



© CNSI/Kepro. All Rights Reserved.

Prior Auth Case Set Up, Essentials and Tips

Acentra
HEALTH

Agenda

Submitting Your Prior Auth Request

Atrezzo Overview and Features

Case Creation and Quick Tips

Post Determination Actions

Provider Resources and Links

Submitting a Prior Authorization (PA)



Atrezzo Provider Portal

- Complete the case set up with directions from Case Wizard app and upload required clinical documents and forms if needed.



Fax

- Fill out the PA Request Form and attach all necessary documents.
- Fax to 800-261-2774



Mail

- Fill out the PA request form, and mail all documents to:
Acentra Health
6802 Paragon Place, Ste. 440
Richmond, VA 23230

Notification of Incorrect Submission

If a fax is submitted to Acentra Health with missing or incorrect information, providers will receive a faxed notification back. *The notification includes why the fax was not processed and may require the sender to correct and resubmit the information.*



6802 Paragon Place, Suite 440
Richmond, VA 23230
Phone: 866-725-9991
Fax: 800-261-2774

<https://inmedicaidffs.acentra.com/>

Notification of Incorrect Submission

Reference:

Prior authorization Request Date:

Dear Provider:

Acentra is in receipt of information from your organization submitted for Prior Authorization for the individual identified above. Unfortunately, the information as submitted does not allow us to initiate a review.

Examples of Notice of Incorrect Submission

- Fax did not include required IHCP form (i.e. Prior Auth Request Form or Prior Auth Revision Request Form)
- Incorrect information or missing information on request (i.e. member eligibility, incorrect member information, no Prior Auth required for primary code or other codes listed)



ATREZZO PORTAL

Atrezzo Overview and Features



Atrezzo Overview Highlights

Acentra Health's proprietary system is designed to be user-friendly and decrease provider burden.

Atrezzo portal highlights include but are not limited to the following:

- ✓ Allows use for multiple accounts; change context to select your account
- ✓ Offers direct communication with clinicians via Notes
- ✓ Provides case status change notifications via messaging
- ✓ Allows upload of documentation directly to the case
- ✓ Ability to easily track current cases and submit requests for action on a case

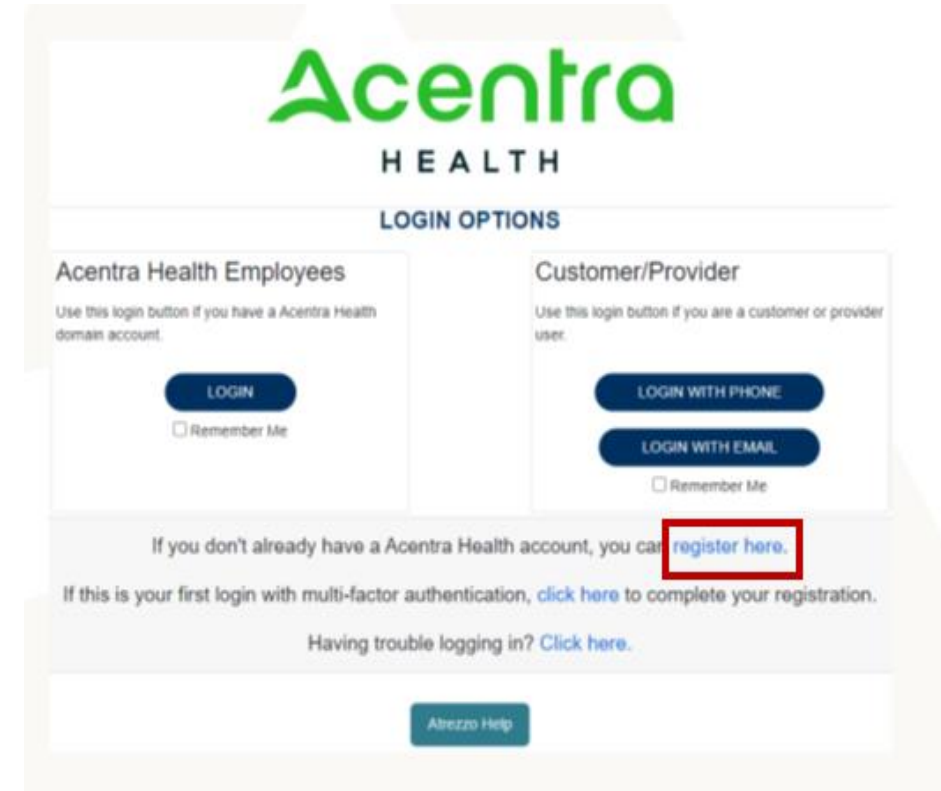


The Atrezzo Log In Screen

SELECT YOUR LOGIN OPTION

If you don't already have access to Atrezzo, reach out to your Provider Group Admin of your account to be set up as a user OR click the **register here** link on the bottom of the page to get started.

If you have questions about registering for an account, please reach out to INPriorAuthIssues@Acentra.com



For registration resources and portal guides, click here: [Training & Education - Indiana Medicaid FFS](#)



Home Screen

Home is always the landing page seen upon successful login and will enable you to view submitted cases and pending submissions. You have different options on how to find and look at a case.

The screenshot shows the Acentra Health Home Screen. At the top is a dark navigation bar with the Acentra Health logo on the left and menu items: Home, Cases, Create Case, Members, Setup, Message Center (with a notification icon), Reports, and Preferences. On the right of the navigation bar is a search box labeled 'Search by #' and icons for help and user profile.

Below the navigation bar, the main content area is divided into sections. On the left, there is a 'HOME' section with a 'Messages for review or action' notification and a 'Go to Message Center' button. To the right, there is a summary table for case statuses:

WORK-IN-PROGRESS	NOT SUBMITTED	SUBMITTED
19	1	18

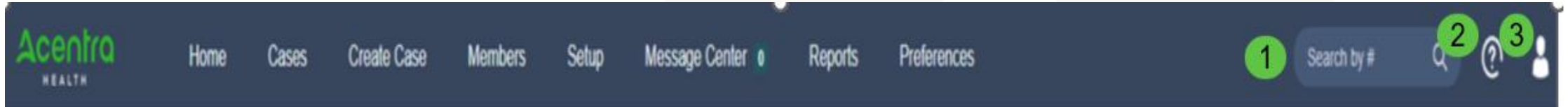
Below this is a message: 'Request Saved But Not Submitted'.

At the bottom, there is a table of case details:

CONTRACT	CASE TYPE	MEMBER ID	MEMBER NAME	DATE OF BIRTH	LAST MODIFIED
Indiana FSSA	UM-OUTPATIENT	500911240999	FRED FLINTSTONE	11/28/1981	12/20/2023 1:12:53 PM



General System Features



1. The **Search by #** field allows you to quickly search for a Case ID or Authorization Number.
2. The “?” **Help** menu will provide access to Atrezzo Help (user guides, FAQ), Community Resources, and Password Guidelines.
3. Click the person icon and use the **Profile** section when you need to edit your user info or log out.
Important Note: Please update your Fax # and/or your email address here, when necessary.

ATREZZO PORTAL

Case Creation



Prior Authorization (PA) Prep and Check



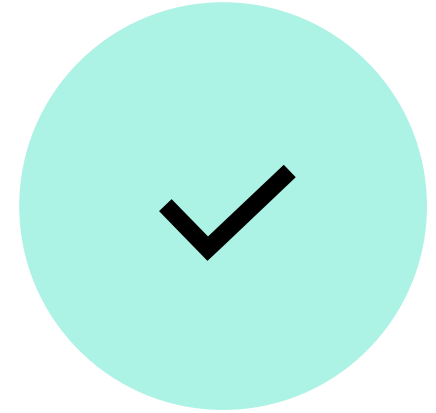
MEMBER ELIGIBILITY

- Check member eligibility to ensure you submit PA to the correct vendor.



PRIOR AUTH REQUIRED?

- Use [Fee Schedules](#) to check if your code(s) require a PA.



REQUIRED DOCUMENTS

- Ensure all documents and paperwork are properly signed and dated prior to sending the PA request.



Creating a Case

Acentra HEALTH Work Queue Cases **Create Case** Consumers Providers Reports Search by # ?

New UM Case Temporary Provider
Requesting Provider

Step 1 Case Parameters Step 2 Consumer Information Step 3 Create Case

Case Parameters / Choose Request Type

Case Type *

UM

Case Contract *

Request Type *

Inpatient Outpatient

Cancel Go To Consumer Information

Quick Tip: Look for the red asterisks* these are the required fields you need to fill in.

Consumer Information and Additional Providers

New UM Case | Requesting Provider | Outpatient

Step 1 Case Parameters | **Step 2 Consumer Information** | Step 3 Create Case

Consumer Information/ Search Consumer/ Results

CONSUMER ID | LAST NAME | FIRST NAME | DATE OF BIRTH

test | 09/14/1989

*Combination of DOB and Last Name or Member ID

Name	DOB	Address	Consumer ID	Contract	Case Count	Action
Member Test	09/14/1989	123 Somewhere Street	TEMP001302022111400000	Minnesota	5	Choose

New UM Case | Denver Provider | CO UM | ANG Test (F)

Step 3 Create Case | **Step 4 Additional Providers** | Step 5 Service Details | Step 6 Diagnoses | Step 7 Requests | Step 8 Questionnaires | Step 9 Attachments | Step 10 Communications | Step 11 Submit Case

Additional Providers/ Provider/Facility

Add Attending Physician

Provider Type	Name	Medicaid ID	Specialty	NPI	Address	County	Phone	Fax	Action
Requesting	Denver Provider	9999999		9999999999	123 Temporary Road , Denver, CO US 99999		(999) 999-9999	(555) 555-5555	Update Remove
Servicing	Denver Provider	9999999		9999999999	123 Temporary Road , Denver, CO US 99999		(999) 999-9999		

Providers in receipt of faxed determination letters: Official communication of service authorization will be sent to the fax number entered above.

Add a Note | Cancel | Go to Service Details

Quick Tip: Ensure servicing provider is correct or click Update to change to correct provider by entering Group/Billing NPI. Keep in mind the Servicing provider will be the one paid.



Service Details and Diagnosis

Step 3 **Create Case** Step 4 **Additional Providers** Step 5 **Service Details** Step 6 **Diagnoses** Step 7 **Requests** Step 8 **Questionnaires** Step 9 **Attachments** Step 10 **Communications**

Service Details/ Enter Service Details

Place Of Service

Service Type *

[View Notes \(1\)](#) [Cancel](#) [Go to Diagnoses](#)

Quick Tip: Ensure you are selecting the correct Service Type. Example: If you select DME, the system will not allow you to select a medical procedure code.

Step 3 **Create Case** Step 4 **Additional Providers** Step 5 **Service Details** Step 6 **Diagnoses** Step 7 **Requests** Step 8 **Questionnaires** Step 9 **Attachments** Step 10 **Communications** Step 11 **Submit Case**

Diagnosis/Add Diagnosis

Code Type * Search

Order Rank Please enter 3 or more characters

Order Rank	Code	Description	Source	Created By	Deactivate
1	R68.89	OTHER GENERAL SYMPTOMS AND SIGNS	Manual		Remove

Showing 10 of 1 [Previous](#) Page 1 of 1 [Next](#)

[Add a Note](#) [Cancel](#) [Go to Requests](#)



Retrospective Reviews

A retrospective review occurs when the entire date span of the request has passed prior to submission. This is considered under the following circumstances:



- Pending or retroactive member eligibility.
- Provider unaware that the member was eligible for services at the time services were rendered and meets one of the three IHCP conditions.

Important: For O/P services since all dates of service are in the past, all clinical documentation to support medical necessity must be submitted at time of request.

Requests

Step 3 **Create Case** Step 4 **Additional Providers** Step 5 **Service Details** Step 6 **Diagnoses** Step 7 **Requests** Step 8 **Questionnaires** Step 9 **Attachments** Step 10 **Communications** Step 11 **Submit Case**

Requests/Request Details

Request Type * FIPS Code Notification Date * Notification Time *

Quick Tip: Important Prior Auth vs. Retrospective Review Request Type

Step 3 **Create Case** Step 4 **Additional Providers** Step 5 **Service Details** Step 6 **Diagnoses** Step 7 **Requests** Step 8 **Questionnaires** Step 9 **Attachments** Step 10 **Communications** Step 11 **Submit Case**

Requests/Request 01/Procedures

Code Type * Search

V5010 (Un-Submitted) N/A - N/A 0 / 0

Modifier Unit Qualifier Model Number



Questionnaires

Step 3 Create Case Step 4 Additional Providers Step 5 Service Details Step 6 Diagnoses Step 7 Requests Step 8 Questionnaires Step 9 Attachments Step 10 Communications

Step 11 Submit Case

Questionnaires/ Take Questionnaires

Request	Questionnaire ID	Questionnaire Type	Questionnaire's Name	Created By	Created Date	Completed By	Completed Date	Score	Action
R01	3749716	Checklist	* Radiology	Kepto	01/19/2023 08:03:51 AM			0	Take

Showing 10 of 1 Previous Page 1 of 1 Next

Add a Note Jump to Submit Cancel Go to Attachments



Attachments

Step 3 Step 4 Step 5 Step 6 Step 7 Step 8 Step 9 Step 10 Step 11

Create Case Additional Providers Service Details Diagnoses Requests Questionnaires Attachments Communications Submit Case

Questionnaires/ Take Questionnaires

Request	Questionnaire ID	Questionnaire Type	Questionnaire's Name	Created By	Created Date	Completed By	Completed Date	Score	Action
R01	3751520	Checklist	* Wheelchair and CRT	Kepto	03/07/2023 04:19:18 PM	A Provider	03/07/2023 04:23:05 PM	5	View

Showing 10 of 1

[View Notes \(1\)](#)

Previous Page 1 of 1 Next

[Jump to Submit](#) [Cancel](#) [Go to Attachments](#)

Upload a document

Max File Size: 4 MB

Allowed File Types: doc, docx, jpg, jpeg, mdi, pdf, tif, tiff, xls, xlsx, xps

REQUEST *

R01

Document Type * **1**

Select One

Drag And Drop Or Browse Your Files. **2**

All files uploaded will be encrypted and stored in a secure location in accordance to HIPAA standards, please do not password protect or personally encrypt any files you wish to upload.


Larger files will take longer to upload/download. Please be patient.

Cancel

Upload **3**



Communications








Step 3  Step 4

Create Case **Additional Providers**

Communications/**Notes**

No notes have been added yet.

Add a note

Step 3  Step 4  Step 5  Step 6  Step 7  Step 8  Step 9  Step 10

Create Case **Additional Providers** **Service Details** **Diagnoses** **Requests** **Questionnaires** **Attachments** **Communications**

Communications/**Notes**

Add a note

Additional Information Here

ExternalNotes * 01/23/2023 01:53:24 PM ** External

Cancel **Go to Submit**



The Review Page

Additional Providers	Service Details	Diagnoses	Requests	
Requesting Denver Provider	Admit Date 03/07/2023	1	Notification Date 03/07/2023	1
Facility Denver Provider	Service Type 364a - OOS Inpatient	Diagnoses H05.421	Request Type Prior Auth	Procedure LOS
Update Providers	Update Service Details	Update Diagnoses	Update Requests	Update Procedures
Questionnaires	Attachments	Communications		
0	0	0		
Questionnaires	Documents	Notes		
View Questionnaires	Update Documents	Update Notes		

Disclaimer

I understand that precertification does not guarantee payment. I understand that precertification only identifies medical necessity and does not identify benefits.

Once you click **Agree**, a case number will be assigned and you will be taken to that case.

Cancel

Agree



Common Error Messages

This section will identify the different types of informational error/warning messages that a user may see while using the Atrezzo platform:

Informational Message	Explanation
Servicing Provider Type Not Allowed for Service Type	This message displays when the servicing provider does not match with the requested service type. The servicing provider must be corrected to be a provider that can bill for the requested service type.
Member Ineligible	This message will display when the member does not have active coverage for the requested timeframe.
Requesting Provider Not Allowed	This message displays when the requesting provider does not match with the requested service type or is not appropriate for the service being requested.
Overlap of Services	This message will display when there is a current request for the same services within the same timeframe. You will need to return to the consumer search and locate the submitted/completed request.
Missing Information	The case cannot be submitted until all required information is submitted. Review specific fields with missing information, then click Submit.
Auth Not Required	This message will populate when one or more procedure codes do not require prior authorization.



Letters/Communications

- Letters are generated at the time of a review completion (this includes pends).
- If submitted via portal, notice of case status change is sent to user who submitted the case through a Message on the portal. (direct communication with clinical reviewer)
- View/download/print the authorization letter within case (under Attachments-Letters).
- Letters are also mailed to the following:
 - The member, as well as the requesting provider and the rendering provider (to address on file)
 - Attending physician (if entered in the case)
- Providers can also check the status of a case by calling our Customer Service team at (866) 725-9991

Quick Tip: For denial or partial approval letters, please read all pages of the letter for details to submit an Admin Review (Recon), Peer to Peer or file for Appeal Rights.



Common Reasons for Denials and Voids

ADMINISTRATIVE DENIALS:

- Missing mandatory form(s) or required documents not received within 7 calendar days of pending to provider.

MEDICAL NECESSITY DENIALS:

- Does not meet medical necessity

PARTIAL APPROVALS:

- Dates/units may be modified according to date of submission.
- Medical Necessity has not been met for the entire requested service.

VOIDS:

- The request is a duplicate of another authorization submitted to Acentra Health.
- The member is not FFS Medicaid and you must submit a PA request to correct MCE.
- Provider did not check Fee Schedule, and the Prior Authorization is not required.



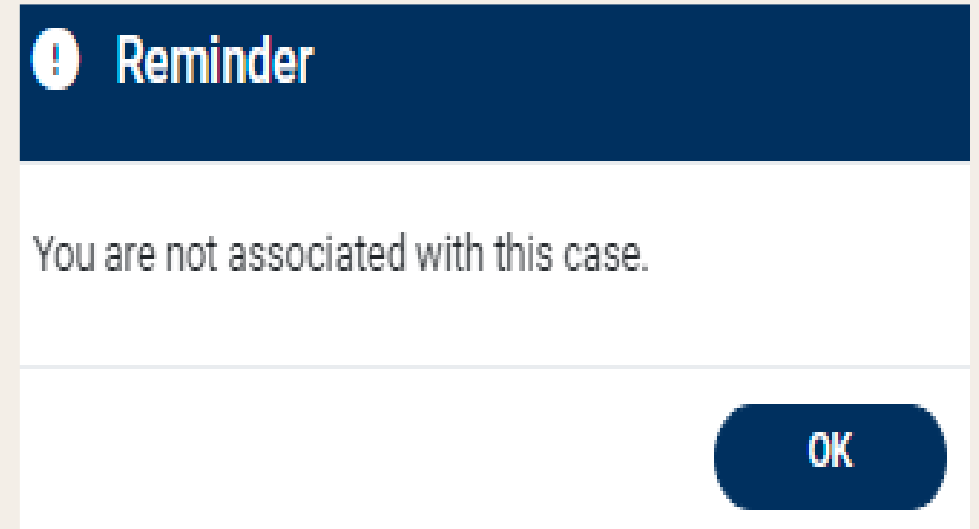
ATREZZO PORTAL

Post Determination Actions



Common Issues Finding a Case

1. When attempting to locate cases, ensure the user is trying to view the case under the correct provider context, otherwise they will receive this pop-up.
2. If you submitted a case but can no longer find it, the case could be voided. Either the member is not eligible for services under FFS Medicaid, or a duplicate/overlapping request was submitted. Call Customer Service for a case status.



Requests for Action on a Case

- The **ACTIONS** dropdown can be accessed from the main screen or from within the case.

This screenshot shows a table of case requests. The 'ACTIONS' dropdown menu is open, showing several options. The 'Add Additional Clinical Information' option is highlighted in yellow. The table below shows a request for 'AGRAND ATEST' submitted on 10/24/2023, categorized as 'Inpatient' with a service type of 'Inpatient Psychiatric'.

Request	Member	Status	Submit Date	Category	Discharge Date	Service Type	Service Dates	Procedures
- Case: 232	300							
Request 01	AGRAND ATEST	Submitted	10/24/2023	Inpatient	N/A	Inpatient Psychiatric	9/28/2023 - 1/13/2024	Approved: 8 View Procedures

This screenshot shows the case summary for 'AGRAND ATEST'. The 'ACTIONS' dropdown menu is open, showing several options. The 'Add Additional Clinical Information' option is highlighted in yellow. The case is categorized as 'INSUFFICIENT INFORMATION' and 'UM-INPATIENT'. The 'CASE SUMMARY' and 'ACTIONS' buttons are visible.

MEMBER NAME	GENDER	DATE OF BIRTH	MEMBER ID	CONTRACT
AGRAND ATEST	F	01/01/1940 (84 Yrs)	300054518099	Indiana FSSA

CASE ID	CATEGORY	CASE CONTRACT	CASE SUBMIT DATE	SRV AUTH
INSUFFICIENT INFORMATION	23	Inpatient	10/24/2023	Indiana FSSA

UM-INPATIENT

Member Details

Provider/Facility

Clinical

Questionnaires

Requesting: Test Hospital

Service Type

Request Type

- Example: **Add Additional Clinical Information.**



Complete the Action Request

- Always type in a **Note** for the clinical reviewer with the details of your request.
- Select **Document Type** being uploaded.
- Choose **Browse** or drag and drop the files from your computer and upload to the case.
- Finish by selecting **Submit**

Add Additional Clinical Information

Case 23 [redacted] Request 01 | YKID ATEST (M) 04/05/2003 | Indiana FSSA Outpatient

Note

Allowed File Types: doc, docx, jpg, jpeg, mdi, pdf, tif, tiff, xls, xlsx, xps.

Document Type

Select One

- Augmentative Communication System Selection
- Certificate of Medical Necessity for Oxygen
- DME Information Form: Enteral and Parenteral Nutrition
- Face to Face Encounter**
- Hospice Authorization Notice for Dually Eligible
- Hospice Election

Drag And Drop Or Browse Your Files.

CANCEL Submit

4/30/2024 - 10/26/2024 Approved



Extension Request Process

- To begin, the user will choose to extend the existing PA. You'll find the extend button from either the queue view or from within the case itself.

CONSUMER NAME	GENDER	DATE OF BIRTH	MEMBER ID	CONTRACT
AGRAND ATEST	F	01/01/1940 (84 Yrs)	300054518099	Indiana FSSA

CASE ID	CATEGORY	CASE CONTRACT	CASE SUBMIT DATE	SRV AUTH
23[REDACTED]	Outpatient	Indiana FSSA	11/02/2023	K24[REDACTED]

COMPLETED

UM-OUTPATIENT

CASE SUMMARY ACTIONS ▾ COPY **EXTEND**

- Case: 23[REDACTED]

300054518099	AGRAND ATEST	Submitted 12/15/2023	Outpatient	N/A	Home Health	12/12/2023 - 6/8/2024	Approved: 1
Request 01	01/01/1940						View Procedures
	Indiana Medicaid						No letters available Actions ▾
							Copy
							Extend

- Case: 233530003

500911240999



Extension Request Process (cont.)

- The system will ask the user to verify the action by clicking Yes.
- The system will now show the case summary. Here the user will scroll down to the Clinical section and click the down caret to expand the section and then scroll to the new Request line .

The screenshot shows the 'Clinical' section of the system interface. It includes a header with a 'Clinical' icon, a set of medical icons, and details for 'Service Type : 13 - Physical Therapy' and 'Request Type : Prior Auth'. A 'Notification Date : 02/05/2024' and 'Notification Time : 04:53 PM' are also displayed. A blue checkmark icon is highlighted with a red box. Below this, a 'Request 02' is shown with a status of 'Un-Submitted'. The 'REQUEST TYPE' is set to 'Prior Auth', and the 'NOTIFICATION DATE' is '02/06/2024'.

- The user will change the requested start date to the date the new units need to start, add the requested end date, duration and quantity. Scroll to the bottom of the screen, check the attestation section and click to Submit.

The screenshot shows the request details and attestation section. The 'REQUESTED START DATE' is '01/24/2024', the 'REQUESTED END DATE' is '04/22/2024', the 'REQUESTED DURATION' is '90', and the 'REQUESTED QUANTITY' is '12'. A 'SUBMIT' button is highlighted with an orange box. Below the request details, there is an attestation section with a checkbox and the text: 'I understand that precertification does not guarantee payment. I understand that precertification only identifies medical necessity and does not identify benefits.'

Tips to Reduce Pends and Denials

- Submit the PA request prior to services being rendered
- Upload all required documentation at the time of submission
- Include all required forms and service specific documentation when submitting the request. Verify:
 - Any required forms are filled out completely and properly signed as required
 - Signed physician order has been included in request
 - The request has not been previously submitted
 - The member is not receiving services from a different provider
- Provide any missing documentation within 7 days of the date the case was pended for Additional Information



Assuming a PA from Another Provider

- Submit your request on the [IHCP Prior Authorization Revision Request Form](#) and fax to 800-261-2774 or call customer service at 866-725-9991 for assistance.
- Provide all relevant information including but not limited to:
 - Member information
 - Originating provider information
 - Authorization number
 - Procedures on the PA request
 - Date PA will be assumed
- Important! Hospice providers are required to submit their completed [Hospice Provider Request Between Hospice Providers Form](#).



Transferring Prior Auth (PA) between Contractors

- When a Member's eligibility changes to FFS, notify Acentra of any current PA; include supporting documentation to substantiate PA. This can be done by submitting request in portal with all documentation and Note or by faxing all information to us with explanation of transfer.
- Original PA letter must provide Acentra with the following:
 - ✓ Member ID (MID).
 - ✓ Provider's National Provider Identifier (NPI).
 - ✓ Duration and frequency of authorization.
- When a member changes eligibility to Fee-For-Service (FFS) coverage from another vendor, Acentra honors existing PAs for specific durations, whichever comes first:
 - ✓ First 90 calendar days from member's effective date in new plan.
 - ✓ Remainder of the PA dates of service.
 - ✓ Until approved units of service are exhausted.



Provider Resources



FSSA Resources for Providers

Provider Fee Schedules

Accessible from the Family and Social Services Administration (FSSA) Provider web page. Check prior to submitting your request to ensure code(s) require a prior authorization.

[Provider Fee Schedules](#)

Provider Modules

Found in the providers references section, always check the IHCP Prior Authorization reference module and refer to your service module for specific requirements.

[Provider Reference Modules](#)

Forms

If prior authorization requires a request form or any other specific forms to be submitted with the request, they can be found on the forms page.

[Forms](#)



Acentra Health Provider Resources

- **Provider Education and Training materials** (Videos, Handbooks, Quick Guides and FAQs) are located at: <https://inmedicaidffs.acentra.com/training-and-education/>
- **Provider Communication and Support email:** INPriorAuthIssues@Acentra.com
Provider registration or issues. Prior Auth submission issues. Guide to Provider resources.
- **Dedicated Customer Service Line Call us at 866-725-9991**
Check case status. Portal assistance. Request a clinical call back. Submit I/P admission request.



Acentra

HEALTH

Accelerating
Better Outcomes