Frame to Completion & Notification
Focused Case Reviews	Web portal Secure fax Telephone	Conduct review of complex cases, high cost procedures and other cases as requested by the Department	Within fourteen calendar days of receipt of all necessary information

At the request of the Department, Telligen will complete Focused Case Reviews of complex cases, high cost procedures, or procedures which may be investigational, and other cases as requested. Focused Case Reviews of Medicaid Participants may be requested by the Department and reviewed by Telligen at any time.

Facilities that receive a medical record request from the Department or from Telligen for a Focused Case Review must submit the complete record within thirty (30) days of the date of the request. Telligen will report Focused Case Review results to the Department.

Section 15: Late Reviews

Telligen will process late reviews as identified in IDAPA 16.03.09.405 and 16.03.09.505. A late review is necessary when the Participant was Medicaid eligible at the time of the facility admission, but the provider failed to obtain the appropriate certification in a timely manner. If the review is completed while the Participant is still in the facility, this is termed as a “late pre-service review” or “late concurrent review”. However, if the review is completed after the Participant has been discharged from the facility, it is termed as a “retrospective review” for late submission of a review that should have been completed prior to admission or concurrently, while the Participant was hospitalized.

DHW will notify providers following receipt of a late review that an untimely request for preadmission and/or continued stay review may result in a penalty from the total Medicaid paid amount for the inpatient hospital stay. The dollar amount for the penalty is based on the number of days late the request is made (Idaho Administrative Procedures Act (IDAPA) 16.03.09.405.05).

DHW will assess the physician a penalty for failure to request a preadmission review for procedures and diagnosis listed on the select list in the Department's Physician Provider Handbook and the QIO Idaho Medicaid Provider Manual. If a retrospective review determines the procedure was medically necessary, and the physician was late in obtaining a preadmission review, the Department will assess a penalty according to Subsection 505.02 of this rule. The penalty will be assessed after payment for physician services has occurred. The Physician Penalty Schedule can be found at IDAPA 16.03.09.505.

Section 16: Notification

Providers who access the secure web portal will receive a secure email regarding the outcome of the review request. The provider will be able to print the notification letter from the portal.

Effective November 1, 2017, for authorization requests received via fax or mail we will notify the requestor by mail via a written notice generated by Qualitrac™. Review letters will no longer be faxed after this date. The decision notice will be mailed to providers without access to or who choose not to use the web portal. Providers are encouraged to register for and use the web portal as it will expedite the completion of the review process as well as the communication of the review results.

If any Quality of Care concerns are identified by the Review Coordinator and confirmed by the Physician Reviewer, we will notify the provider of the Quality of Care concern including any related reference to evidence-based care standards. If a pattern of concern occurs, we will refer the provider to the Idaho Medicaid Program Integrity Unit.

Section 17: Quality of Care Reviews

Overview

Quality of care reviews are performed on services reviewed by Telligen. The purpose of quality of care reviews is to determine whether the quality of service provided to Medicaid Participant meets the professionally recognized standards of health care. The processes for these retrospective reviews are found below.

Quality Review Criteria

Medical records are initially reviewed by the Clinical Reviewer utilizing MCG Care Guidelines criteria and CMS Quality of Care screens. Determinations of quality of care concerns are based on generally recognized standards of medical care and physician professional medical judgment. **See Section 21** for Centers for Medicare and Medicaid Services (CMS) Quality of Care screens.

Quality Review Process

Telligen Clinical Reviewers complete the initial quality of care review of the available medical record. If there are no concerns and all screening criteria are met, the case will be approved by the Telligen Clinical Reviewer. If one or more potential quality of care concerns is identified by the Clinical Reviewer,

the case if referred to the Peer Reviewer. The Peer Reviewer reviews the available medical record to determine:

a) If the quality of care concerns identified and referred by the Clinical Reviewer are valid; and

b) If the review of the medical record demonstrates additional concerns not identified by the Clinical Reviewer.

The peer reviewer makes a determination based on the above-mentioned findings.

Quality of Care Issue Notification

Quality of care concerns are tracked by Telligen to identify developing trends. Issues across institutions are addressed in educational communication, such as the Telligen Newsletter. Trends within a single institution result in a notification letter to the designated hospital contact liaison and, if appropriate, to the physician. Notification letters will include any requested response. Each concern results in written notification to the designated Hospital Contact Liaison or involved physician (in some instances both) indicating the identified concern. Providers and/or the attending physician have 60 days to respond to quality concerns. The date of the letter of notification is considered Day zero (0).

Section 18: Reconsideration Review (Tier Three)

Review Type	Submission Method/ Review Components	Description	Time Frame to Completion & Notification
Reconsiderations	Requests via portal, fax or mail	Additional supporting documentation	Within fourteen calendar days of receipt of all necessary information

Idaho Medicaid review procedures detail how Telligen processes reconsideration requests received from providers for reduced or denied admission, services or procedures.

Telligen will review all information submitted by the provider with the request for the reconsideration review. The following documentation must be submitted for reconsideration review requests:

1. Original review documentation and physician review decision;
2. Letter from the requester including substantiation for medical necessity of the services; and
3. Documentation pertinent to the case including medical records, equipment consultations, progress notes, case histories, therapy evaluations, etc.

The attending physician or facility may request a reconsideration of a case that has received a full or partial denial. The reconsideration request must be received within six (6) months of the date of the notification letter.

The Review Coordinator will review all submitted information and prepare a case summary for Peer Review. The reconsideration is then referred to a Physician Peer Reviewer. Telligen will use a Peer

Reviewer not involved in the original review decision to complete the reconsideration review. The Peer Reviewer will be Idaho licensed and Board Certified. The Peer Reviewer will base the review decision on information used to make the initial determination, the decision and rationale of the original Peer Reviewer, and the additional supporting documentation supplied by the provider.

Using medical judgment, the Peer Reviewer will make a determination and provide a medical rationale for their decision.

The reconsideration review determination may result in confirmation or modification of the original decision, or a complete reversal of the denial.

Telligen will notify the requesting provider and Participant of the reconsideration review result in writing following the review determination. The written notice will include the final determination and the rationale for the decision.

If any denied or modified service remains following reconsideration review, the notification letter will clearly advise the provider and the Participant of their right to request an appeal of the adverse decision.

Section 19: Healthy Connections

The Healthy Connections Program is team-based health care led by the primary care physician (PCP) and the Participant. The goal of the program is to develop a healthcare team that works with the Participant to address all their healthcare needs, improve the quality of their health care and overall well-being, and to make sure they get appointments with the healthcare team quickly. Involving the Participant's PCP at the time of a hospital admission is an important step to optimizing care coordination and promoting the best possible outcome for the Participant. When a request for review of a hospital admission is received, Telligen's Review Assistant notifies the HC PCP of the Participant's admission to the hospital (if the HC PCP is not the admitting physician).

Section 20: Review Types

Review Type	Submission Method/ Review Components	Description	Time Frame to Completion & Notification
Pre-Service Review	Web portal Secure fax Telephone	conduct pre-service reviews for selected diagnosis and procedures that require prior authorization	Non-urgent; Fifteen calendar days Urgent; Three business days
Psychiatric Hospital Pre-Admission and Continued Stay Review under 21	Web portal Secure fax Telephone	Conduct pre-service reviews of all admissions of Participants under the age of 21 with primary psychiatric diagnoses according to IDAPA 16.03.09 Sections 700-719	Pre-Admission Non-urgent; Fifteen calendar days Pre-Admission Urgent; Three business days Concurrent Non-Urgent: Three business days

			Concurrent Urgent: Three business days
Continued Stay Review for stays exceeding previously authorized hospital stays	Web portal Secure fax Telephone	Conduct medical necessity review of services that received pre-service authorization when the stay reaches the scheduled discharge date and discharge is not anticipated	Concurrent Non-Urgent: Three business days Concurrent Urgent: Three business days
Continued Stay Reviews for all hospital admissions exceeding 3 days length of stay	Web portal Secure fax Telephone	Conduct review of medical necessity for diagnosis/procedures that do not require pre-service review when the length of stay exceeds three days	Concurrent Non-Urgent: Three business days Concurrent Urgent: Three business days
Continued Stay Review for Cesarean Section hospital stays	Web portal Secure fax Telephone	Conduct review for medical necessity when the length of stay exceeds four days (only if the primary diagnosis code is identified as needing this review by the Department)	Concurrent Non-Urgent: Three business days Concurrent Urgent: Three business days
Retrospective Pre-Payment Reviews	Web portal Secure fax Telephone	Conduct review for outpatient or inpatient hospitalizations where the primary diagnosis or procedure would have required pre-service review or when the hospitalization exceeded three days	Within thirty calendar days from receipt of all necessary documentation
Focused Case Reviews	Web portal Secure fax Telephone	Conduct review of complex cases, high cost procedures and other cases as requested by the Department	Within fourteen calendar days of receipt of all necessary information
Quality of Care Assessment Reviews	Web portal Secure fax	Complete as requested by the Department	As mutually agreed upon between Telligen and the Department

Section 21: Appendices

Appendix A: UM-QM Idaho Medicaid Glossary of Terms

Admission Review: A review and determination by a review organization of the medical necessity and appropriateness of a patient's admission to a specific facility or a review prior to a patient's admission to a hospital to determine, for payment purposes, the reasonableness, medical necessity, and appropriateness of placement at an acute level of care.

Agency: Any state agency, board, or commission other than the University of Idaho, the Idaho State colleges, the courts, the Legislature, or any officer or agency established by the Constitution of Idaho.

Agent: A person authorized by a superior or organization to act on their behalf.

Business Day: Any weekday, excepting public holidays.

Calendar Day: Every day shown on the calendar; Saturdays, Sundays and State/Federal holidays included. Not to be confused with "Work Day".

CMS: Centers for Medicare and Medicaid Services.

Complete Medical Record:

1. History and physical performed no more than 7 days before admission or with 48 hours after admission;
2. Admitting Diagnosis;
3. Results of all consultative evaluations;
4. Documentation of complications, hospital acquired conditions, and unfavorable reactions to anesthesia or drugs;
5. Properly executed consent forms for procedures and treatments;
6. All practitioner orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, vital signs, and other information necessary to monitor the patient's condition; and
7. Discharge summary with final diagnosis, outcome of hospitalization, disposition of case.

Concurrent Review: A review performed to evaluate whether the Medicaid Participant requires an extension of services, in light of ongoing clinical conditions and/or functional limitations.

Continued Stay Review: A periodic review of available pertinent medical information conducted during the hospitalization to ensure that the patient continues to require the level of care being provided, continues to receive the appropriate level of care, and the services provided meet professionally recognized standards of care.

Criteria: Predetermined elements of health care, developed by health professionals relying on professional expertise, prior experience, and the professional literature, with which aspects of the quality, medical necessity, and appropriateness of a health care service may be compared.

Critical Access Hospital (CAH): Section 1820 of the Social Security Act, as amended by 4201 of the Balanced Budget Act of 1997, established the Medicare Rural Hospital Flexibility Program by allowing a State to establish Critical Access Hospitals (CAHs) and at least one rural Health Network. This new program replaced the Essential Access Community Hospitals (EACHs) and the Rural Primary Care Hospitals (RPCHs) Program.

Diagnosis Related Group (DRG): A group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications. A system for classifying inpatient hospital discharges. DRGs are used for purposes of determining payment to hospitals for inpatient hospital services under the Medicaid prospective payment system.

Discharge Review: A component of a retrospective review that entails the review of all pertinent medical information to determine if the patient was medically stable and appropriate discharge planning had been completed prior to dismissal of the patient.

Documentation: The user manuals and any other materials in any form or medium customarily provided by the contractor to the users of the Licensed Software which will provide the State with sufficient information to operate, diagnose, and maintain the Licensed Software properly, safely, and efficiently.

DRG Validation: A part of either a) a retrospective review for inpatient hospital services reimbursed on a DRG payment methodology, or b) the prospective payment system, in which a QIO validates that DRG assignments are based on the correct diagnostic and procedural information for Medicaid payment purposes.

Indicators: Indicators are measures, or measurement tools used to monitor and/or measure some component of health care delivery.

Initial Denial Determination: An initial negative decision by a review organization regarding the medical necessity, quality, or appropriateness of health care services furnished or proposed to be furnished, to a patient.

Mandatory: Required, compulsory or obligatory.

May: Denotes discretion.

Medical Review Criteria: Medical review criteria are systematically developed standards that can be used to assess specific health care decisions, services, and outcomes.

Medically Reasonable and Necessary: Health care services and supplies which are medically appropriate and:

1. Necessary to meet the basic health needs of the Participant;
2. Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
3. Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical research, or health care coverage organizations or governmental agencies;
4. Consistent with the diagnosis of the condition;
5. Required for means other than convenience of the Participant or his or her physician;
6. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
7. Of demonstrated value; and
8. No more intense level of service than can be safely provided.

The fact that the physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, or mental illness does not mean that it is covered by Medicaid. Services and supplies that do not meet the definition of medical necessity set out above are not covered.

Must: Denotes the imperative, required, compulsory or obligatory.

Outliers: Those cases that have either an extremely long length of stay or extraordinarily high costs when compared to most discharges classified in the same DRG.

Pattern Analysis: Pattern analysis is the clinical and statistical analysis of data from case review.

Peer Review: A review by health care practitioners of services ordered or furnished by other practitioners in the same professional field.

Prepayment review: A review conducted prior to payment. This may, among others, include prior authorization review. Prior authorizations include inpatient rehabilitation services, select surgical procedures, and out-of-state services.

Pre-procedure Review: A review of a surgical or other invasive procedure prior to the conduct of the procedure.

Prior Authorization: An approval of a request for services before services is provided.

Quality: Quality is the degree to which health services for individuals and populations increase the likelihood of desired outcomes and are consistent with current professional knowledge.

Quality Improvement Organization (QIO): QIOs are required under Sections 1152-1154 of the Social Security Act, and 42 CFR 476. For purposes of a review under section 1154(a)(4) of the Social Security Act, a QIO must determine whether the quality of services meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings. QIOs are required to offer providers quality improvement assistance pertaining to health care services.

Quality Review: For the purposes of this RFP, Quality Review applies to physical health services. Explicit review criteria and generally recognized medical standards of care are used to evaluate all services.

1. Appropriateness, adequacy, and timeliness of clinical and diagnostic evaluation;
2. Appropriateness, adequacy, and timeliness of treatment;
3. Monitoring of patient response;
4. Management of any complication; and/or use of specialists/consultants;
5. Documentation concerning patient status, clinical findings, and supporting rationale for the plan of care;
6. Achievement of adequate patient stability with appropriate discharge planning (beginning on the day of admission), support and/or follow up evidenced at dismissal; and
7. Appropriate and safe transfer/referral to another facility for specialized and/or complex care.

Random Sample: A random sample is a group selected for study which is drawn at random from the universe of cases by a statistically valid method.

Reconsideration: Reconsideration results from a reexamination of an initial denial determination and is performed by a physician who was not involved in the original determination. There are further appeal rights to this determination.

Retrospective Review: A review performed when Medicaid eligibility is established after services have already been provided.

Shall: Denotes the imperative, required, compulsory or obligatory.

Should: Indicates an expectation.

Special Reports and Consultation: Reports determined in collaboration with the department that are generated, analyzed and interpreted by the Contractor to provide the Department with data and information necessary to comply with federal and state requirements to advise informed policy decisions. Reports may include, but not be limited to utilization analysis by diagnosis or service, non-certification reviews and closed reviews analysis.

Will: Denotes the imperative, required, compulsory or obligatory.

Section 22: Centers for Medicare and Medicaid Services (CMS)

Center for Medicare & Medicaid Services (CMS) Quality of Care Screens Category	Description and Use
C01	**Apparently did not obtain pertinent history and/or findings from examination.** This category is used for a failure to provide an accurate history; this is also for failure to include information obtained by the performance of an appropriate physical exam.
C02	**Apparently did not make appropriate diagnoses and/or assessments.** This category is used for a failure to perform an appropriate assessment and establish a diagnosis.
C03	**Apparently did not establish and/or develop an appropriate treatment plan for a defined problem or diagnosis which prompted this episode of care [excludes laboratory and/or imaging (see C06 or C09) and procedures (see C07 or C08) and consultations (see C13 and C14)]** This category is used for a lack of organized, appropriate diagnostic and management plans related to the condition for which the patient was admitted; incomplete, inappropriate, or lack of treatment plan for principal diagnosis.
C04	**Apparently did not carry out an established plan in a competent and/or timely fashion (e.g., omissions, errors of technique, unsafe environment).** This category is used for failure to take necessary precautions, lack of appropriate equipment maintenance, medication errors, technical and/or procedural errors, and failure to follow physician's orders, delayed completion or reporting of studies.

Center for Medicare & Medicaid Services (CMS) Quality of Care Screens Category	Description and Use
C05	**Apparently did not appropriately assess and/or act on changes in clinical/other status results.** This category is used for failure to recognize clinical changes which occur in the patient's condition; this category also applies if the clinical changes are noted but not acted on.
C06	**Apparently did not appropriately assess and/or act on laboratory tests or imaging study results**. This category is used for a failure to provide ongoing monitoring and evaluation of the patient's laboratory or imaging studies by failing to evaluate and/or act on diagnostic studies.
C07	**Apparently did not establish adequate clinical justification for a procedure which carries patient risk and was performed**. This category is used for failure to document accepted indications for a procedure.
C08	**Apparently did not perform a procedure that was indicated (other than lab and imaging, see C09).** This category is used for failure to perform a medically necessary procedure that is indicated by the patient's condition.
C09	**Apparently did not obtain appropriate laboratory tests and/or imaging studies.** This category is used for failure to order diagnostic (laboratory and/or imaging) studies that are deemed appropriate for the patient's condition.
C10	**Apparently did not develop and initiate appropriate discharge, follow-up, and/or rehabilitation plans.** This category is used for a lack of follow-up arrangements or plans for conditions continuing to require treatment and/or monitoring prior to or following discharge; failure to develop a plan that reflects an appropriate transition of care; failure to identify additional needed resources; failure to provide appropriate teaching; failure to transmit pertinent information.
C11	**Apparently did not demonstrate that the patient was ready for discharge.** This category is used for failure to assure that the patient is stable enough for discharge to the setting into which the patient is being discharged.

Center for Medicare & Medicaid Services (CMS) Quality of Care Screens Category	Description and Use
C12	**Apparently did not provide appropriate personnel and/or resources.** This category is used for lack of sufficient staff to handle patient load; lack of credentialed staff for provision of offered services; equipment unavailable to carry out treatment plan.
C13	**Apparently did not order appropriate specialty consultation.** This category is used for those cases in which a specialty consultation that would have been necessary to adequately assess and treat the patient was not ordered. If there is a distinct clinical management concern over and above failure to order the consultation, cite that category as well, even if it is C03.
C14	**Apparently specialty consultation process was not completed in a timely manner.** This category is used when a specialty consultation is not ordered in a timely manner or is not completed in a timely manner. If the only issue is the delay, do not additionally cite C03. If there is a distinct clinical management concern over and above the delay in ordering or completing the consultation, cite that category as well, even if it is C03.
C15	**Apparently did not effectively coordinate across disciplines.** This category is used when there is poor communication and coordination between specialists or clinicians that adversely impacts the patient's care.
C16	**Apparently did not ensure a safe environment (medication errors, falls, pressure ulcers, transfusion reactions, nosocomial infection).** This category is similar to category C04 but is more specific to patient safety and protection from injury.
C17	**Apparently did not order/follow evidence-based practices.** This category of concern is used when there is a specific aspect of the treatment plan that doesn't follow current guidelines and evidence-based practices.
C18	**Apparently did not provide medical record documentation that impacts patient care**. This category is used for poor or missing documentation that makes it difficult to follow the plan of care and patient progress.

Center for Medicare & Medicaid Services (CMS) Quality of Care Screens Category	Description and Use
C99	**Other quality concern not elsewhere classified.** This category is used in exceptional cases. The vast majority of cases should be able to fit into the above listed categories.

Section 23: Resources

CMS-Centers for Medicare and Medicaid: www.cms.gov
Milliman Care Guidelines
Telligen: www.telligen.com

Section 24: Contact Telligen

The Telligen Clinical Reviewers are available Monday through Friday 8:00 am to 6:00 pm mountain time. Information may be submitted to Telligen by:

Mail: Telligen Idaho Medicaid Review Agent
670 East Riverpark Lane, Suite 170
Boise, ID 83706

Web page/Portal: http://idmedicaid.telligen.com/home
Secure Toll-Free Fax: 866-539-0365
Toll Free Call Center: 866-538-9510
Local Phone: 208-433-7500