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

Provider Manual
Idaho Medicaid
2021

Contents

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 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 (UM) 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 Diagnosis Related Group (DRG) validation. As a Utilization Review Accreditation Commission (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

Transforming lives and economies by improving health.

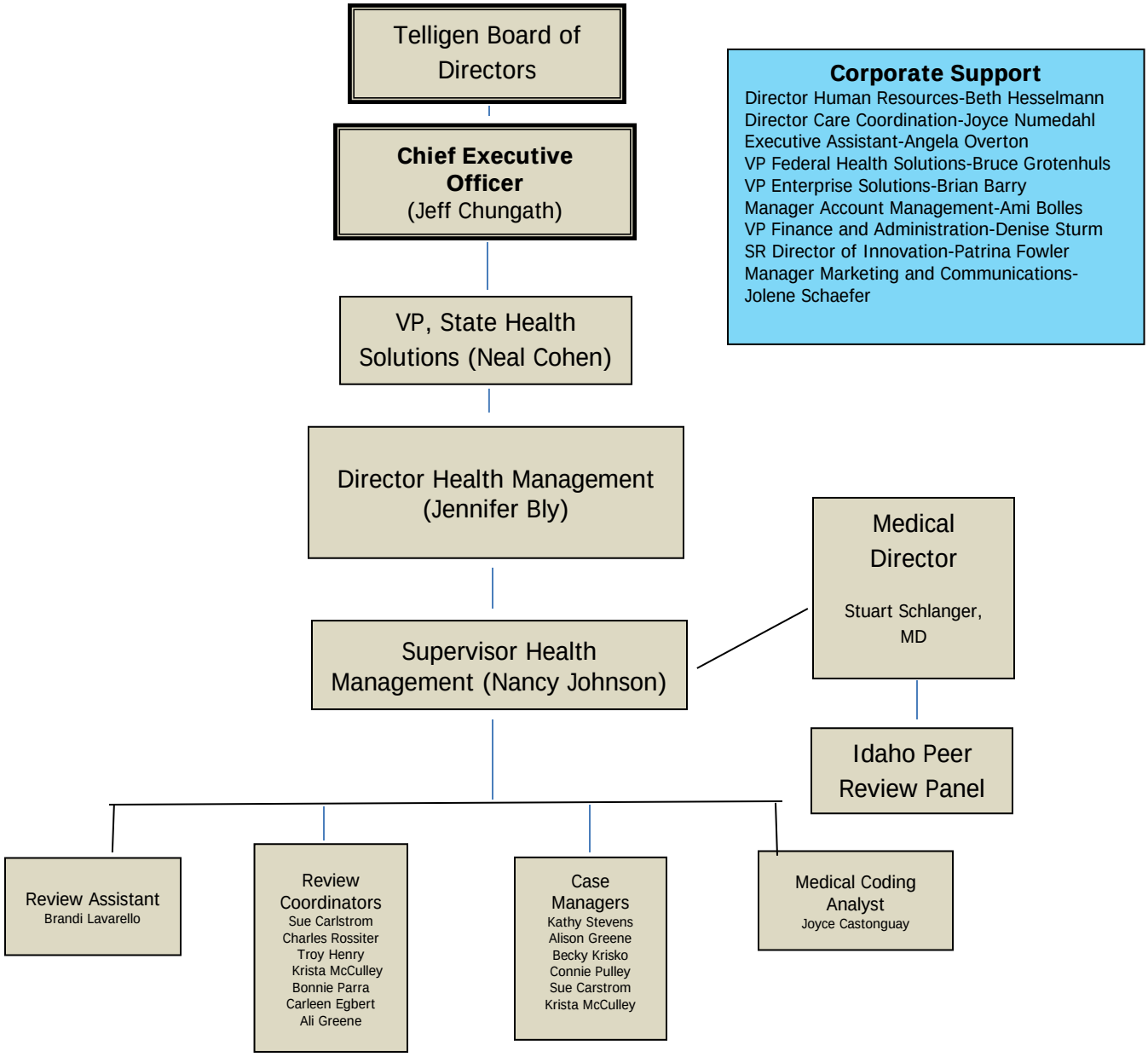
VISION

To be one of the most sought-after companies to transform the health of populations.

CORE VALUES

Ownership~Integrity~Ingenuity~Community

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	• 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
Case Manager	• Participates in the assessment, planning, facilitation, care coordination, evaluation, advocacy to meet a Participant's comprehensive health care needs.	• Certified case manager credentials through the Commission for Case Manager Certification or other credentials approved by IDHW

Section 4: Provider Manual Overview

Authority

The Idaho Department of Health and Welfare (IDHW) contracts with Telligen to implement and manage quality and utilization management (UM) program for services, and individual case management for Idaho Medicaid Participants with complex medical conditions. Quality and UM includes reviews of hospital acute inpatient, acute outpatient, acute behavioral health, Children's Habilitation Intervention Services, and genetic testing services, along with DRG validation and medical necessity reviews.

Telligen performs 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 Provider Manual

The purpose of this document is to notify providers of the process that Telligen will follow for review of services provided to Idaho Medicaid participants. This manual is also to notify providers of the process that Telligen will follow for case management services.

Objectives

The IDHW 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.

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 HIPAA

Regulation and Guidance

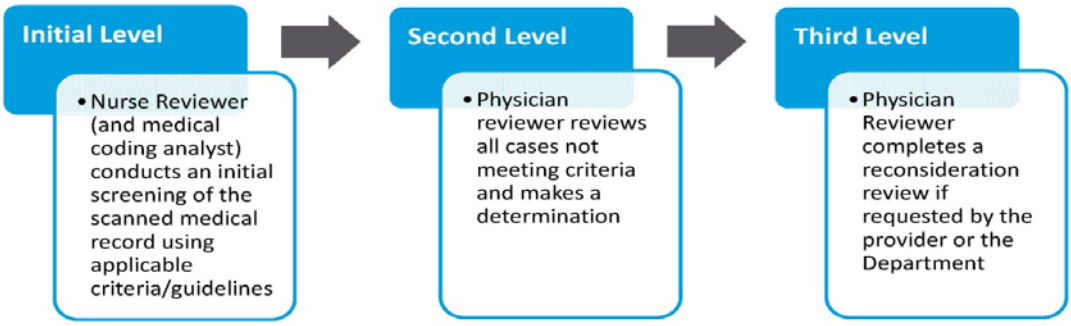
The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 enacted by Congress, includes Administrative Simplification provisions that mandated the adoption of federal privacy protections for individually identifiable health information, national standards for electronic health care transactions and code sets, unique health identifiers, and security. Under terms of this contract and as a contracted partner with IDHW, 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. Responsibility for Copying and Mailing Medical Records

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. This results in a more efficient and 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 7: Telligen Review Process Overview

Our review process includes three levels:



Our review program is based upon a combination of initial screening by the nurse review coordinator and/or medical coding analyst using applicable criteria/guidelines and physician peer review.

Review Screen Criteria

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

MCG 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 an internal Quality Assurance process.

Auto Authorization (Tier One-Initial Level)

Telligen offers an Auto Authorization process that allows providers to submit their requests through Telligen's secure Qualitrac™ 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 Milliman Care Guidelines™ (MCG), allowing the provider to enter and upload applicable clinical information resulting in an approval or referral to a nurse reviewer.

Initial Review (Tier One-Initial Level)

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.

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.

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) calendar days following the initial contact, Telligen will administratively deny the requested service and issue a Technical Denial letter.

- For all pre-payment reviews, the case may be reopened. The provider must submit the requested information within 180 calendar days for the case to be eligible for re-opening.

- For all retrospective post-payment medical necessity and DRG validation reviews, after the administrative denial, all requested information must be submitted to Telligen within 30 days of the date on the technical denial notice for a reconsideration. If no information is received by Telligen within the 30 days, the technical denial becomes final.

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 IDHW 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. Providers are encouraged and welcome to contact the Telligen review staff via phone or email with any questions regarding the requested information.

Peer Review Referral (Tier Two-Second Level)

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).

Reconsideration Review (Tier Three-Third Level)

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.

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, consultations, progress notes, case histories, therapy evaluations, etc.

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 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 render a determination and provide medical rationale for their decision.

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.

As of July 1, 2021, concurrent, and continued stay reviews are not required for facilities subject to DRG reimbursement. Prior authorization for the Acute Rehabilitation and Long-Term Acute Care Hospital is no longer required for facilities subject to DRG reimbursement.

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 in facilities 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 exceeding three (3) days length of stay or exceeding previously authorized units associated with procedures and services requiring prior authorization. For hospital stays associated with a Cesarean Section primary diagnosis code the review is necessary when the inpatient stay exceeds four (4) days length of stay. 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.
- 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.
- Children's Habilitation Intervention Services (CHIS). Evidence-informed or evidence-based therapeutic techniques based on applied behavior analysis principles used to result in positive outcomes. The review determines if the services are medically necessary and in alignment with Medicaid rules and policies.

- Emergency Medical Services (eMed) Reviews. Retrospective pre-payment medical necessity reviews for emergency services rendered to a non-Citizen. An individual not meeting the U.S. citizenship requirement may receive medical services necessary to treat an emergency medical condition, including labor and delivery.
- Retrospective Post-Payment Reviews. Reviews are conducted for inpatient hospitalizations to determine whether healthcare services were medically necessary, delivered in the most appropriate setting, and met professionally recognized standards of care.
- DRG Post-Payment Reviews. Reviews are conducted to validate the submitted claims for All Patient Refined (APR) Diagnosis Related Group (DRG) reimbursement.

Medically Necessary

A service is medically necessary, per Idaho Administrative Code/Idaho Administrative Procedures Act (IDAPA) 16.03.09.11.17 and 16.03.10.12.15, if:

1. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endangers life, cause pain, or cause functionally significant deformity or malfunction; and
2. There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly.
3. Medical services must be of a quality that meets professionally recognized standards of care and must be substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request.

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 8. Submitting Prior Authorization Requests

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

1. Secure Web Portal (preferred method)
    - *https://id.qualitrac.com*
2. Phone
    - 866-538-9510
3. Confidential Fax
    - 866-539-0365
4. Mail (paper or electronic media)

    Telligen
    Attn: Idaho Medicaid
    670 East Riverpark Lane, Suite 170
    Boise, ID 83706

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.

- Refer to the Idaho Medicaid fee schedule for Pre-Service Review procedures and services that require a prior authorization.
  https://healthandwelfare.idaho.gov/providers/idaho-medicaid-providers/information-medicaid-providers
- As of July 1, 2021, concurrent, and continued stay reviews are not required for facilities subject to DRG reimbursement. Prior authorization for the Acute Rehabilitation and Long-Term Acute Care Hospital is no longer required for facilities subject to DRG reimbursement.

The cost of copying a medical record and mailing it to Telligen is the responsibility of the facility. Telligen will not pay or reimburse the facility for this expense. Telligen will not accept any medical record delivery COD (cash on delivery).

Section 9: Review Types

Review Type	Submission Method/ Review Components	Description	Time Frame to Completion
Pre-Service Review • Surgical procedures • Genetic Testing	Web portal Secure fax Telephone Mail	Conduct pre-service reviews for selected diagnosis and procedures that require prior authorization	Non-Urgent: 15 calendar days Urgent: Three (3) calendar days.
Psychiatric Hospital Pre-Admission and Continued Stay Review under 21 in facilities not subject to DRG payment.	Web portal Secure fax Telephone Mail	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 in facilities not subject to DRG payment.	Web portal Secure fax Telephone Mail	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
Concurrent Stay Reviews for all hospital admissions exceeding three (3) days length of stay in facilities not subject to DRG payment.	Web portal Secure fax Telephone Mail	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
Concurrent Stay Review for Cesarean Section hospital stays exceeding four (4) days	Web portal Secure fax Telephone Mail	Conduct review for medical necessity when the length of stay exceeds four days (only if the primary diagnosis code	Concurrent Non-Urgent: Three business days Concurrent Urgent: Three business days

length of stay in facilities not subject to DRG payment.		is identified as needing this review by the Department)	
Retrospective Pre-Service/Payment Reviews	Web portal Secure fax Telephone Mail	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 Mail	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 documentation
Outpatient Therapy Intervention (Children's Habilitative Intervention Services)	Web portal Secure fax Telephone Mail	Conduct pre-service review of medical necessity for intervention services and annual assessment and clinical treatment plans (ACTPs). Conduct a post-service review of medical necessity for initial ACTP or screening	Non-urgent: 10 business days Urgent/Crisis: 3 business days
Emergency Medical Services (eMed)	Web portal Secure fax Telephone Mail	Conduct retrospective pre-payment medical necessity reviews for emergency services rendered to a non-Citizen.	Within 30 calendar days from receipt of all necessary documentation
Retrospective Post-Payment Reviews	Web portal Secure fax Mail	Conduct review for inpatient hospitalization to determine whether healthcare services were medically necessary, delivered in the most appropriate setting, and met professionally recognized standards of care	Within 30 calendar days from receipt of all necessary documentation
DRG Post-Payment Reviews	Web portal Secure fax Mail	Conduct review to validate the submitted claims for All Patient Refined (APR)-Diagnosis Related Group (DRG) reimbursement.	Within 30 calendar days from receipt of all necessary documentation

Section 10: Late Reviews

Telligen will process late reviews as identified in Idaho Administrative Code/Idaho Administrative Procedures Act (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. IDHW 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 (IDAPA 16.03.09.405.02 or 16.03.09.505.02).

IDHW will assess the physician a penalty for failure to request a preadmission review for procedures and diagnosis listed on the select list in the Idaho Medicaid Fee Schedule and the QIO Select PreAuth List. 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 11: 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 12: Notice of Decisions (NODs)

- Telligen will report to IDHW all outcome determinations.
- All outcome letters will clearly advise the provider and the Participant of their right to request a reconsideration and an appeal.
- Providers who access the secure web portal will receive a secure email regarding the outcome of the review request within one (1) business days of the date of decision. The provider will be able to print the notification letter from the portal.
- All outcomes will be mailed to attending physicians/providers, facilities, and participants (if applicable) within five (5) business days of the date of decision.

Technical Denial Process

- Prepayment reviews: If the provider fails to submit the record within 10 days, a technical denial will be issued to the provider. Technical denial determinations are subject to reconsideration and/or appeals. Telligen may re-open a technical denial determination once all requested information is submitted. The provider must submit the requested information within 180 calendar days for the case to be eligible for re-opening.
- Retrospective post-payment medical necessity and DRG reviews: All requested information must be submitted to Telligen within 30 calendar days of the technical denial notice. If no information is received by Telligen within the 30 calendar days, the technical denial becomes final.

Telligen will notify the attending physician and/or the requesting/treating provider and Participant of the technical denial in writing within five (5) business days of when the decision is made.

Approvals:

- Written notice of approved services will be sent to attending physicians/providers and facilities within five (5) business days of the date the decision is made clearly stating the reason for the action.
- Written notice of approved services will be sent to the Participant, in addition to the attending physicians/providers and facilities, within five (5) business days of the date the decision is made clearly stating the reason for the action for Children's Habilitative Intervention Services and Psychiatric Residential Treatment Facility related requests.

Adverse Determinations:

Telligen will provide written notification to the Participant, the attending physicians/providers, and facilities of all adverse determinations within five (5) business days of the date the determination is made clearly stating the reason for the action. Adverse determinations include denials, partial approvals, and modifications to decisions.

Section 13: Case Management Services

Case Management (CM) services are provided for catastrophic, complex, high cost, high risk, or sensitive cases.

Referral Sources

- Participant self-referral
- Requested by IDHW
- Medicaid providers

Referrals may be called in to (888) 897-9003 or emailed to CMIdaho@telligen.com

- Conditions that may qualify for case manager services (not limited to):
  - High-risk pregnancy
  - Infants in the NICU with extreme prematurity (23-24 weeks)
  - Infants born less than 38 weeks with major medical issues or other complex health conditions.
  - Currently in or status post, acute rehab or long-term acute care hospital, with multi-trauma, stroke, or new paralysis.
  - Organ transplant or seeking transplant services.
  - Burns

Consent for Case Management

The Telligen Nurse Case Managers (NCM) will obtain consent for Case Management (CM) services. Telligen encourages early consent for participation in the CM program, however circumstances may warrant a delay. The timeframe for obtaining consent may vary dependent on the member's current medical condition.

Expectations:

- The goal is to obtain consent, either from the participant, the participant's family member, or a caregiver no later than 21 calendar days of identification of a prospective member. In the event consent is not able to be obtained the catastrophic case will be closed.
- Consent can be obtained while the participant is still in the hospital receiving medical care, prior to discharge. Telligen will work through the hospital social worker to ensure the member is medically stable or to identify potential family members or care givers to discuss the CM program.
- The consent is valid through the life of the active CM case, unless otherwise requested by the member. Once the case has been closed, the consent is no longer valid and additional consent must be obtained for any subsequent cases in CM.
- Once the NCM determines catastrophic care management services are appropriate the following occurs:

- The CM roles and processes are explained to the member/representative.
- Verbal consent is obtained from the participant/representative verbally and documented in the case notes prior to the initiation of the CM process and is valid throughout the life of the specific case management case.
- An assessment is completed.

- During the initial discussion with the member when consent for CM is obtained:
  - The participant is verbally educated on their member rights.
  - The participant/caregiver is provided the nurse care manager's contact information.
  - The participant is verbally educated of their choices regarding services.
  - The participant is verbally educated of their right to have input into the case management plan. Input will include assisting the CM in developing member goals and providing updates on their individual goals each month when the CM contacts the member.
  - Participants/caregivers are educated on the use of a personal health care record to facilitate communication with providers regarding treatment plans, medication knowledge and transitions of care.
  - The participant is verbally educated on their right to refuse treatment or services, including case management services and the implications of such refusal relating to benefits eligibility and/or health outcomes. The member will be instructed to contact their CM verbally if they chose to withdraw from the program.
  - The participant is verbally educated on the use of end of life and advance care directives as applicable.
  - The participant is verbally educated on their right to obtain information regarding the criteria for case closure. The member may request this information verbally from their CM.
  - The participant is verbally informed that information obtained in case management may be shared with a third party when related to the administration of benefits and/or claim payment.
  - The participant is verbally educated on their right to receive notification and a rationale when case management services are changed or terminated. The nurse case manager explains to the member when benefits are changed or terminated, they will receive verbal and/or written notification from their nurse case manager.
  - Alternative approaches when the participant, family and/or caregivers are unable to fully participate in the assessment phase including collaboration with the health care provider and collaboration with the treatment are provided verbally to the participant, family, and/or caregiver.
  - The participant is verbally informed that they will receive written notification via the United States Postal Service (USPS) when there is a review of healthcare services (home care, medication therapy services, etc.).

- In the event the participant, participant's family and/or caregiver(s) are not available to fully participate in the assessment phase of the case management program, the nurse case manager will collaborate with the attending physician and treatment team to obtain assessment information. The nurse case manager may also collaborate with the medical director in addition to the attending physician and treatment team to determine the best approaches to case manager for the participant.
- The written consent/authorization letter is mailed to the member/representative within two (2) business days of receiving consent from the participant. This communication to the participant advises them that all protected health information provided to Telligen is confidential and shared only in accordance with state and federal laws.
- In the event the participant displays an imminent threat to self or others, there is a legal issue, or a quality of care has been identified, services may be initiated without consent. The nurse case manager will discuss the case with their direct manager and/or medical director before initiating services when consent from the participant has not been obtained.
- Telligen CM program's philosophy is that participants, their families, and the treatment team are fully informed of the CM process, the nature of the relationship, as well as the be active participants in assessment, care planning, goal setting, and evaluation. The participant, their representative, and the treatment team will also be informed of the process for filing any complaints or objections to the CM process.
- The participant's right to privacy is very important and will not be violated except to protect the safety of the participant and others.
- Variances to these requirements are outlined in the client profiles, client contracts, and/or state regulations.

Psychiatric Residential Treatment Facility (PRTF) Case Management

Telligen will assist the Department in PRTF placement and case management of children under twenty-one (21) who qualify for the specific level of care. This includes, but is not limited to:

1. Complete focus care reviews (FCRs) for initial and continued stay requests, working with a Physician reviewer on all initial requests unless otherwise approved by the Department.
    a. Telligen will reach out to appropriate parties when more information is needed for reviews and/or continued stay documentation has not been submitted timely by the provider.
2. Identify, document, and notify the Department of any identified risks, concerns, and/or treatment recommendations when working with the facilities, parents, and/or guardians.
3. Participate in treatment plan meetings, discharge planning, and oversight when participants are hospitalized while in the PRTF in conjunction with Department staff.
4. Communicate with providers, parents, and/or guardians regularly to encourage communication and ensure satisfaction with care.

Case Management Reporting to IDHW

Telligen will provide written periodic status reports for open cases at IDHW's request and participate in monthly case management meetings with IDHW staff. Telligen will provider closure reports detailing interventions and outcomes for individual cases within two (2) weeks of case closure.

Section 14: Definitions

Acronyms

APR All Patient Refined

CFR Code of Federal Regulation

CM Case Management

CMS Center for Medicare and Medicaid Services

DRG Diagnosis Related Group

IDAPA Idaho Administrative Procedures Act/Idaho Administrative Code

IDHW Idaho Department of Health and Welfare

MCG Milliman Care Guidelines

PRTF Psychiatric Residential Treatment Facility

Definitions

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.

Case Management – A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes.

Clinical Reviewer (Review Coordinator and/or Medical Coding Analyst) – A registered nurse or medical coder with appropriate education and clinical background, trained in the performance of utilization, coding/DRG validation and quality assurance review to perform chart reviews, pre-admission authorization, out-of-state service authorizations, and prior surgical authorizations for specified surgical procedures in accordance with the contract with IDHW.

Continued Stay/Concurrent Review – A period 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.

Diagnosis Related Group (DRG) – A group of similar diagnoses combined based on patient age, procedure coding, co morbidity, 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.

DRG Validation – A part of the prospective payment system which validates that DRG assignments are based on the correct diagnostic and procedural information. Idaho Medicaid utilizes an All Patient Refined (APR) DRG methodology.

Eligibility Related Retrospective Review – A review of pertinent medical information conducted after a service was delivered when the client was not eligible for Medicaid at that time a prior authorization or a pre-admission review would have been required. The review will be conducted using the same criteria as would have been used had the client been eligible at the time the service was delivered. The review is only available in cases where the client was not eligible at the time of service but was later determined retroactively eligible.

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

Medical Director – A physician (MD or DO) employed by Telligen Health to manage and direct the review process, pre-admission authorization, out-of-state authorizations, and surgical procedure authorizations in accordance with the contract with IDHW.

Medical Review –The collection of information and clinical review of medical records by physician advisors or a peer review team to ensure that payment is made only for services that meet coverage, coding, and medical necessity requirement.

Medically Necessary as defined in IDAPA 16.03.09.11.17 AND 16.03.10.12.15

A service is medically necessary if:

1. It is reasonably calculated to prevent, diagnose, or treat conditions in the participant that endangers life, cause pain, or cause functionally significant deformity or malfunction; and
2. There is no other equally effective course of treatment available or suitable for the participant requesting the service which is more conservative or substantially less costly.

3. Medical services must be of a quality that meets professionally recognized standards of care and must be substantiated by records including evidence of such medical necessity and quality. Those records must be made available to the Department upon request.

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

Outpatient – A person who has not been admitted as an inpatient but is registered on the hospital records as an outpatient and receives services.

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

Physician Reviewer – A physician (MD or DO) contracted by Telligen to perform reviews. The physicians will hold a current and unrestricted license and be engaged in the active practice of medicine.

Prior Authorization – A favorable determination transmitted to the hospital or facility, and the fiscal intermediary approving the request for services or payment purposes.

Reconsideration – Reconsideration results from a re-examination 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 – Retrospective Review is a review conducted after services are provided to a patient. The review is focused on determining the medical necessity, appropriateness of the setting, reasonableness, and quality of health care services provided.

Technical Denial – A technical denial is a denial of authorization by Medicaid issued for reasons other than medical necessity.

Validation – The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accordance with standards for data collection and analysis

Section 15: Resources:

CMS-Centers for Medicare and Medicaid: www.cms.gov
Idaho Department of Health and Welfare: https://healthandwelfare.idaho.gov
Milliman Care Guidelines**:** www.mcg.com
Telligen: www.telligen.com

Section 16: 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