Acentra HEALTH

Psychiatric Inpatient Concurrent Review Manual

In Partnership with

California Mental Health Services Authority (CalMHSA)

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Version: January 2025

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Welcome to the Medi-Cal Fee-For-Services Provider Manual

Thank you for your participation in Medi-Cal Fee-For-Service acute psychiatric inpatient services. This Provider Manual serves as a comprehensive resource for acute psychiatric inpatient providers who submit Concurrent Review and Treatment Authorization Requests (TARs) as part of the participating counties within the California Mental Health Services Authority (CalMHSA) combined concurrent review program. It provides detailed information

about the processes involved in partnering to deliver high-quality, cost-effective mental health care.

Acentra Health is responsible for reviewing documentation submitted by contracted and non-contracted Fee-for-Service acute psychiatric inpatient hospitals. The team authorizes hospital stays when submitted documentation meets the medical necessity criteria for admission, continued stay, and administrative day requirements.

We are committed to supporting you in navigating these updates and ensuring seamless collaboration in providing essential mental health care to Medi-Cal beneficiaries.

For questions, requests, or feedback regarding this manual, please contact us via email at CAReviews@acentra.com or by phone at (866) 449-2737. We look forward to continuing our partnership and achieving our shared goal of delivering exceptional mental health services across participating counties within the CalMHSA combined concurrent review program.

Get in Touch:

Web:
https://calmhsa.acentra.com/

Email:
CAReviews@acentra.com

Call:
866-449-2737

SECTION ONE

Acentra Health Introduction

An Introduction to Acentra Health

Acentra Health, formed in 2023 by the merger of industry leaders CNSI and Acentra Health, combines public sector knowledge, clinical expertise, and technological ingenuity to modernize the healthcare experience for state and federal partners and their priority populations. We are headquartered in McLean, Virginia with 32 office locations nationwide and a location in Chennai, India.

Acentra Health brings together a deep collective of expertise across all facets with 30+ years of public sector health knowledge and experience. We deliver continued excellence through our services and solutions to produce maximum value and impact. Our power derives from our ability to integrate innovative technology with high-quality care management, quality oversight, and clinical assessment capabilities. This, combined with access to claims, encounter, provider, and clinical data, helps us create a critical longitudinal view of beneficiary and member health and social services interactions. Our goal is to help our clients unify and analyze these data sets to inform better real-time decisions to improve care and accelerate better health outcomes.

Our Purpose

is to accelerate better health outcomes through technology, services, and clinical expertise

Our Vision

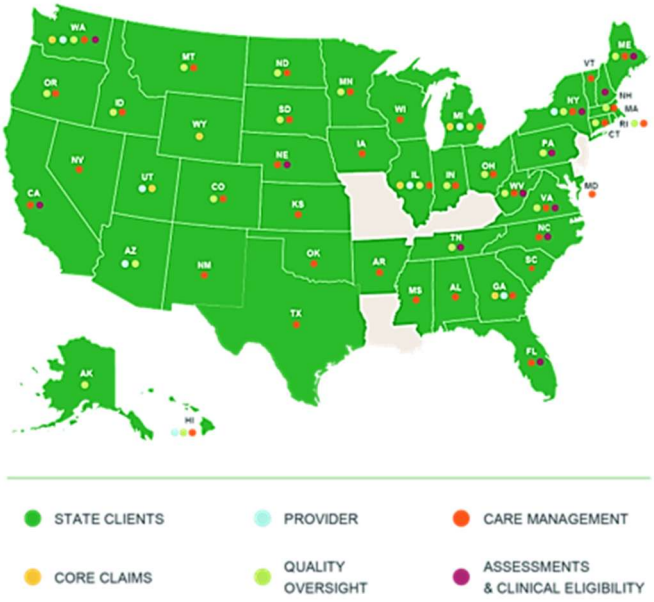
is to be the vital partner for healthcare solutions in the public sector

Our Mission

is to continually innovate solutions that deliver maximum value and impact to those we serve

With an expansive network, Acentra Health requires the hard work and dedication of our 3,000 employees, 4,500+ credentialed clinicians, and 450 physicians serving on the company's Advisory and Review panel. Together, our team of technology and business experts, skilled clinicians, and highly talented healthcare professionals work as one to help state and federal partners lead the way in achieving better health outcomes for priority populations we serve.

Acentra Health's extensive experience developing innovative, collaborative models of utilization management, care management, provider relations and quality improvement emphasizes community partnerships, training, and technical assistance. Acentra Health has been highly successful in improving collaboration and coordination among providers, increasing access, and improving clinical outcomes while controlling costs.



Acentra Health utilizes its proprietary, internet-based authorization system, Atrezzo®, which providers use to participate in the California Behavioral Health Utilization Review program. Atrezzo is a proprietary technology platform that integrates essential care management features and all relevant data into one comprehensive solution. Leading-edge technology coupled with intuitive user experience provides a foundation for proactive care management.

Atrezzo supports an array of foundational healthcare services, including Utilization Management, Care Management, and Eligibility & Assessments, and layers in higher-level functions, including business rule processing, automated workflows, and integrated analytics and dashboards.

Designed as a modular system with an emphasis on configuration vs. customization, deploying new client instances can be done with ease and does not require additional IT resources. Acentra Health's Provider Manual is designed to inform providers about, and guide providers through, the processes and programs Acentra Health utilizes to achieve these goals.

Diversity, Equity, Inclusion, and Belonging

Collectively Stronger with Our Celebrated Differences

At Acentra Health, we fully embrace differences in ethnicity, race, religion, gender, sexual orientation, age, and ability as central to our core values. We seek to educate and celebrate how our differences unite us and make us individually better and collectively stronger as a company. Diversity, equity, and inclusion power our solutions and services, everything from our culturally competent clinician services like Care and Case Management, Utilization Management, Assessments, and Prior Authorization services, to our healthcare technology innovations. Our company is better when the people we employ reflect the diversity of our clients and the people we serve.

Confidentiality

Acentra Health, its subsidiaries, and affiliates, are committed to ensuring that our privacy practices comply with the industry's best practices, and as applicable, all federal and state laws and regulations including but not limited to the Health Insurance Portability and Accountability Act (HIPAA). Acentra Health's Chief Privacy Officer, Melissa Leigh is responsible for the development and implementation of Acentra Health privacy policies and procedures.

Call Center and Contact Information

Telephonic and Fax Information

- **Toll-Free Telephone Number:** (866) 449-2737

Option 1:	Press 1 to connected with a Customer Service Representative.
Option 2:	Press 0 to leave a voicemail.

- **Fax Number:** (833) 551-2637
- **Email:** CAReviews@acentra.com
- **Communication/Language Assistance:** The California Call Center utilizes CTS Language Link to assist callers needing an interpreter and 711 TTY-based Telecommunications Relay Service to support people with hearing or speech disabilities.

Office Hours and Observed Holidays

- Acentra Health is open Monday through Friday from 8:00am to 5:00pm. Our offices will be closed in observance of the following holidays:

✓ New Year's Day
✓ Martin Luther King, Jr. Day
✓ Memorial Day
✓ Juneteenth
✓ Independence Day
✓ Labor Day
✓ Veteran's Day
✓ Thanksgiving Day and Friday after
✓ Christmas Day

Executive Leadership Team

Sr. Vice President Operations

Susan Baker, MSW, CEAP
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Vice President, Operations

Robert Noble, MBA
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Clinical Director

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Clinical Supervisor

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Organization Chart

The CalMHSA organization chart provides a visual representation of the organization's structure, detailing leadership roles, department breakdowns, reporting lines, and team arrangements to clarify workflows and responsibilities. This chart is available upon request and can be shared to support the understanding of CalMHSA's internal structure and operations.

Escalation Tree

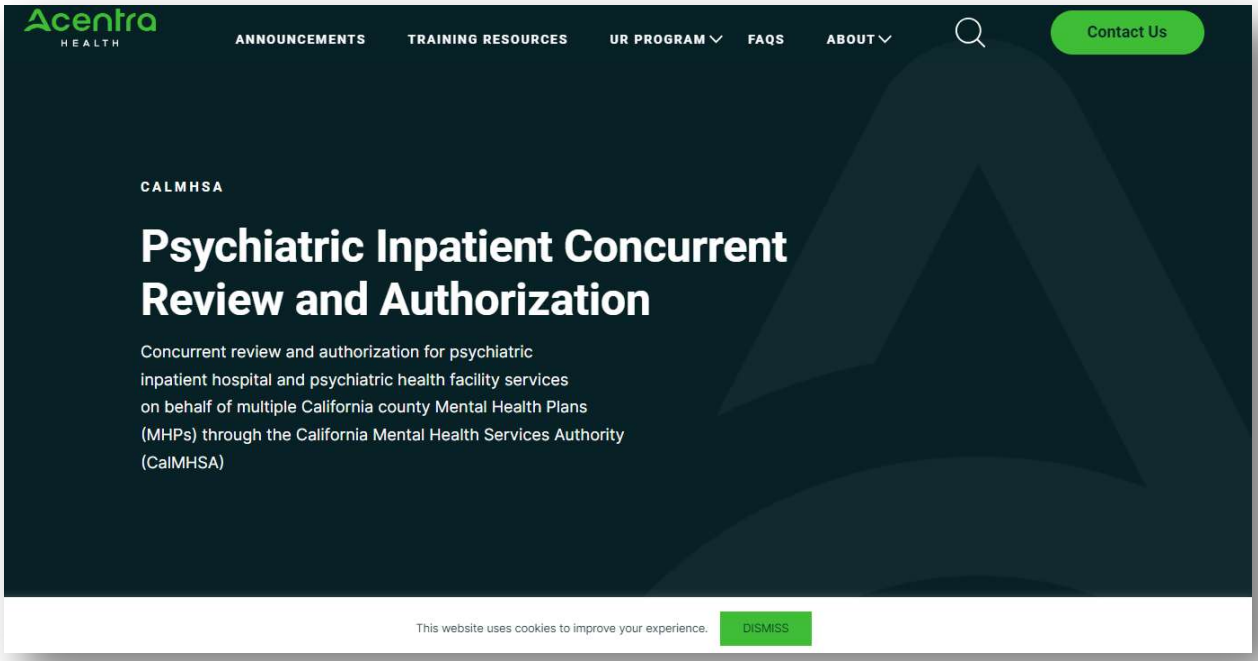
Atrezzo	Members & Appeals	Clinical Questions	Training & Reporting
CAReviews@acentra.com (866) 449-2737	AppealsCA@acentra.com (866) 449-2737	CAReviews@acentra.com (866) 449-2737	CAReviews@acentra.com (866) 449-2737
Crystal Zapata, Lead CSR crystal.zapata@acentra.com	Jade Rivera, Appeals Spec jade.rivera@acentra.com	Ani Hacopian, Clinical Sup. ani.hacopian@acentra.com	Crystal Zapata, Lead CSR crystal.zapata@acentra.com
Julia Hales, Program Mgr. julia.hales@acentra.com	Julia Hales, Program Mgr. julia.hales@acentra.com	Keisha Ingram, Clinical Mgr. keshia.ingram@acentra.com	Julia Hales, Program Mgr. julia.hales@acentra.com
Rob Noble, VP robert.noble@acentra.com	Rob Noble, VP robert.noble@acentra.com	Rob Noble, VP robert.noble@acentra.com	Rob Noble, VP robert.noble@acentra.com

CalMHSA Website

The CalMHSA website, managed by Acentra Health, provides news and updates, member training resources, provider information, training materials, and details on reviewed services. It is specifically designed for counties that delegate these services to Acentra via a contract with CalMHSA

To visit our website, go to https://calmhsa.acentra.com/

The CalMHSA-Acentra website is designed to support California's mental health services by providing a platform for concurrent review and authorization of psychiatric inpatient services. It serves multiple California county Mental Health Plans (MHPs) by offering resources, policy and procedures, and training materials focused on the use of the concurrent review process. These tools are aimed at ensuring effective coordination and compliance with mental health service requirements while streamlining the review and authorization of psychiatric health facility services. The site supports healthcare providers and counties by facilitating the efficient delivery of mental health services for Medi-Cal beneficiaries and uninsured patients in participating counties.

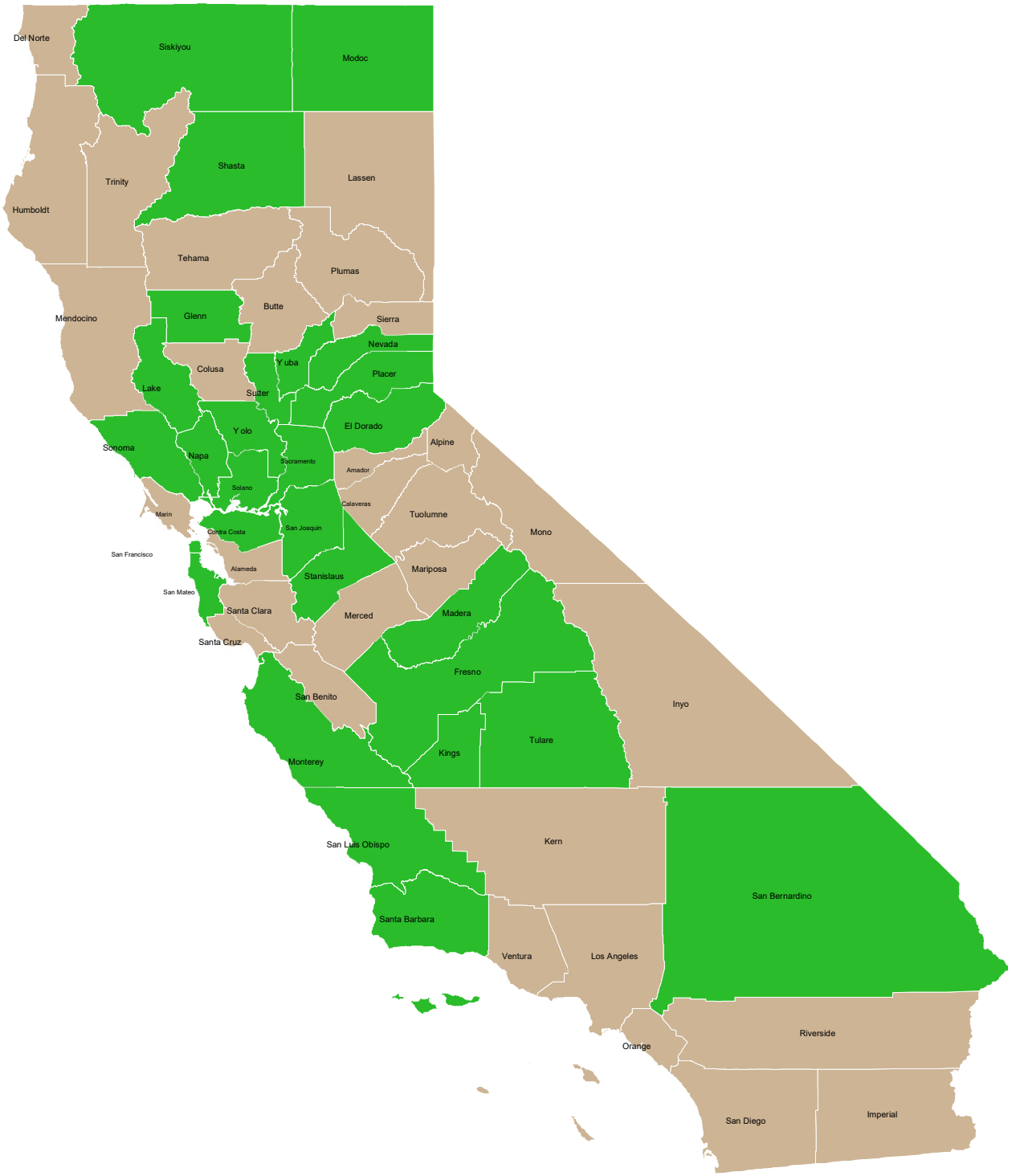


SECTION TWO

Participating Counties

Participating Counties

CODE	COUNTY	GO-LIVE DATE
#07	Contra Costa County	09/04/2023
#09	El Dorado County	02/01/2023
#10	Fresno County	07/11/2022
#11	Glenn County	10/24/2022
#16	Kings County	10/04/2022
#17	Lake County	05/16/2022
#20	Madera County	07/01/2022
#25	Modoc County	10/24/2022
#27	Monterey County	08/01/2022
#29	Napa County	10/10/2022
#29	Nevada County	08/15/2023
#31	Placer County	01/13/2025
#34	Sacramento County	05/01/2023
#36	San Bernardino County	05/15/2023
#39	San Joaquin County	05/23/2022
#40	San Luis Obispo County	05/16/2022
#41	San Mateo County	07/15/2024
#42	Santa Barbara County	10/10/2022
#45	Shasta County	10/09/2023
#47	Siskiyou County	06/15/2022
#48	Solano County	10/10/2022
#49	Sonoma County	11/14/2022
#50	Stanislaus County	12/12/2022
#51	Sutter County	07/01/2022
#54	Tulare County	02/01/2023
#57	Yolo County	02/15/2025
#58	Yuba County	07/01/2022



SECTION THREE

Concurrent Review Process

Definitions

Acentra Health: An organization collaborating with CalMHSA to conduct concurrent reviews and authorizations for psychiatric inpatient hospital and psychiatric health facility services on behalf of participating California county Mental Health Plans (MHPs).

Administrative Denial/Rejection: A denial of services that is based on reasons other than the lack of Medical Necessity.

Appeal Request: A formal request submitted by a provider or patient to reconsider a denied service authorization, typically involving a review of the initial decision and any additional supporting information.

Atrezzo: Acentra Health's medical management information system.

Behavioral Health Information Notice (BHIN): Communications issued by the Department of Health Care Services (DHCS) to inform and guide counties and providers on policies, procedures, and requirements related to behavioral health services.

Beneficiary: An individual person who is the direct or indirect recipient of the services of the Company. Depending on the context, Consumers may be identified by different names, such as "member," "enrollee," "client," "patient, "consumer," etc. A Beneficiary relationship may exist even in Cases where there is not a direct relationship between the Beneficiary and the Company.

Care Coordination: The deliberate organization of patient care activities and sharing information among all participants concerned with a patient's care to achieve safer and more effective care.

Certification – General Definition: A professional credential, granted by a national organization, signifying that an individual has met the qualifications established by that organization.

CalMHSA (California Mental Health Services Authority): A joint powers authority that provides administrative and fiscal services in support of mental health service delivery for California counties and cities.

Clinical Review/Utilization Management ("UM"): Ensures that Medi-Cal beneficiaries have appropriate access to specialty mental health services. The UM must evaluate medical necessities, appropriateness and efficiency of services provided prospectively, such as through prior or concurrent authorization, or through retrospective authorization procedures. Utilization Management encompasses Prospective, Concurrent and Retrospective Review.

Clinical Review Criteria: The written screens, decision rules, medical protocols, or guidelines used by the organization as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services in accordance with California law.

Clinical Peer Reviewer: The individual(s) selected by the Company to review a Case. All Reviewer(s) who are health care practitioners must have the following qualifications:

1. Active U.S. California Licensure from the Board of Behavioral Sciences.
2. Recent experience or familiarity with current body of knowledge and mental health practice.
3. At least five (5) years of experience providing health care.
4. If the Reviewer is an M.D. or D.O., they possess board certification by a medical specialty board approved by the American Board of Medical Specialties or the American Osteopathic Association.

Concurrent Review: The process of evaluating the medical necessity and appropriateness of ongoing inpatient psychiatric services during a patient's hospital stay to ensure the provision of necessary and effective care.

Denial or Non-Certification: A determination by the Company that admission, extension, or stay has been reviewed and, based on the information provided, does not meet the clinical requirements for medical necessity, appropriateness, or effectiveness under the health benefit plan.

Discharge Planning: A process that involves preparing a patient for a safe and timely discharge from an inpatient setting, ensuring continuity of care by arranging necessary follow-up services and support.

Licensure/License: A license to practice that is (1) issued by California Board of Behavioral Sciences; and (2) required for the performance of job functions.

Licensed Practitioner of the Healing Arts
Includes the following: Physician, Nurse Practitioner, Physician Assistant, Registered Nurse, Registered Pharmacist, Licensed Clinical Psychologist, Licensed Clinical Social Worker, Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapists, or License Eligible Practitioner working under the supervision of licensed clinicians.

Medical Director
A Doctor of Medicine or Doctor of Osteopathic Medicine who is duly Licensed to practice medicine and who is an employee of, or party to a contract with, an organization, and who has responsibility for clinical oversight of the organization’s Utilization Management, credentialing, quality management, and other clinical functions.

Mental Health Plan (MHP)
The county mental health that is responsible for or for arranging for the treatment of specialty mental health services to the Medi-Cal beneficiaries who reside in their county.

Notice of Adverse Benefit Determination (NOABD)
A uniform notice provided to the beneficiary with required information about their rights under the Medi-Cal program and any of the following actions taken by the Company in accordance with the Contract.

Provider
Any attending physician, facility rendering service, or other health professional that delivers health care services.

Retrospective Review
Utilization review conducted *after* services have been provided to the beneficiary. Retrospective authorizations are allowed under the following conditions:

1. Retroactive Medi-Cal eligibility determinations;
2. Inaccuracies in the Medi-Cal Eligibility Data System;
3. Authorization of services for beneficiaries with other health care coverage pending evidence of billing, including dual-eligible beneficiaries; and/or
4. Beneficiary's failure to identify payer.

Regulatory and Compliance Requirements

- **Purpose**: Provides guidelines for concurrent review standards for psychiatric inpatient hospital services and psychiatric health facilities in accordance with Department of Health Care Services (DHCS).
- **Legal Basis**: Operates in compliance with all applicable requirements, including but not limited to California Code of Regulations (CCR) Title 9, Section 1810.440(b), Department of Health Care Services (DHCS) Behavioral Health Information Notice (BHIN) 22-017, or any subsequent and/or superseding BHIN/ released by DHCS.
- Acentra Health will **only** review cases where the responsible payor is Medi-Cal or a contracted county.
- Acentra Health will **not** review cases with other insurance coverage; if a primary payor is no longer covering the hospitalization, an explanation of exhausted bed days (EEBD) from the insurance company or other documentation stating coverage has terminated must be uploaded for the Medi-Cal portion of the stay to be reviewed.
- Acentra Health will **not** review cases if the responsible county is not contracted with Acentra Health (e.g., Los Angeles County cases)

- Every month, counties are required to upload their MMEF file via CalMHSA's Dropbox to be shared with Acentra Health for insurance verification.

Medical Necessity

- Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

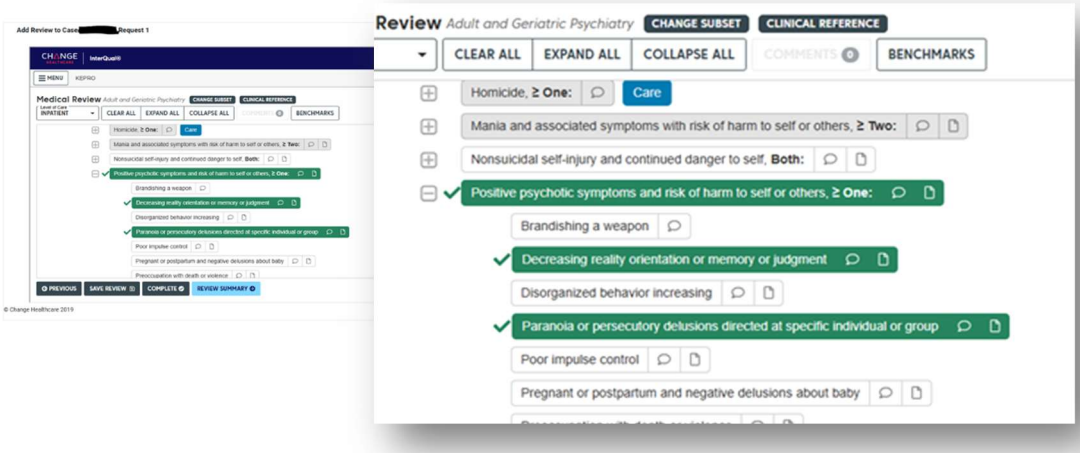
- For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code, Section 1396d(r)(5) of Title 42 of the United States Code, including all Medicaid-coverable health care services needed to correct and ameliorate mental illness and conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition and are thus covered as Early and Periodic Screening, Diagnostic and Treatment (EPSDT).

- Acentra Health Clinical Reviewers utilize InterQual Inter-rater Reliability software to confirm the medical necessity of each case.

- The medical necessity criteria built into the InterQual system ensures that each length of stay is assessed by the clinician and confirmed through the software for eligibility. The program was developed using diagnostic criteria from 2025 ICD-10 Codes for child, adult, and geriatric psychiatry.

- If the Clinical Reviewers diagnostic assessment of the patient does not fit the diagnostic criteria, the InterQual program will report that medical necessity is not met and will not allow the request to be approved.

- Below is an example of an initial InterQual review for a patient presenting with symptoms of psychosis



- Below is an example of how the completed InterQual review appears in Atrezzo

Final InterQual Report

Requested Start Date : 2/4/2025
Requested Stop Date : 2/6/2025

Criteria Status : MET
Severity of Illness : N/A
Intensity of Service : N/A

Criteria Set : BH:Adult and Geriatric Psychiatry
Criteria Subset : Adult and Geriatric Psychiatry
Criteria Version : InterQual® 2024, Dec. 2024 Release (RM24)

[X] Select Level of Care, One:
[X] INPATIENT, One:
[X] Episode Day 1, ≥ One:
Assaultive within last 24 hours and high risk of re-occurrence, ≥ One:
Catatonia
Command hallucinations with direction to harm self or others within last 24 hours
Co-occurring medical condition, All:
Eating disorder symptom unstable, ≥ One:
Fire setting within last 24 hours with risk of harm to self or others, ≥ One:
Homicide, ≥ One:
Mania and associated symptoms with risk of harm to self or others, ≥ Two:
Nonsuicidal self-injury and continued danger to self, Both:
[X] Positive psychotic symptoms and risk of harm to self or others, ≥ One:
Brandishing a weapon
[X] Decreasing reality orientation or memory or judgment
Disorganized behavior increasing
[X] Paranoia or persecutory delusions directed at specific individual or group
Poor impulse control
Pregnant or postpartum and negative delusions about baby
Preoccupation with death or violence
Reckless driving within last 24 hours
Stalking despite protection or restraining order
Substance use within last 24 hours
Threatening harm to another within last 24 hours

Initiation Authorization

- **Admission Notification**
  Hospitals and Psychiatric Health Facilities (PHFs) are required to notify Acentra Health within 24 hours of a patient's admission, or on the next working day. This notification must include the admission orders, an initial plan of care, and a face sheet that contains relevant patient information. All documents should be submitted through Atrezzo.
  The face sheet should include the following information (if available):
    - Hospital name and address
    - Patient name and Date of Birth (DOB)
    - Insurance coverage
    - Medi-Cal number and county of responsibility identified in the Medi-Cal Eligibility Data System
    - Current address/place of residence
    - Date and time of admission.
    - Working (provisional) diagnosis
    - Name and contact information of admitting, qualified and licensed practitioner
    - Utilization review staff contact information

- **Documentation Requirements**:
    - The face sheet must include patient name, DOB, insurance coverage, Medi-Cal number, hospital name, diagnosis, and admitting practitioner details.
    - Admission orders, Initial psych evaluation (IPE), treatment plans, and progress notes must all be signed by a licensed healing arts practitioner.
- **Emergency Care**: No prior authorization is required for emergency psychiatric admissions.
- **Review Timeline**: Acentra Health must make an authorization decision within **72 hours** of receiving the request.

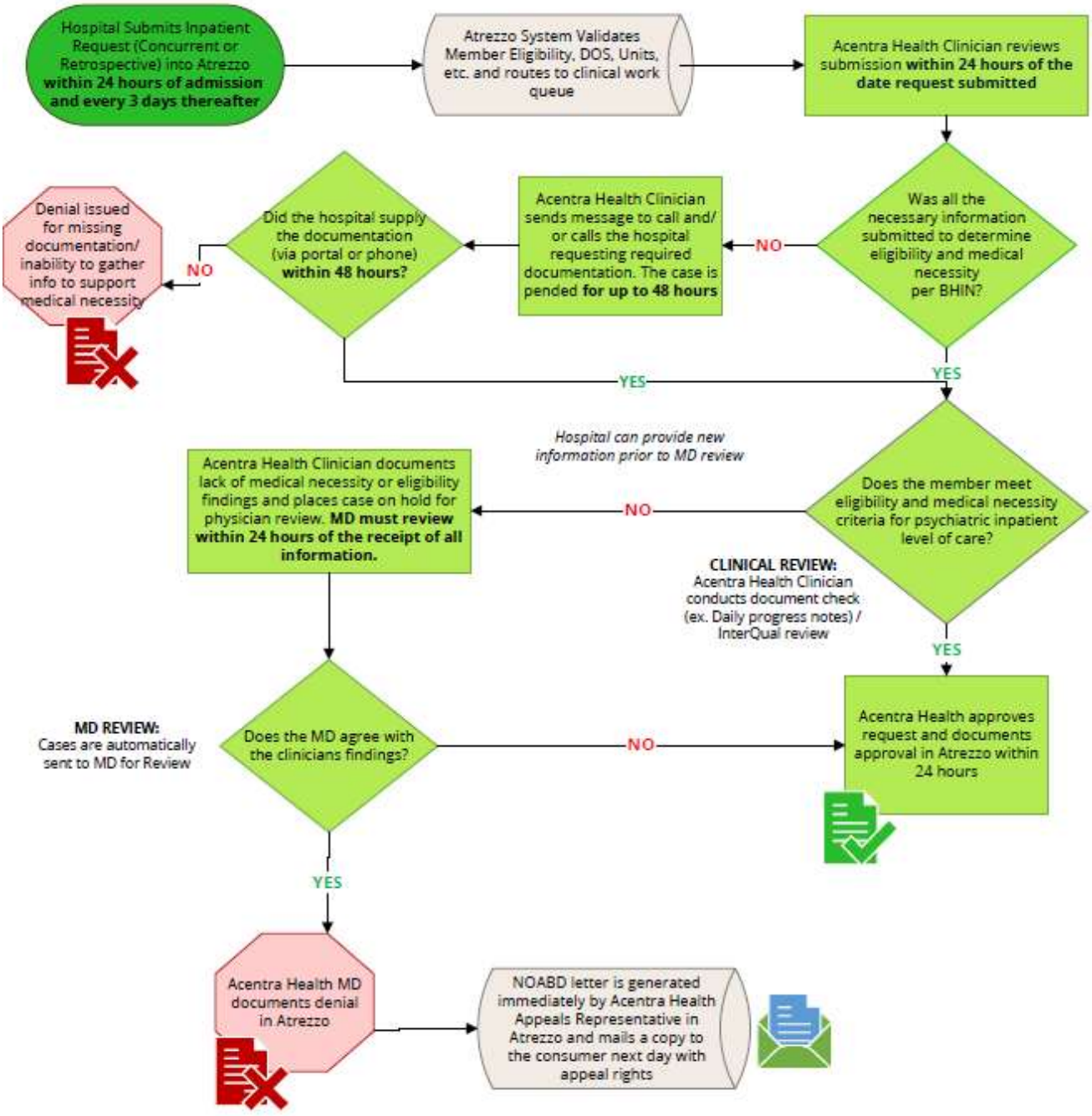
Continued Stay Authorization Process

- **Submission Timeline**:
    - Before the end of the 3-day initial authorization period, hospitals must submit a **continued stay authorization** request for a period of an additional **3** days or less.
    - Signed progress notes must be uploaded for each day of hospitalization.

- A signed discharge summary must be uploaded into the case post-discharge.

- **Information Exchange**:
  - Acentra Health may request information necessary to decide on the request, including treatment progress, risk assessments, medications, and discharge planning.
- **Review Timeline**: Acentra Health must make an authorization decision within 24-hours of receipt of the request and all information reasonably necessary to make a determination.
  - If you are missing or additional information is needed for the case, a Clinical Reviewer will send a message in the Atrezzo portal to the provider asking for the documentation to be uploaded within 48 hours. The Clinical Reviewer will pend the case at this time. If the information is not provided to Acentra Health within 48 hours, the case will be denied for missing documentation.
- **Questionnaires:**
  - **Admission Questionnaire:** Will be required for all Psychiatric Inpatient Services.
  - **Continued Stay Review Questionnaire:** Will be required for all continued stay authorization requests.

Concurrent Review & Authorization Workflow



Administrative Days and Placement

- **Administrative days** are used when a patient no longer meets medical necessity for acute care but has not yet been accepted at a non-acute facility.
- Acentra Health will **not** put patients on admin days but may suggest the provider switch to admin days if appropriate.
- **Outreach Requirement**:
    - Acentra Health will review that the hospital has documented having **made at least one contact to a non-acute residential treatment facility per day** (except weekends and holidays), starting with the day the beneficiary is placed on administrative day status. **Once five contacts have been made** and documented, any remaining days within the seven-consecutive-day period from the day the beneficiary is placed on administrative day status can be authorized.
- **Waivers**:
    - The outreach requirement can be waived if there are fewer than five appropriate facilities or in specific circumstances.

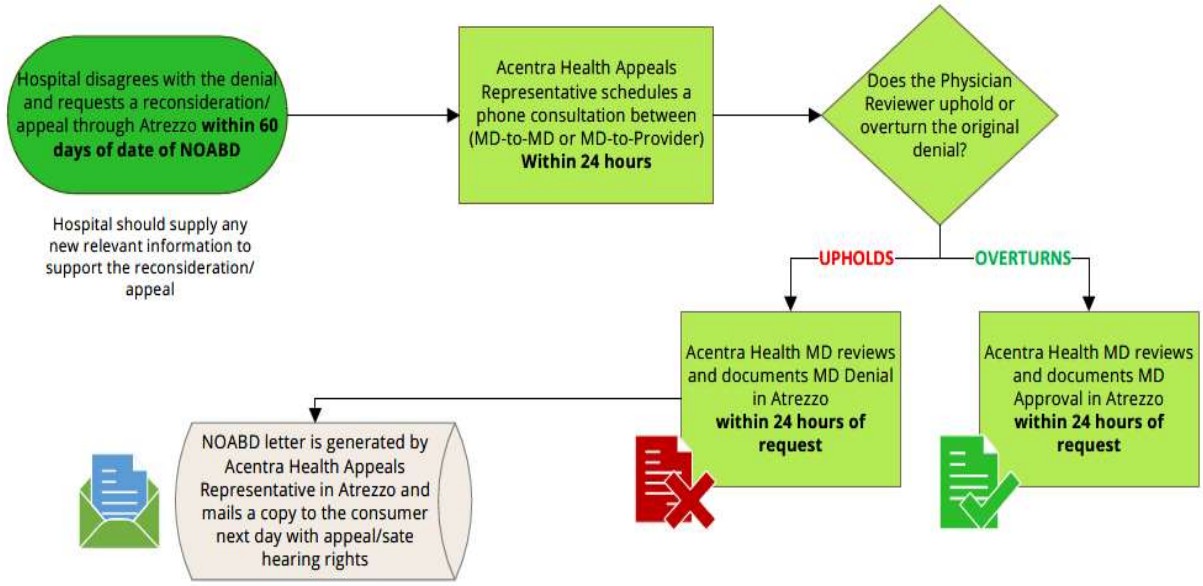
      Examples of appropriate placement status options include, but may not be limited to, the following:

        - The beneficiary's information packet is under review;
        - An interview with the beneficiary has been scheduled for [date];
        - No bed available at the non-acute treatment facility;
        - The beneficiary has been put on a wait list;
        - The beneficiary has been accepted and will be discharged to a facility on [date of discharge];
        - The patient has been rejected from a facility due to [reason]; and/or,
        - A conservator deems the facility to be inappropriate for placement.

Adverse Benefit Determination and Appeals

- **Adverse Determination**:
    - If Acentra Health denies an authorization request, a notification to the hospital and patient with a **Notice of Adverse Benefit Determination (NOABD)**, explaining the reasons for denial and providing appeal instructions will occur.
- **Peer-to-Peer or MD-to-MD** consultations can be requested via the Appeals Specialist. The provider's physician's name and phone number will need to be provided to the Appeals Specialist for the consultation to be scheduled.
- Additional clinical information supporting medical necessity can be provided telephonically via the **Clinical Reviewer Call Center** without needing to schedule a Peer-to-Peer consultation.
- **Appeals**:
    - Appeals must be filed within **60 calendar days** of receiving the NOABD.
    - Decisions on appeals must be made within **30 calendar days**.
    - **Second Level Appeals** are to be processed through DHCS and do not involve Acentra Health
    - **Expedited appeals** are to be requested when the patient's provider has determined that the time for a standard appeal could seriously jeopardize the patient's life, health, or ability to attain, maintain, or regain maximum function (Cal. Code Regs. Title 42, CFR § 1850.208; DHCS BHIN 18-010E).
        - A decision on expedited appeals must be made within **3 business days**, or up to 14 business days if an extension is requested by the provider or by Acentra Health to gather additional information

Appeals Flow Chart



Retrospective Authorization Process

- **Applicable Cases**:
  - Retrospective reviews may be conducted when there is a retroactive Medi-Cal eligibility determination, inaccuracies in eligibility data, or authorization from another payer pending (e.g., for Medi-Medi beneficiaries).
  - Retrospective review requests must be submitted **within 60 days** of identifying the case as eligible. Acentra Health will complete the review **within 30 days** of receipt.
  - Retrospective reviews will be completed **within 30 days** of receipt of all required documentation, including TAR and UB04 if applicable. Reviews are conducted according to the same standards as concurrent reviews, and InterQual Interrater Reliability reviews are also completed.

Treatment Authorization Request (TAR) Processing Overview

This guide outlines the standardized process for completing Treatment Authorization Requests (TAR Form 18-1) in accordance with California Code of Regulations (CCR), Title 9, Section 1820.220. It is designed to support both clinical and non-clinical staff in accurately processing TARs across various scenarios, including IMD, Acute, Admin, Subacute, and Denial cases.

1. Receipt and Verification

Upon receiving the TAR Form, staff must first verify that the hospital has accurately completed the top portion of the form, specifically Boxes 6 through 22B. This initial check ensures that the request is complete and ready for review.

2. Clinical Review and Outcome Determination

The Clinical Reviewer from Acentra Health evaluates the submitted TAR to determine the appropriate outcome. The possible determinations include:

- **Approved** – The request meets all criteria and is authorized as submitted.
- **Denied** – The request does not meet criteria and is not authorized.
- **Approved as Modified** – The request is partially authorized with specific modifications.

3. Documentation of Clinical Decision

Once the outcome is determined, the Clinical Reviewer documents the decision across several key sections of the TAR:

- **Section 22C**: Provides a summary and explanation of the clinical rationale behind the decision.
- **Sections 23–42**: Completed to reflect the outcome and relevant clinical details.
- **Section 42A**: Indicates the type of stay (e.g., Acute, Admin).
- **Section 42B**: Must include the Clinical Reviewer's signature to validate the decision.
- **Section 44**: Records the date the TAR was completed and signed.
- **Section 45**: Includes the county code corresponding to the county of responsibility.

Treatment Authorization Request (TAR) Submission Requirements

- **Timeline**: Hospitals must submit a **TAR** within **14 calendar days** of discharge or after **99 calendar days** of continuous service. IMDs must also upload a **UB04** to be submitted to the county responsible.

- **Processing**: Acentra Health must process and submit the TAR to either the DHCS Fiscal Intermediary or the County within **14 calendar days** of receipt.

Atrezzo Reports

- **How to Access Reports:** All reports will be accessible within the Atrezzo system. To view the reports, please select the "Reports" option from the navigation panel. It is important to note that only individuals holding an administrative role will be granted access to view reports for their organization. Should you require access, kindly contact your primary administrator. For comprehensive guidance on managing and accessing reports, please refer to provider reference guide “How to Manage Reports.”

Report Definitions

Data Field	Data Definition
Acentra Case ID	Unique identifier assigned by Acentra Health to each case for tracking and reporting purposes.
Acentra Review Date	Date the case was reviewed by Acentra Health (if applicable), indicating a significant checkpoint in case processing.
Admission Date	Date the beneficiary was admitted for services, marking the start of the service period.
Admission Source	Source from which the beneficiary was referred (involuntary or voluntary).
AID Code	Code representing the specific type of aid or assistance category the beneficiary qualifies for under the insurance program.
Auth End Date	Date when the authorization period ends, indicating the last date services are approved under this authorization.
Auth Start Date	Date when the authorization period begins, indicating when services are approved to start.
Auth Status	Current status of the authorization request (e.g., pending, approved, denied), reflecting progress in the approval process.
Beneficiary Address	Physical address of the beneficiary, used for communication and verification purposes.
Beneficiary Age	Age of the beneficiary, derived from the DOB for quick reference.
Beneficiary DOB	Date of birth of the beneficiary, used to verify age and eligibility.
Beneficiary Ethnicity	Ethnicity of the beneficiary, often collected for demographic and service evaluation purposes.
Beneficiary First Name	First name of the beneficiary receiving the service.
Beneficiary Gender	Gender of the beneficiary as reported on their insurance or identification documents.

Beneficiary Language	Primary language spoken by the beneficiary, relevant for communication and service accessibility.
Beneficiary Last Name	Last name of the beneficiary receiving the service.
Clinical Reviewer	Name or ID of the clinical reviewer assigned to evaluate the request, responsible for determining the appropriateness of care.
County Name	County in which the beneficiary resides, often relevant for eligibility and regional reporting.
Date Requested	Date on which the authorization or service request was initially submitted.
Discharge Date	Date on which the beneficiary was discharged from services, marking the end of service provision.
Hospital Name	Name of the hospital where the beneficiary is receiving or received services.
Hospital NPI	National Provider Identifier (NPI) for the hospital, used for billing and identification purposes.
Insurance	Type or provider of insurance covering the beneficiary's services, such as Medicaid or private insurance.
Length Of Stay	Total duration (in days) of the authorized stay or service period.
Messages	Any internal or external messages related to the case, used for communication.
NOABD In Case	Indicates whether a Notice of Action Based Denial (NOABD) is included in the case, signifying formal communication of a denial.
Notes	Additional notes or comments relevant to the case, which may include clinical observations or administrative remarks.
Outcome Reason	Reason for the outcome of the case, typically used to explain approvals, denials, or other decisions.
Primary Diagnosis	Main behavioral diagnosis prompting the request for services, typically in ICD format.
Reason For Admission	Primary reason or diagnosis prompting the admission of the beneficiary.
Request Line	Specific request line within the Atrezzo Case ID. Each request represents new dates of service (generally another 3 days).
Request Type	Category of request (e.g., concurrent, retrospective, administrative days) that specifies the nature of the services being requested.
Short Doyle	Field indicating whether the service falls under the Short-Doyle program, specific to mental health funding in some states.
Start Date Of Admin Day	The date the administrative day period began, typically awaiting residential placement.
Subscriber ID	Unique identifier for the insurance subscriber (e.g., Medicaid ID), which could be the beneficiary or a family member.
TAR Control Number	Unique identifier for the TAR, essential for tracking and follow-up on authorization requests.
TAR On File	Field indicating if a TAR is on file, confirming if the formal request document has been recorded.

TAR Sent	Date the Treatment Authorization Request (TAR) was sent, used to track processing time.

Utilization Review and Auditing

- **Utilization Review**:
    - Acentra Health's utilization review is distinct from authorization functions and focuses on documentation standards, detecting needs and overutilization of services as outlined by DHCS.
- **Quality Auditing:**
    - Acentra Health conducts monthly Clinical Documentation Audits (CDA) and call center audits or "phone monitoring."
    - Quarterly "deep dive" audits are conducted by management regarding cases, interrater reliability, and adherence to state and federal regulations.

- **Local Quality Improvement Committee:**

  Acentra Health's Local Quality Improvement Committee (LQIC) plays a pivotal role in enhancing healthcare services by focusing on continuous quality improvement (CQI) within the organization. The committee's responsibilities include:

    - **Developing and Implementing Quality Improvement Plans**: The LQIC formulates strategies to address identified issues and oversees their execution to enhance service quality.
    - **Monitoring Clinical Outcomes**: By analyzing performance data, the committee assesses the effectiveness of care provided and identifies areas for improvement.
    - **Supporting Medical and Behavioral Health Departments**: The LQIC collaborates with various departments to ensure the delivery of high-quality care across all services.
    - **Leading Quality and Performance Improvement Activities**: The committee facilitates organization-wide initiatives aimed at improving performance and outcomes.
    - **Participating in Clinical Practice Oversight**: The LQIC contributes to oversight committees to maintain high standards of clinical practice.

Through these efforts, the LQIC ensures that Acentra Health maintains a culture of excellence, continuously striving to improve healthcare quality and patient outcomes.

SECTION FOUR

Atrezzo Provider Portal

Atrezzo Provider Portal

Introduction

The Atrezzo system is a person-centered, web-based solution that transforms traditional, episodic- based care management into proactive and collaborative population healthcare management. This system allows users to document interactions accurately and efficiently between Care Coordinators and Utilization Reviewers with providers.

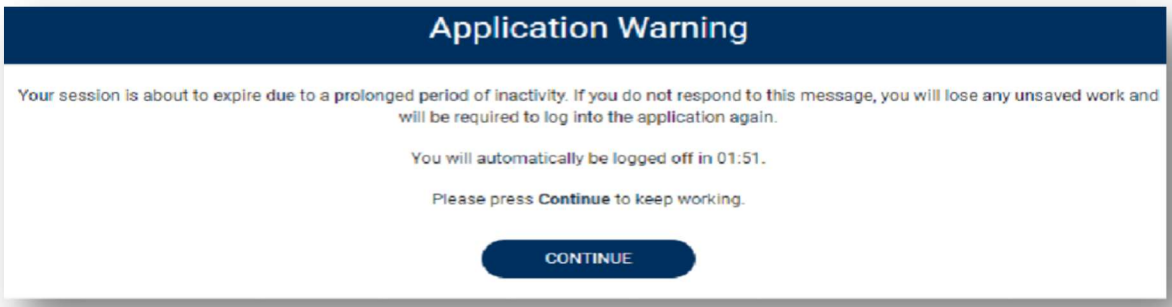
The purpose of this user guide is to provide an overview of the Provider Portal with Utilization Management functions. This user guide was designed to be easy-to-use for users familiar with a basic PC and internet environment.

Security

The Atrezzo portal is designed to support specific roles. Prior to accessing the system, you will be assigned a specific user role with pre-defined system permission. Access, functionality, and system activities will be based on the assigned user role.

The system will automatically terminate an active session after 30 minutes of consecutive inactivity. A pop-up will appear with a 2-minute countdown to logging out. If you are actively working within the system, you will not receive this pop-up warning.

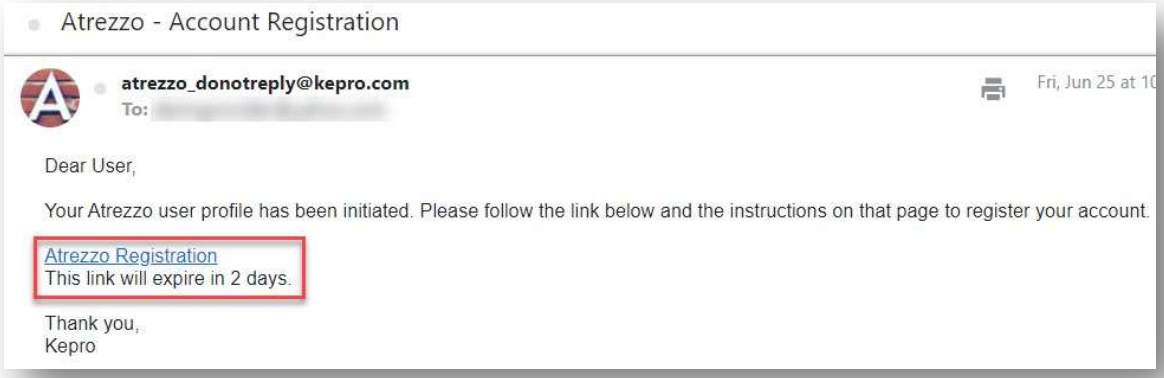
To continue working, click Continue. If you do not select continue before the countdown reaches 0, you will be required to log in again to continue utilizing the system. The system AutoSaves as you navigate and complete fields. Completed work will not be lost; however, any unsaved work will be lost if the system times out due to inactivity.



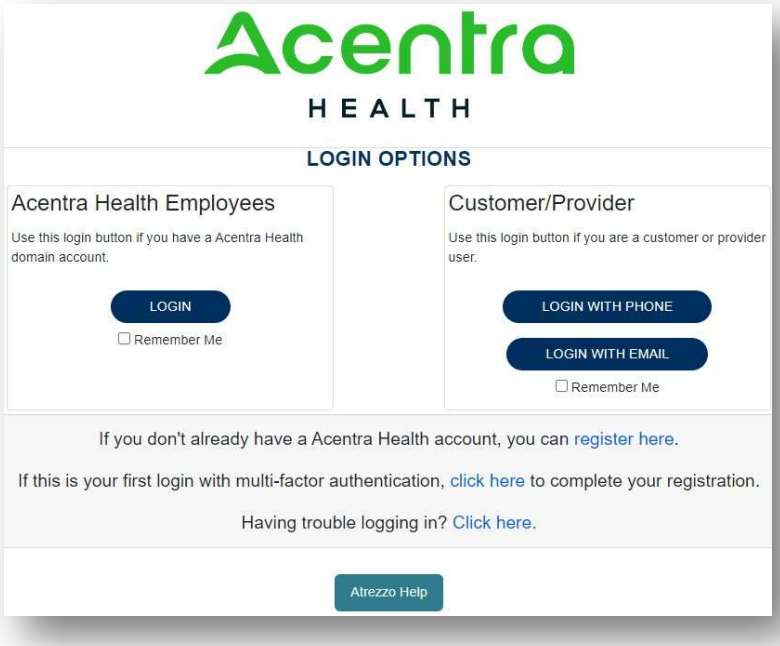
Getting Started

Atrezzo is configured to function in all internet browsers; however, Google Chrome is preferred. Chrome users will have the best system and functionality performance over other browsers.

You will receive access to the system by a Provider Administrator. You will receive a system generated email containing a link to complete Account Registration. The link will expire after 2 days if account registration is not complete.

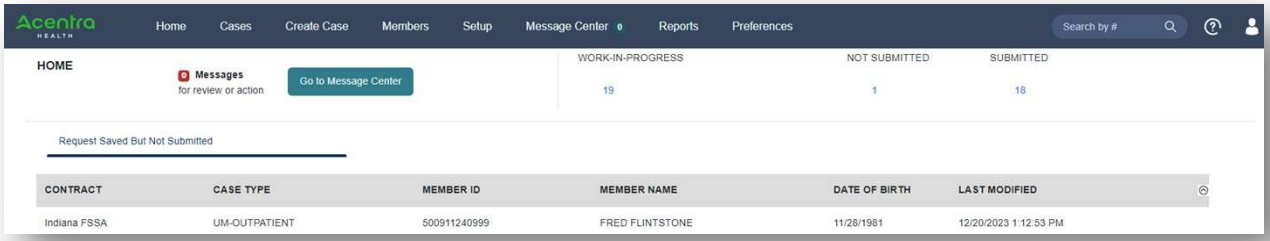


You will be required to complete Multi-Factor Authentication (MFA) during registration. This is a one-time process. Future login will be under the Customer/Provider side of the login screen.



System Navigation

Upon successful login, you will be taken to the Atrezzo Provider Portal Home Page. The navigation bar will remain in place regardless of location and user role, which allows for quick and easy navigation from any screen.

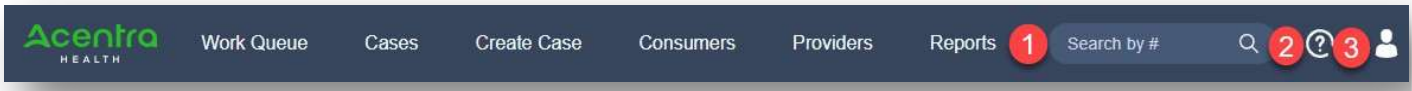


The legend below gives a brief overview of each area within Atrezzo. For a more detailed description, and for all available workflows, click the hyperlink.

Home	This is the default page upon successful login and will enable you to view submitted cases and any pending submissions.
Cases	This section will enable you to search for cases based on specific parameters. To ensure efficient search results, try selecting specific information in each drop down to narrow search results.
Create Case	This section will enable you to create a new request using the Create Case Wizard.
Consumers	This section will enable you to search for Consumer (Member/Beneficiary) specific information utilizing the Consumer ID or last name and date of birth. Consumer specific data will be rendered based on information entered.
Setup	**Visible to Provider Administrator users only** This section will enable Provider Administrators to manage, edit, and add provider users for the facility and add additional provider groups.
Message Center	This section will enable you to view messages from the clinical review team regarding specific consumers and/or cases.
Reports	This section will display all available reports for those who have access. User specific reports will be listed on this page, no search required.
Preferences	**Visible to Provider Administrator users only** This section will enable you to set preferred diagnosis, procedure codes or preferred servicing providers. This will allow for quicker request submission.

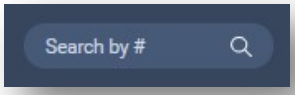
General System Features

This section highlights the features found on all screens throughout the system and provides information on how to utilize these features for optimal navigation.



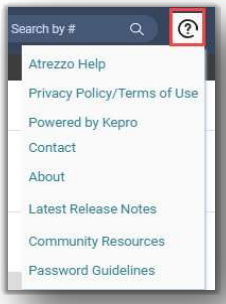
Button 1 - Search

The Search by # field allows you to quickly search for a Case ID or Authorization Number. Enter the Case ID or authorization number, then hit enter on your keyboard or click outside the search field to be taken to the specified case. (See Searching by Case ID for step-by-step instructions).



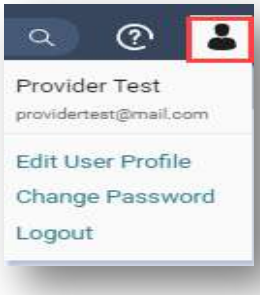
Button 2 - Help

The Help menu will provide access to Atrezzo Help (user guides, FAQ), Community Resources, and Password Guidelines.



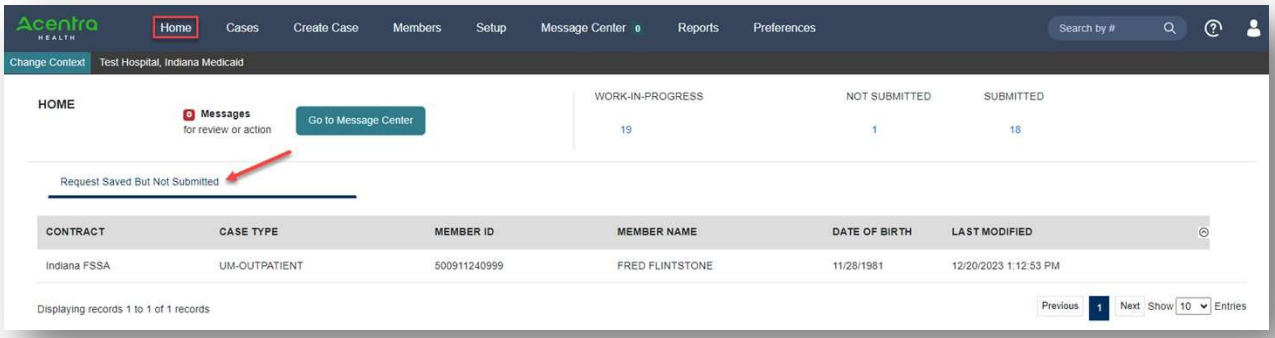
Button 3 - Profile

The Profile section will identify the user logged in. Click on the person icon in the upper right corner to open menu options where you can Edit User Profile, Change Password, or Logout.

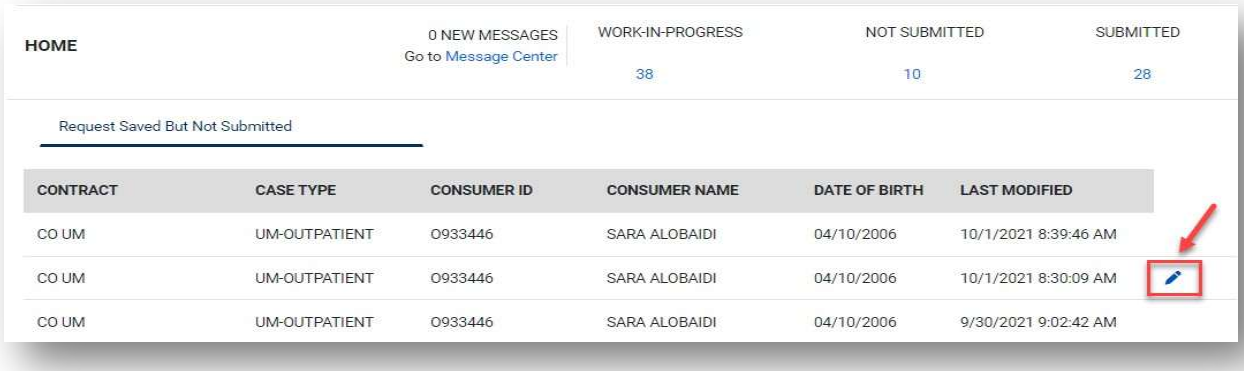


Home Screen View

Once successfully logged in, you will be taken to the Atrezzo Home Screen which defaults to display available Request Saved but Not Submitted. This will provide a list of Consumers with cases that have been started but are incomplete and have not been submitted for clinical review.



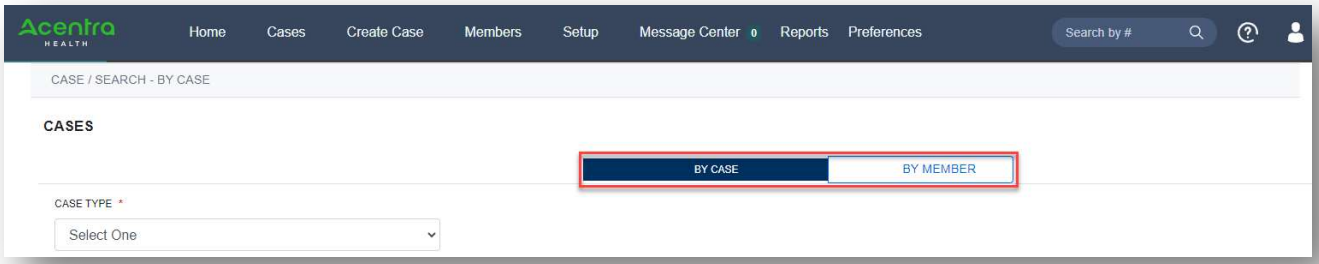
To complete the saved case, you can click the edit icon that will appear when hovering over the specified Consumer line.



The numbers below Work-In-Process, Not Submitted, and Submitted are a total of your organization's cases in that status. Clicking the hyperlinked numbers will bring you to the case search page.

Cases

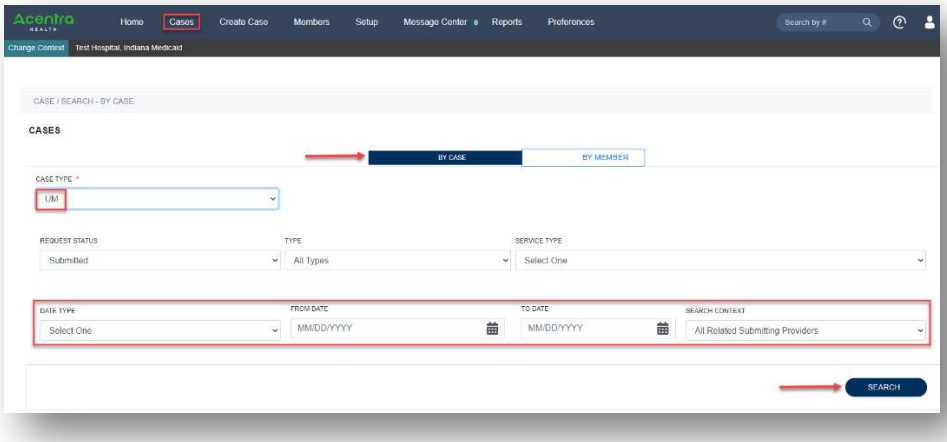
This section is searchable by Case or Consumer. Select the desired search option at the top.



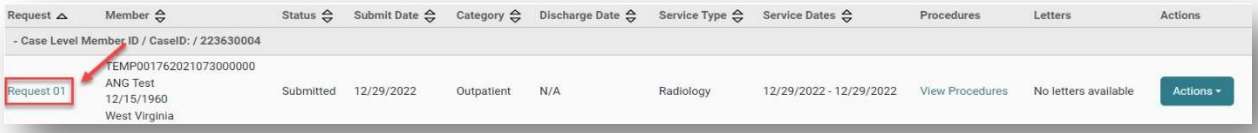
Searching by Case

To search By Case, select Case Type UM from the drop down. Once the Case Type is specified, additional search parameters will appear. To identify specific cases and ensure efficient search results, try selecting specific information in each drop down to narrow search results.

Note: You must enter a submitted or 30-day service date span for search results to render.



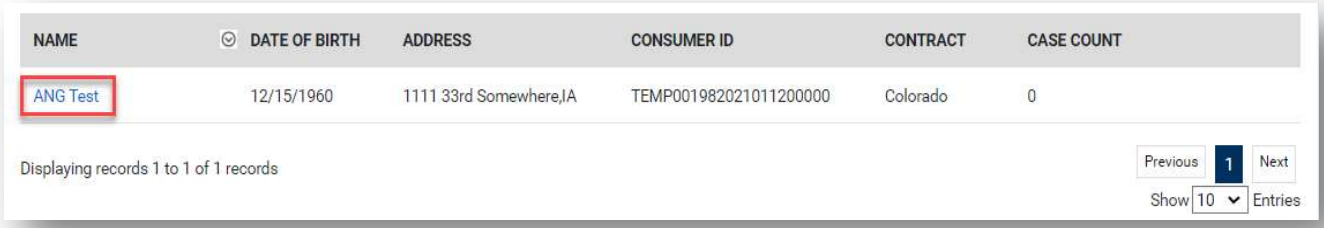
Search results will populate below.



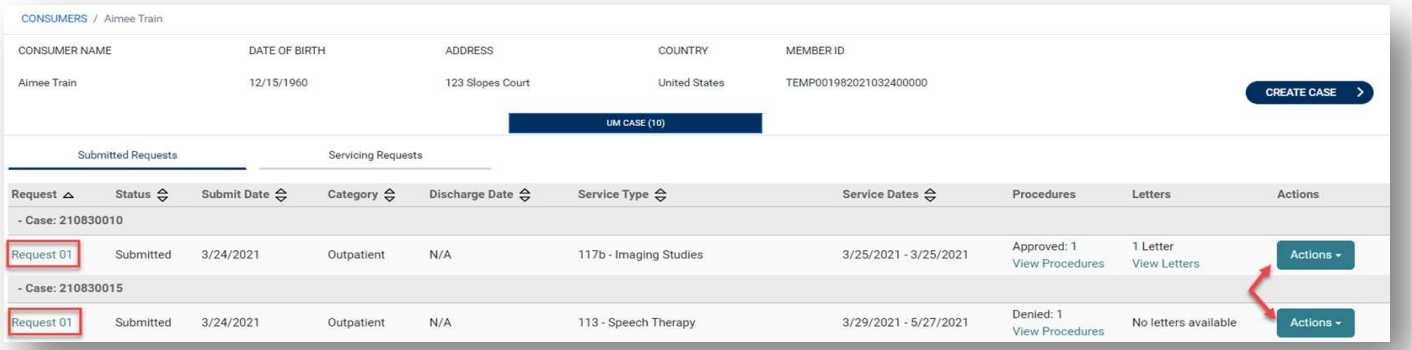
Searching by Consumer

To search By Consumer, you must enter Last Name and DOB or Member ID and click Search. Note: Some contracts will require additional information.

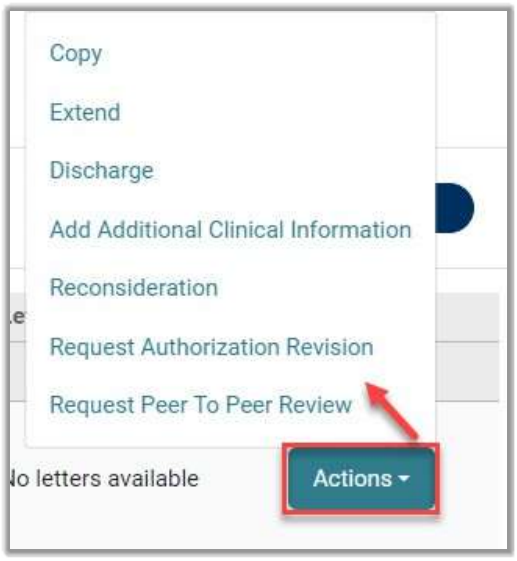
Search results will render below.



The Consumer Name is a hyperlink which will populate all Submitted and Servicing Request for that consumer.

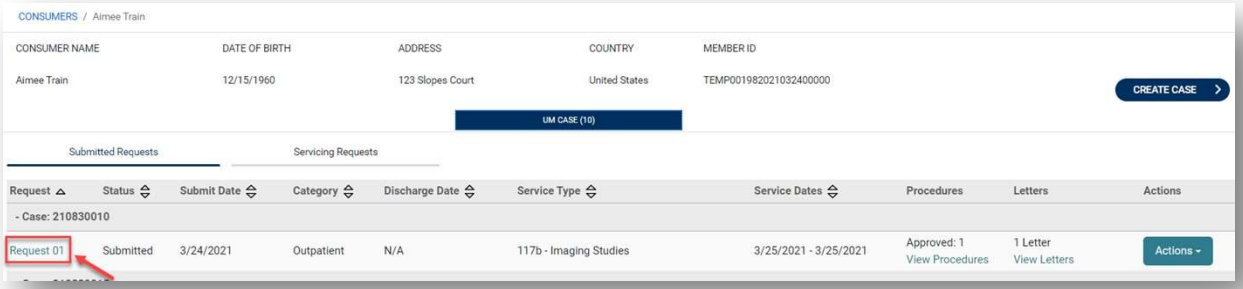


Regardless of how you navigate to the request, the Actions button on the right side of each request allows you to carry out specific functions such as Copy, Extend, Discharge, Add Additional Clinical Information, Reconsideration, Request Authorization Revision, or Request Peer to Peer Review. Click here for step-by-step details on using these actions.



Note: *Available information in the Actions button will vary by contract and user role permissions.*

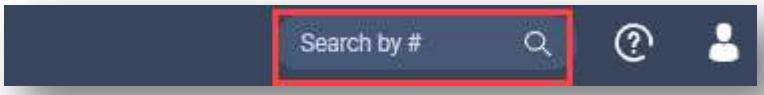
Clicking a Request hyperlink will bring you into the case where you will have limited functionality.



The Consumer Name is a hyperlink that will bring you to the consumer's information page and the status of the case will be visible in the top right corner of the page.

Searching by Case

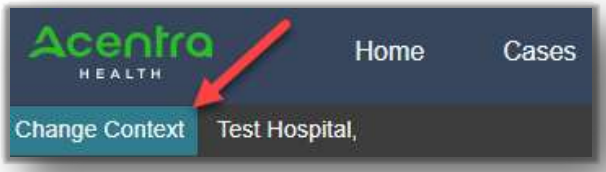
To search directly for a case, enter the Case ID in the search by # box on the top right of any page, then hit enter on your keyboard or click anywhere outside of the search box.



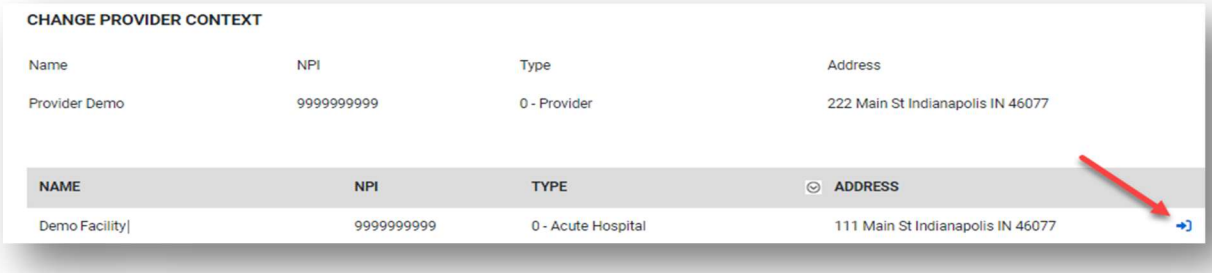
If a message is received indicating you are not associated with the case, be sure you are logged in under the appropriate provider.

Change Context

To update which provider/location you are logged in under, click Change Context in the upper left corner.



To select a different provider, click the arrow icon to the far right of the preferred selection.



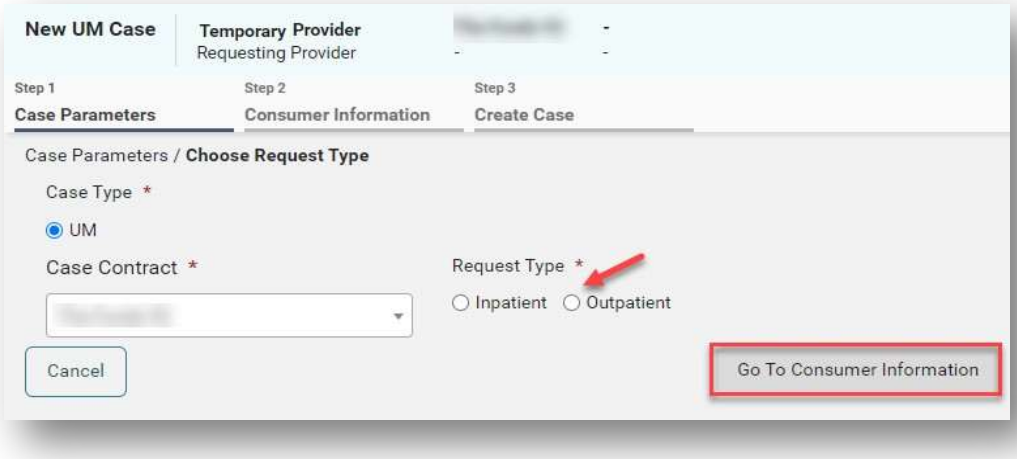
The selected provider will be displayed in the banner at the top left of the screen.

Submitting a New Request

The Create Case Wizard will walk you through the steps to create a new inpatient or outpatient request. In the navigation pane, click Create Case.

The Create a Case Wizard will load. Select Case Type as UM, enter the appropriate Case Contract and Request Type. Then click **Go to Consumer Information**.

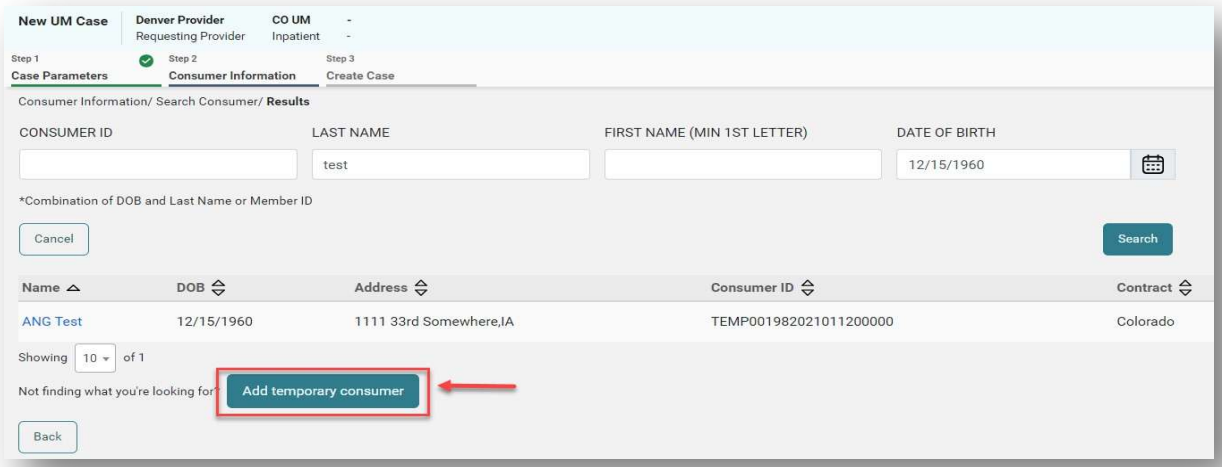
Note: Some options, such as Case Type and Case Contract will pre-populate for certain provider users. The Go To Consumer button will remain grayed out until all required fields are populated.



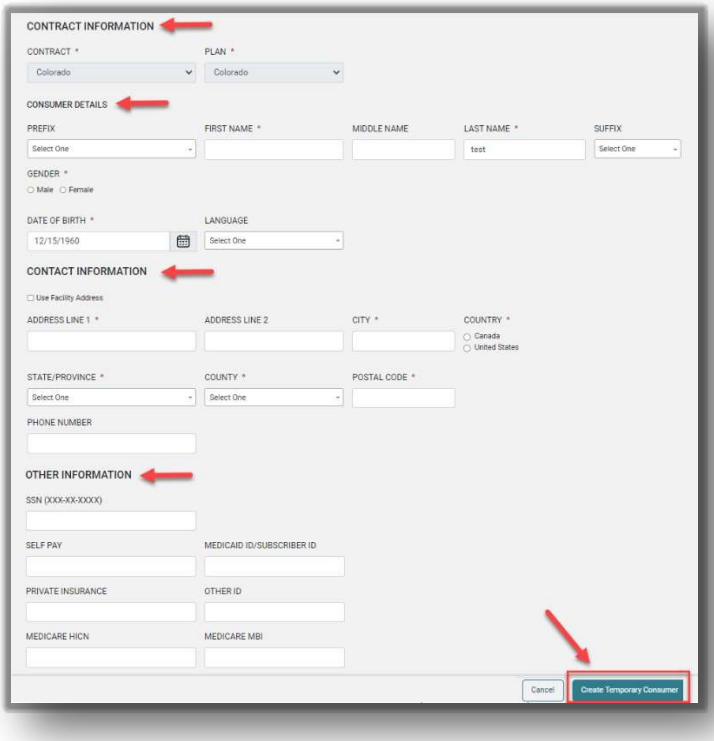
Enter required consumer information and click **Search**. You will be required to enter Consumer ID, or Last Name and Date of Birth. Some contracts may require more information to search consumers.

From the results that display, click **Choose**, for the correct consumer.

If you do not find the consumer you are looking for, you can click **Add Temporary Consumer**, if enabled for your contract.

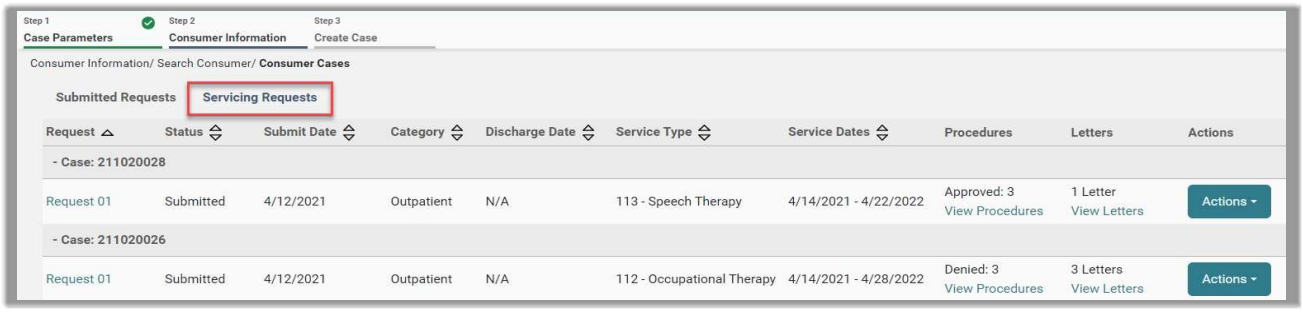


The Contract Information will auto populate. Enter at least the required fields for Consumer Details, Contact Information, and Other Information. Then Click Create Temporary Consumer to be taken to the Create Case confirmation page.



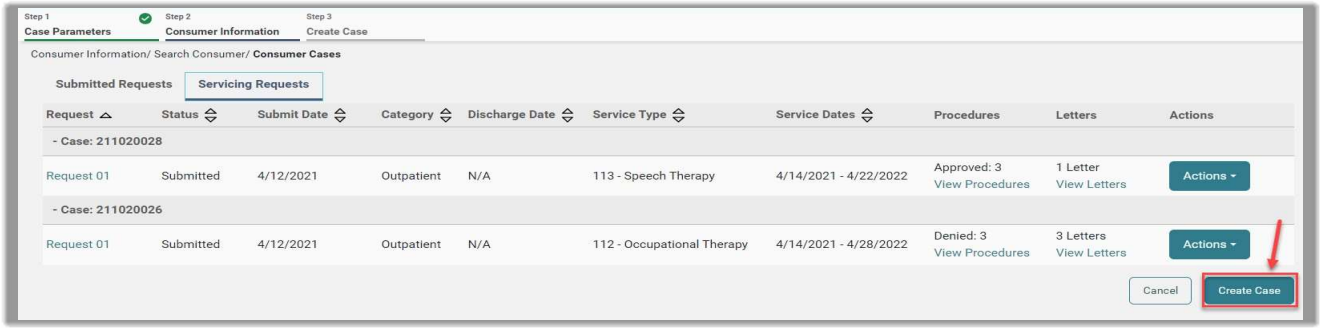
If any previous requests have been created for this consumer, they will display below under either the Submitted Requests or the Servicing Requests tab. Submitted Requests are those you have created and submitted.

Servicing Requests are those another provider or facility created but your organization is listed as the servicing provider.



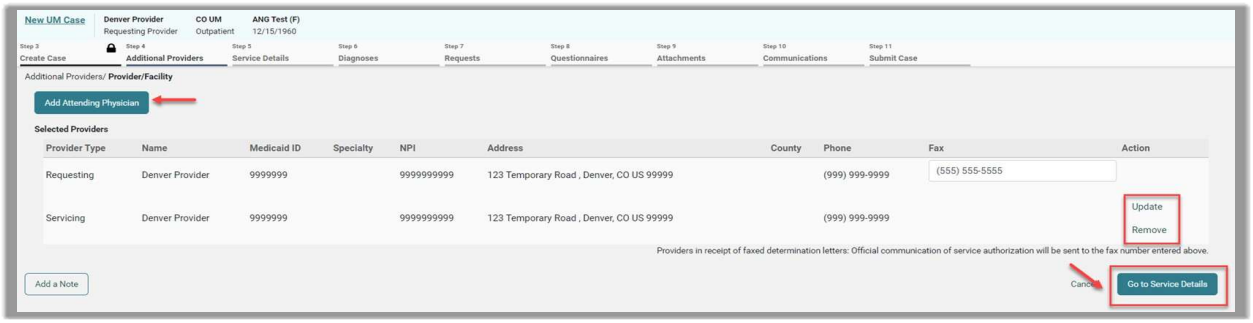
In either tab, you can click on each request hyperlink to ensure it is not a duplicate.

Once you are sure the case you are creating is not a duplicate, click Create Case.

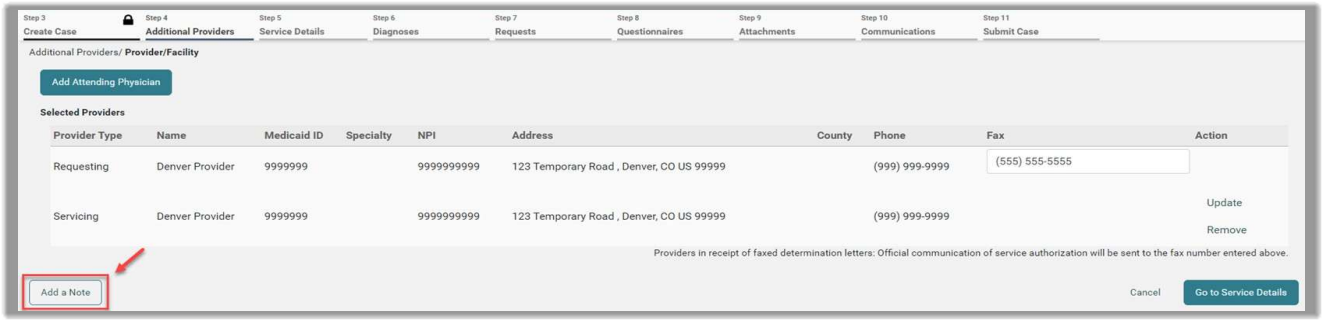


Your case has been created, but more information is required to be submitted. Requesting provider information will automatically fill and cannot be updated. Servicing provider information will default to match and can be updated by using the Update or Remove links. You can also add attending physicians clicking the Add Attending Physician button. Once the provider information is accurate, click Go to Service Details.

Note: Available physician/facility information will vary by contractual requirements for submission. If the wrong requesting provider is listed, you must cancel the case and change context to ensure you are logged in under the appropriate provider group.

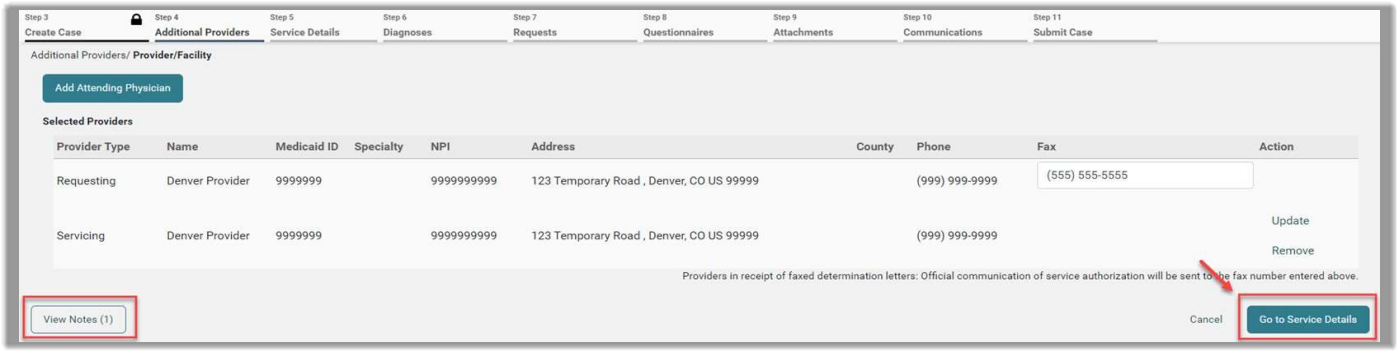


Below the provider information, you will see a button to Add a Note. Click this to add a note associated with the provider information.



In the pop-up window enter your note and click Add Note.

You will notice that the Add a Note button now says, View Notes. Once you are done adding notes and additional providers, click Go to Service Details.

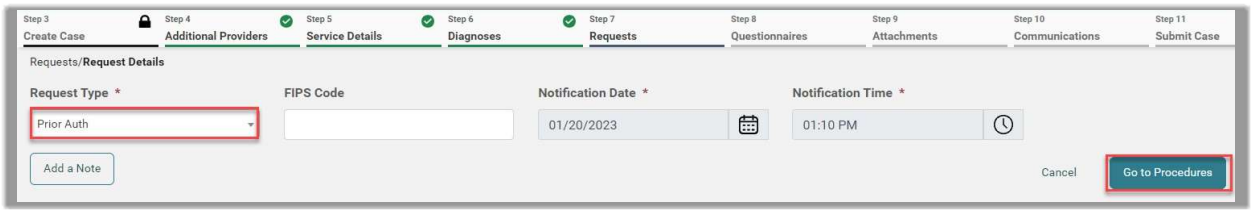


In the Service Details tab, enter appropriate Place of Service and Service Type. Available options will vary based on service type and contract requirements. Then click Go to Diagnosis.

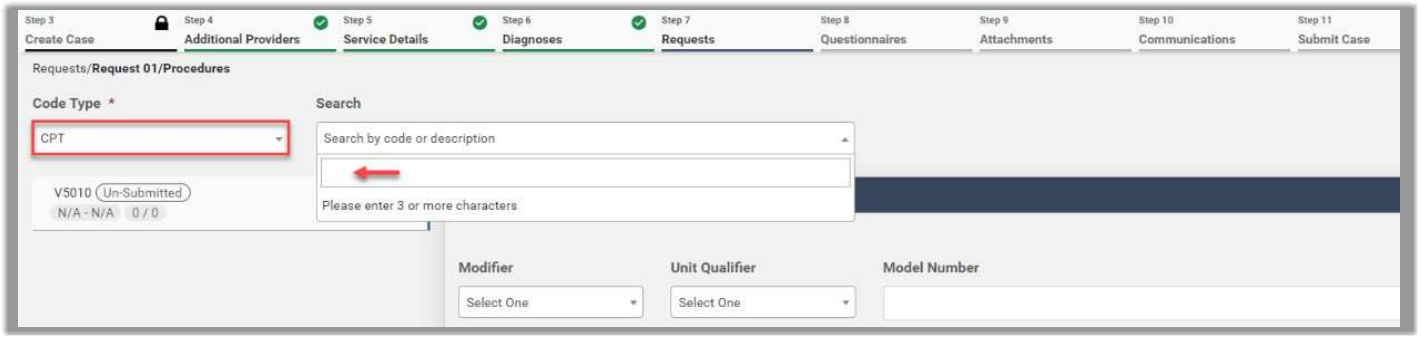
In the Diagnoses tab, select the appropriate Code Type and enter at least 3 characters into the search box. (Note: Search can be completed by diagnosis code or description.) Select the appropriate codes to populate them in the list below and then drag and drop to identify the primary diagnosis. Once all diagnoses are added, click Go to Requests.

In the Requests tab, select appropriate options for each field and then click Go to Procedures.

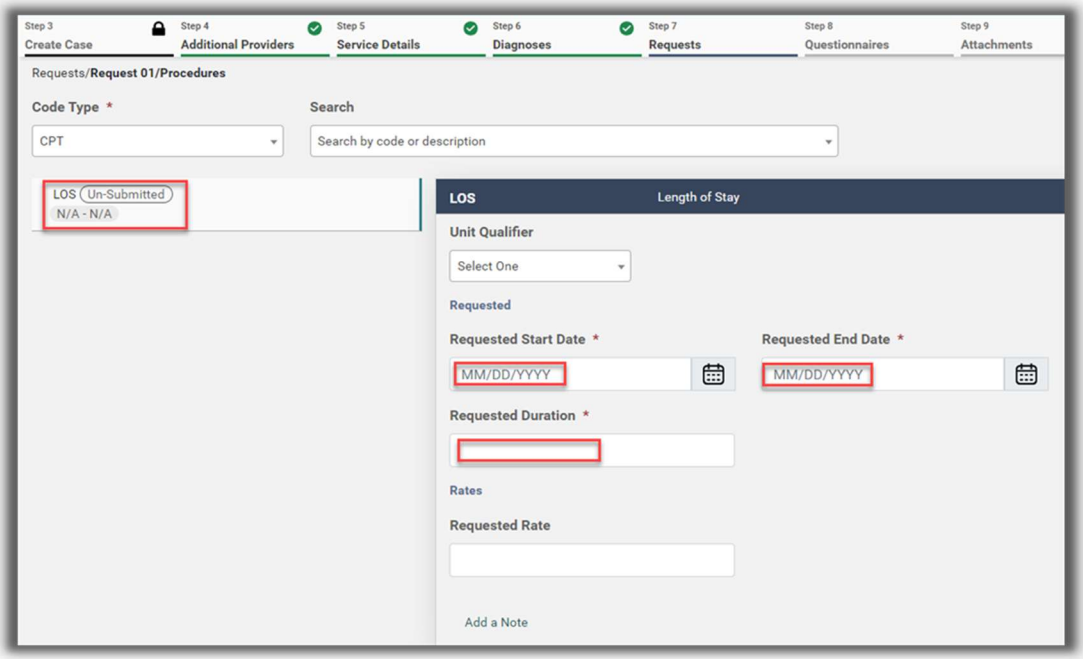
NOTE: Notification date and time will auto populate and are not editable.



Select the appropriate Code Type and enter at least 3 characters into the search box. (Note: search can be completed with procedure code or description.) Select the appropriate codes to populate a request for that procedure. Repeat to add all necessary codes.



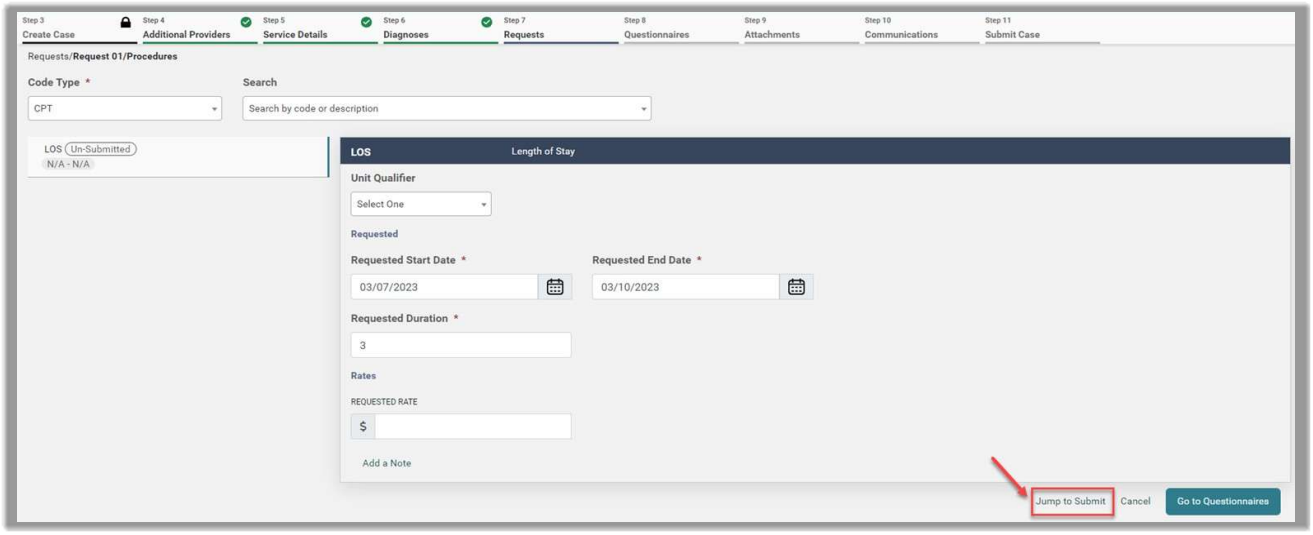
Once all procedures have been added, click each procedure code box to enter additional required information (indicated by an *). Required options will vary by contract and procedure code.



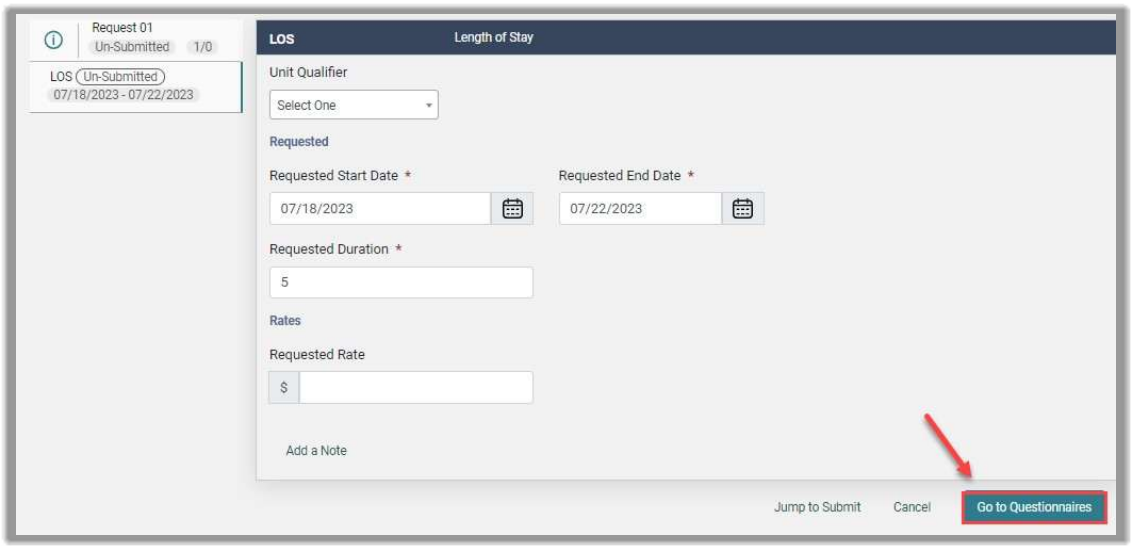
NOTE: Inpatient cases will automatically enter the LOS line that will need to be completed. Not all inpatient requests will require additional procedure codes.

Once all procedure codes are fully filled out, you have two options.

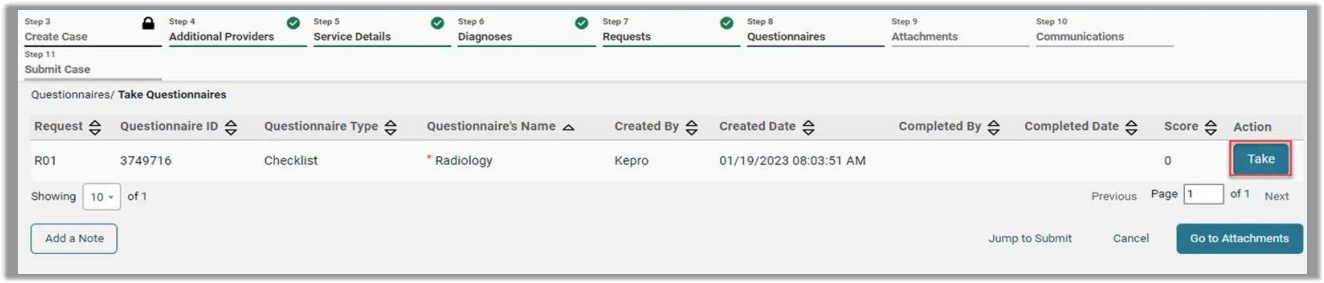
If you have no Questionnaires to fill out, no attachments to add, or communications to enter, you can click Jump to Submit. This will bring you to the end of the process – click here to skip to the Submit step.



If you have questionnaires, attachments, or communications to add, click Go to Questionnaires.



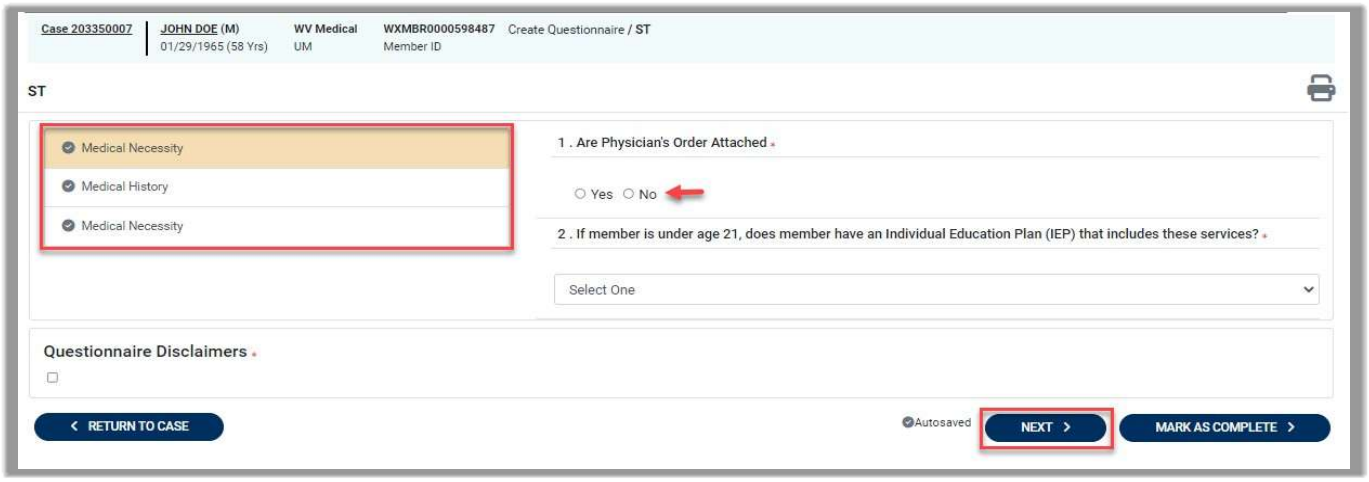
All required questionnaires will populate in the Questionnaires tab. Click Take to complete.



NOTE: Questionnaires are added based on procedure code and contractual requirements. Not all submissions will require questionnaires; some codes may require multiple questionnaires.

Questionnaires will open in a new browser tab, answer all questions in all sections by

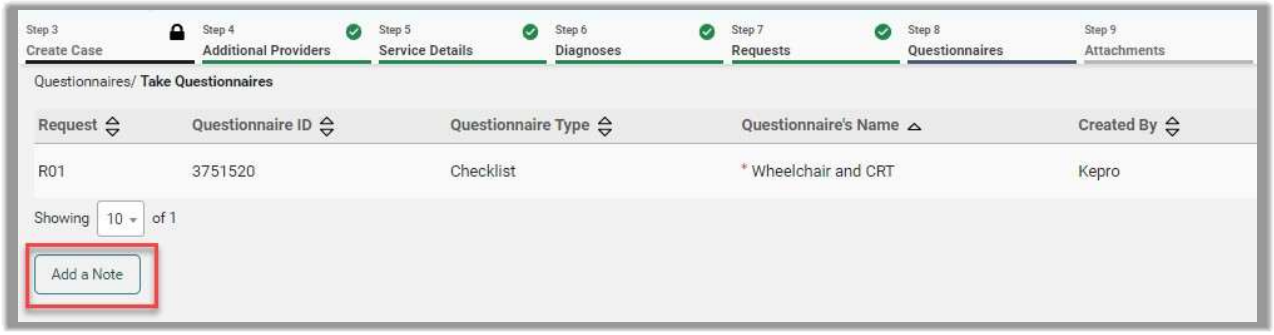
choosing the correct radio button or drop down. Some Questionnaires have multiple sections and have a **Next** button at the bottom to navigate between the sections.



Ensure when completing a questionnaire that all sections have a green check mark before clicking
Mark as Complete at the bottom of the page to return to the case wizard.

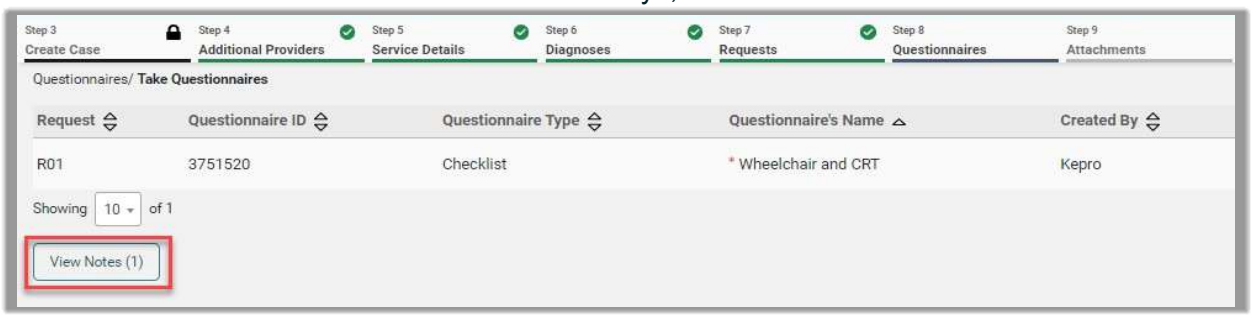
Note: Once complete, the questionnaire can no longer be edited.

Below the questionnaires you will see a button to **Add a Note**. Click this to add a note associated with the questionnaire step.



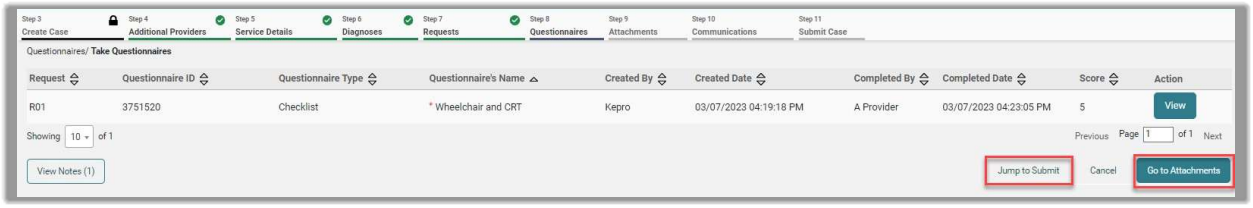
In the pop-up window enter your note and click Add Note.

You will notice that the Add a Note button now says, View Notes.

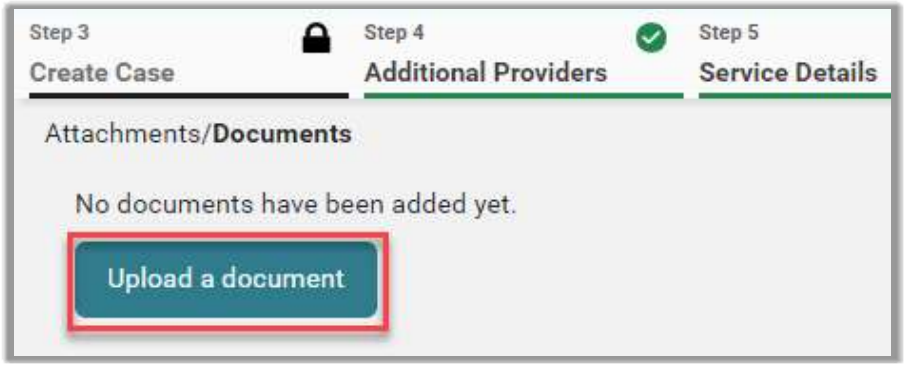


Once all questionnaires are complete you have the options to Jump to Submit or Go to Attachments.

Jump to Submit This will bring you to the Submit Case step – click here to skip to the Submit step. To add supporting clinical documentation, click Go to Attachments.



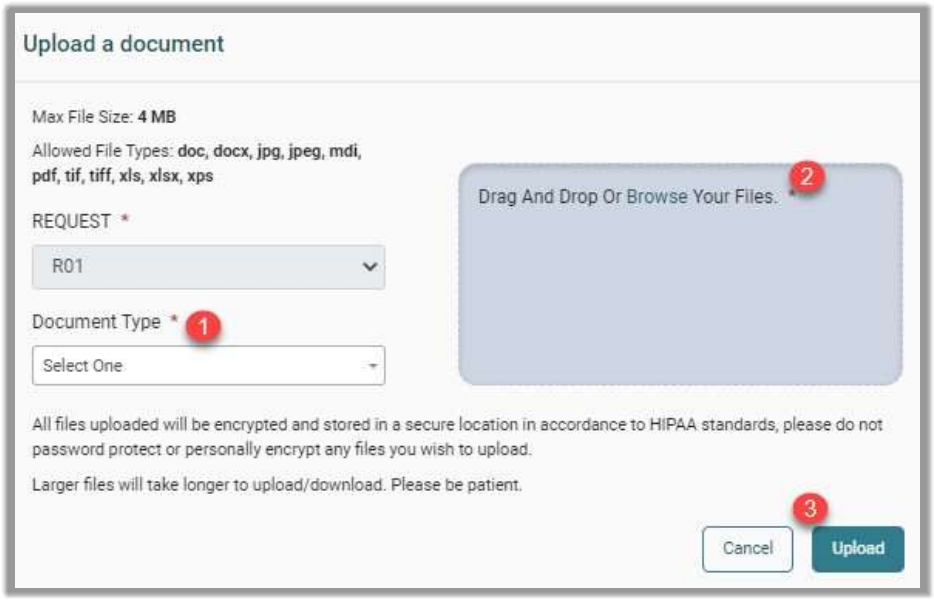
To upload documentation, click **Upload a Document**.



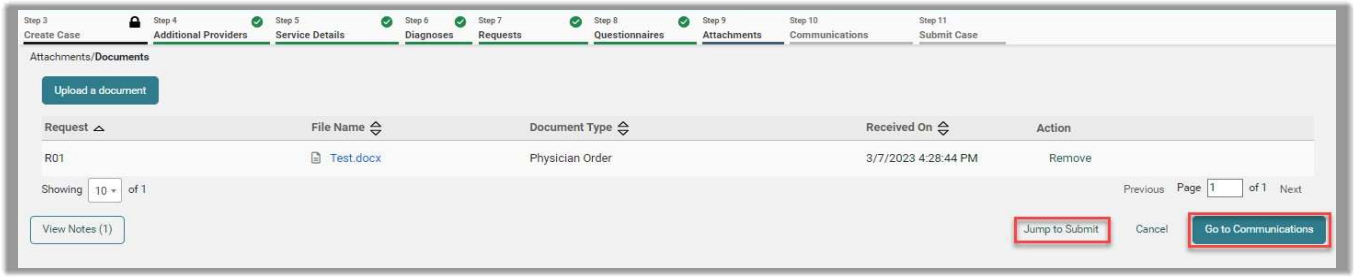
Select appropriate 1) Document Type, 2) add your documents by dragging and dropping or

clicking Browse, and then 3) click **Upload**.

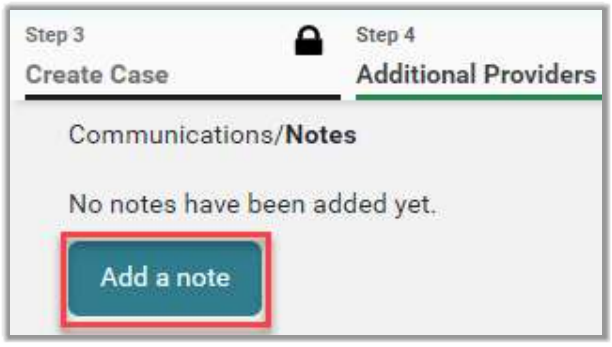
NOTE: All uploaded documents will have a max file size. If document is too large, it will need to be reduced for uploading.



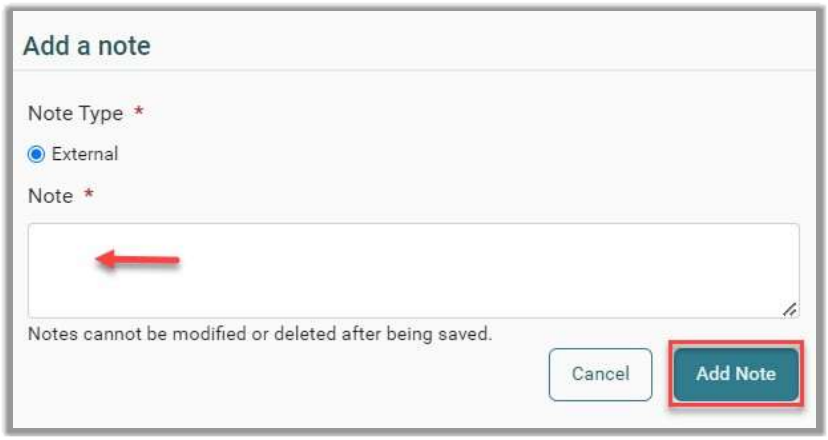
Once all supporting documentation is added, either click **Jump to Submit** or **Go to Communications.**



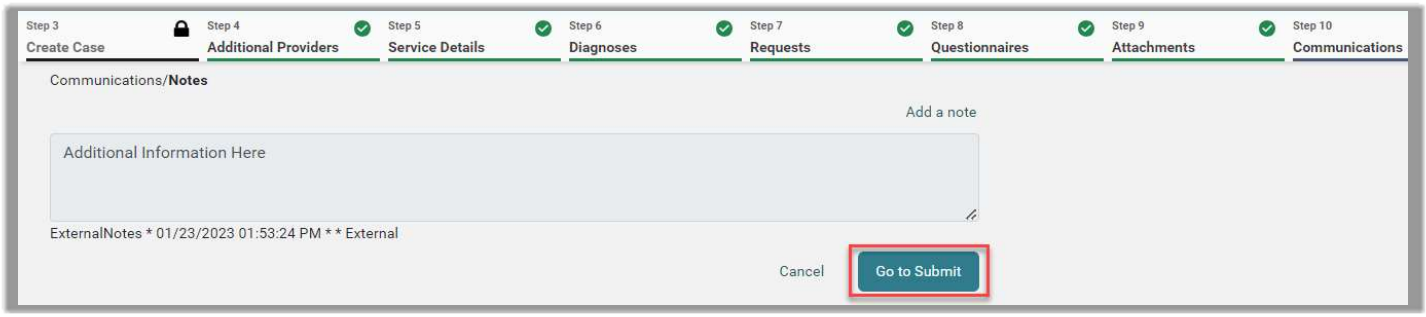
To add additional information click **Add a Note**.



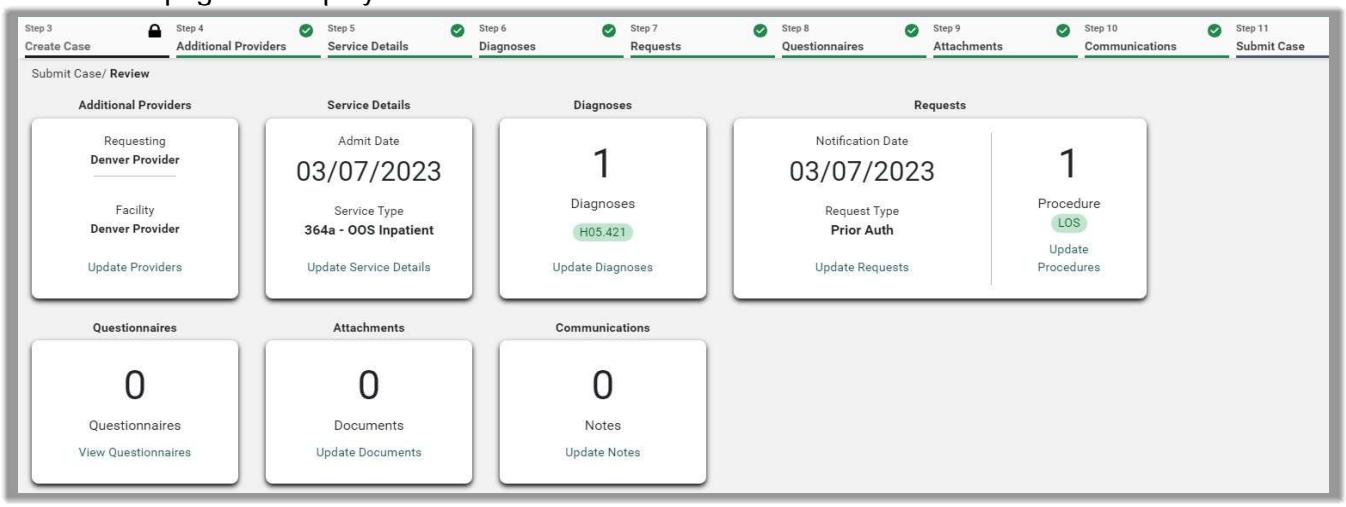
Enter note into the Note field and click Add Note to save. Notes cannot be modified or deleted once saved.



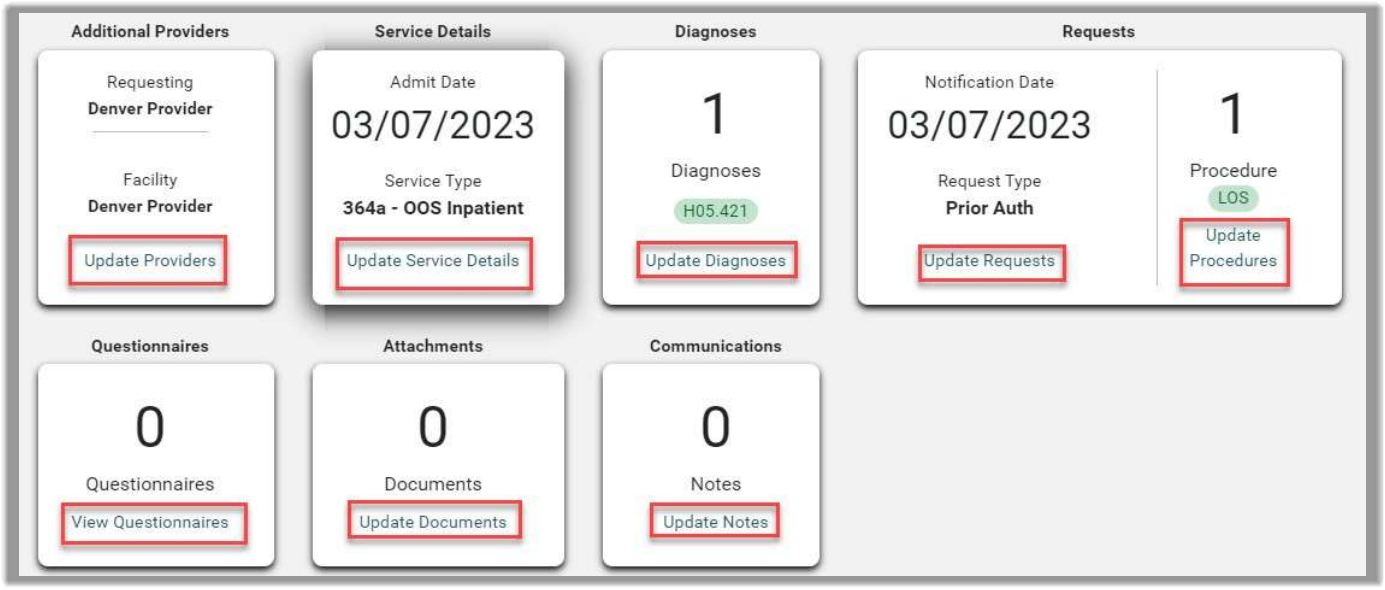
After documentation is completed, click **Go to Submit.**



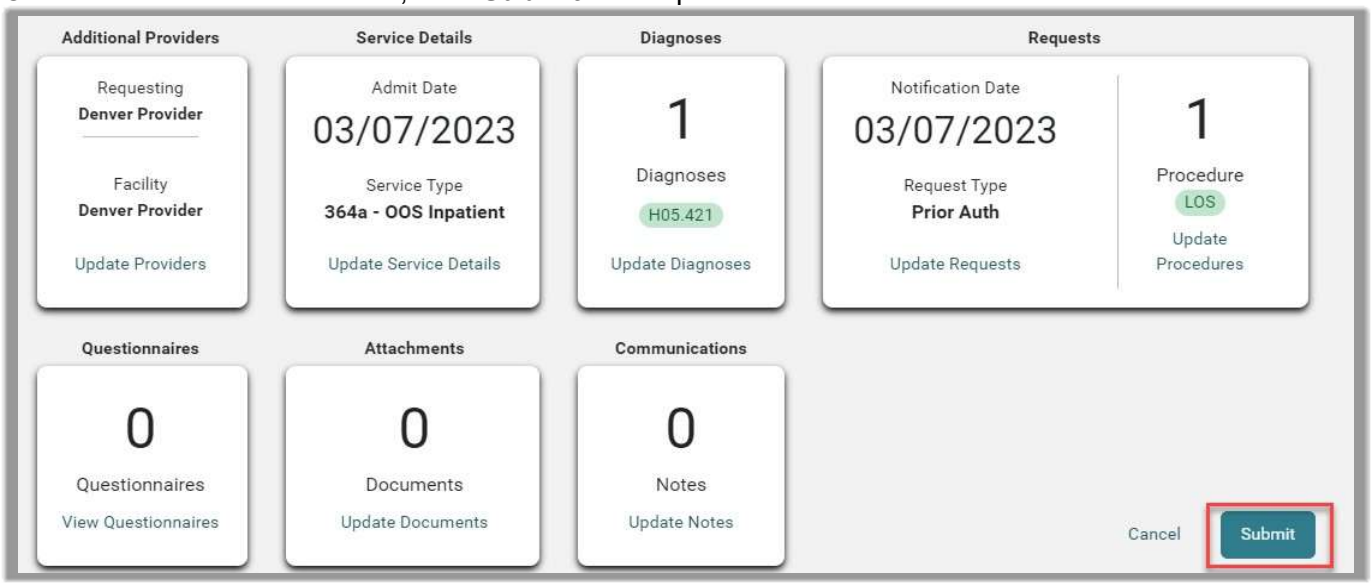
The Review page will display cards of all information entered.



If needed, click **Update** on the appropriate card to edit a specific section.



Once the information is correct, click **Submit** to complete the case and submit it.

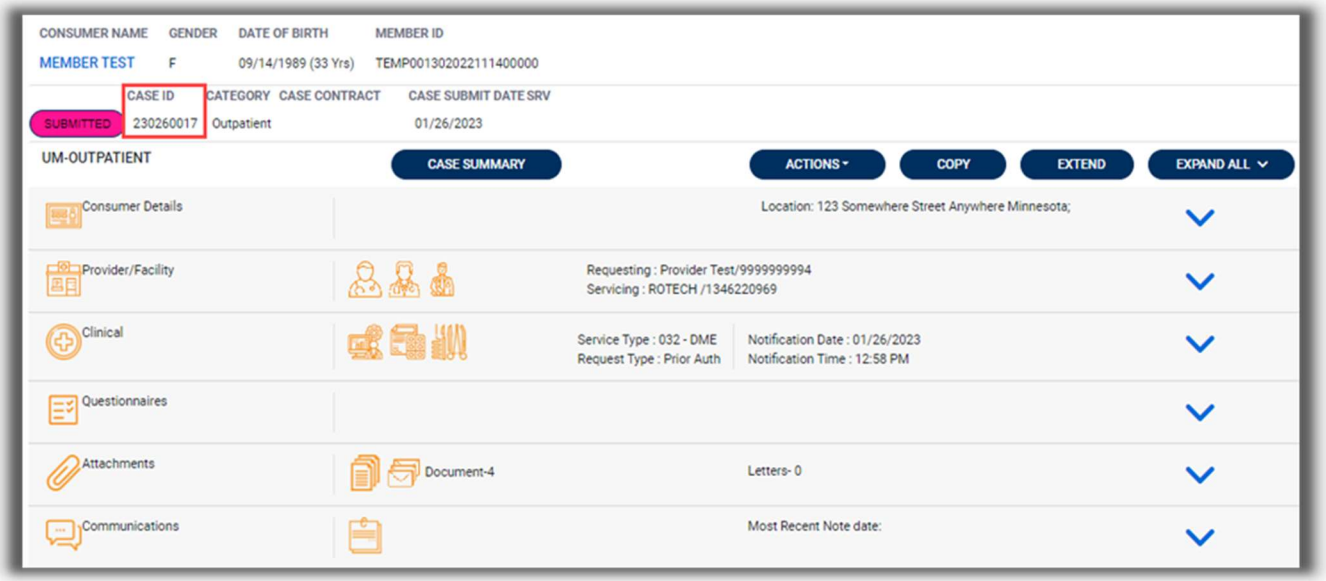


Review the disclaimer and click Agree.

If no errors or warnings are noted, the case will be submitted. A Case ID will be generated which is a unique numerical identifier that can be used for identification purposes and status updates.

HINT: For easy status updates, make note of the Case ID.

The case page will provide the status along with an overview of the submitted request.



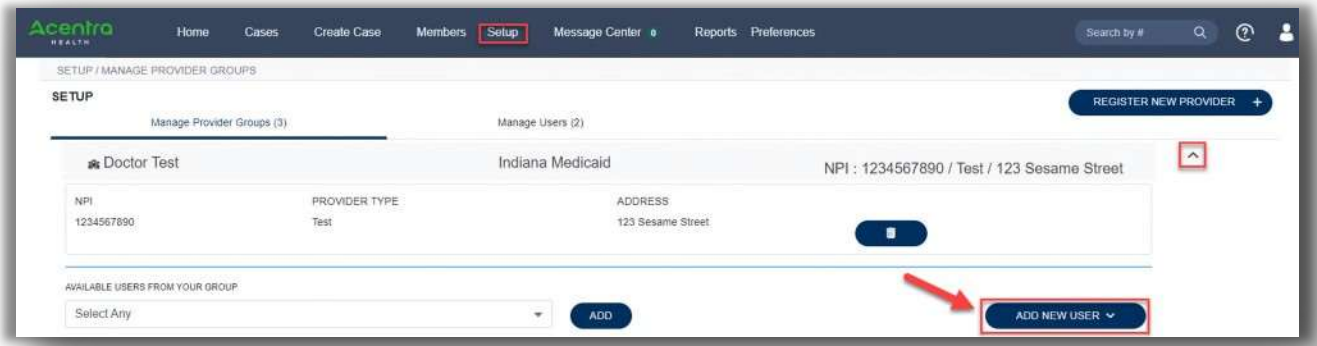
Provider Portal Quick Reference Guides

How to Add a User

A user with an Admin role can create accounts for other users. An Admin user will first need to register in the system and have the information for the additional users that are needed. The instructions below describe how to create accounts for additional users.

Step 1 - Open Setup

Click on SETUP from the top navigation menu. In the “Manage Provider Groups” section, you will see the provider groups that you have access to manage. Expand the desired provider group by clicking on the small arrow on the right. Click **ADD NEW USER.**



Step 2 - Add New User

You will create a username and enter the user’s contact information. Then click **CREATE**. A message will display confirming the user was created successfully. User roles default to Provider Staff Account (which is the general user role).

Helpful Hints:

- Use common naming convention for usernames for all staff on your team.
- You will not be able to edit the username in the future.

Step 3 - New User Access Email

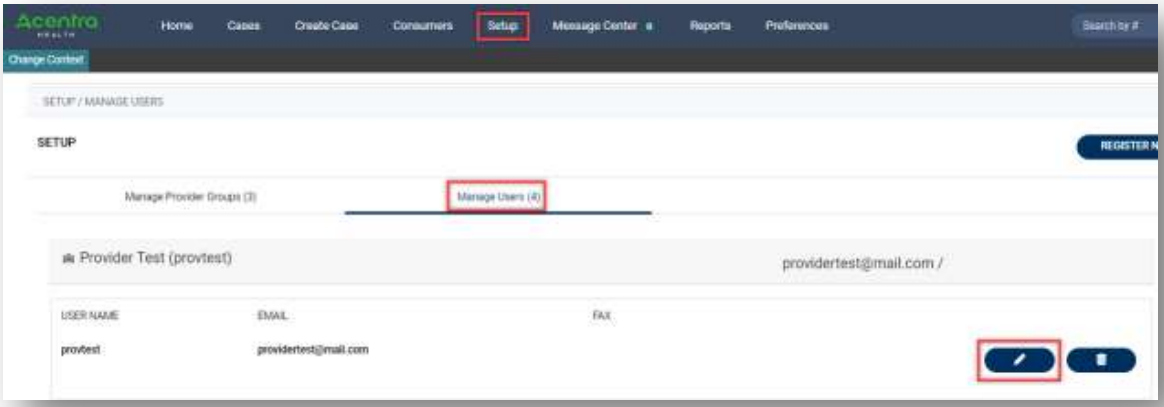
After the new user is entered in the system by the Admin, an email will be sent with a link to complete the registration process. The new user must click the link in the email within 2 days to complete the registration process.

How to Reset User's MFA

Only **Provider Admins** will have access to perform this function. If users change their email or phone number, or if they fail to complete the registration process within the allotted two days, the provider admin can reset the MFA to have a new system generated email sent to the user.

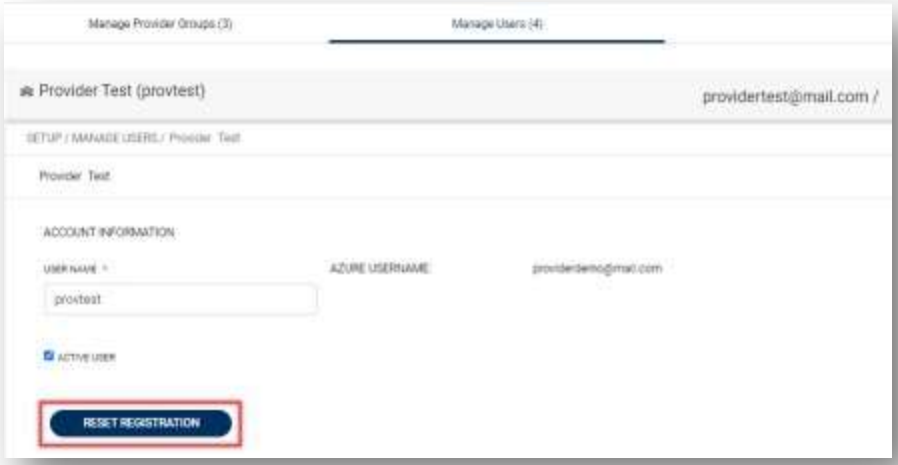
Step 1 - Find User

Click Setup from the top navigation pane and click on Manage Users. Expand the correct user and click the pencil icon to edit.



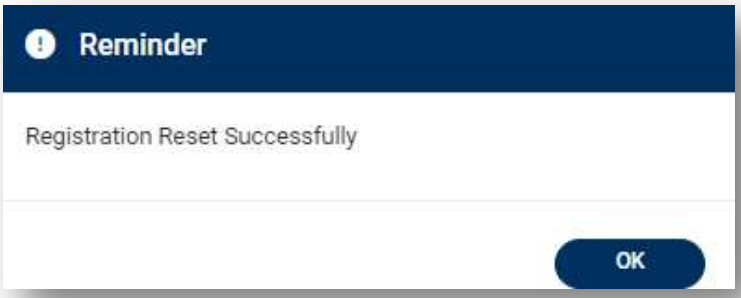
Step 2 - Reset Registration

Click the Reset Registration button under the username.



Step 3 - Click Ok on Confirmation Message

A pop-up window will confirm that the reset was successful, and the user will receive an email notification that they have 2 days to complete their MFA registration.



How to Reset Password or Unlock Account

For a forgotten password, a user can reset their password by following the instructions below.

Step 1 - Click Forgot Password

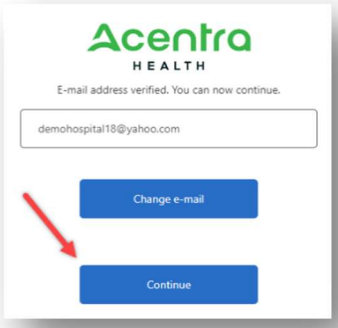
From the login page, click Forgot Password

Step 2 - Enter Email Address

Enter the email address associated with the account and click Send Verification Code.

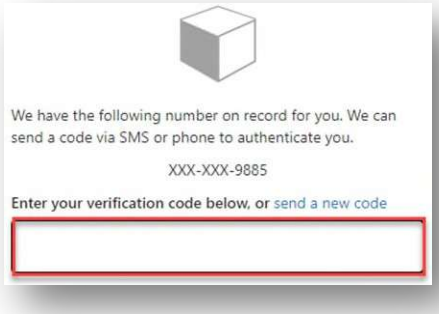
Step 3 - Email Verification

Enter verification code sent to email, click Verify code, then click Continue.



Step 4 - Phone Verification

Select Send Code or Call Me for the phone verification. Enter code received via SMS or press # to complete call verification. Create new password and click Continue.



Account Locked. After several unsuccessful login attempts, your account will lock. To unlock, you will need to contact Customer Support for assistance.

How to Change Context

Users associated with more than one provider can change their context to see location information or cases associated with each provider. The instructions below detail how to change context in the Atrezzo Provider Portal.

Step 1 - Click on Change Context

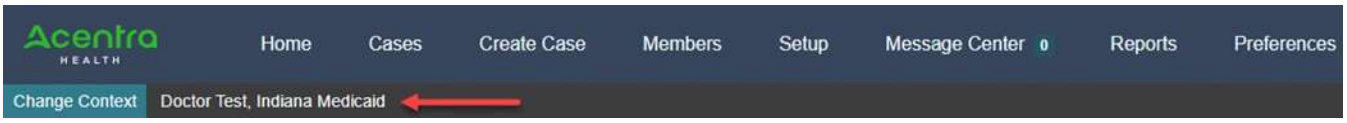
Users with access to more than one context will see a black bar just below the navigation bar, indicating the current context. Click CHANGE CONTEXT just below the company logo.

Step 2 - Select New Context

The current provider information displays in the top section. Your available provider contexts will be listed below. Click on the arrow to the right of the desired provider to log into that context.

Step 3 - Navigate the System

The system will refresh, the black bar will display the new provider context, and the information available will be for that provider only.

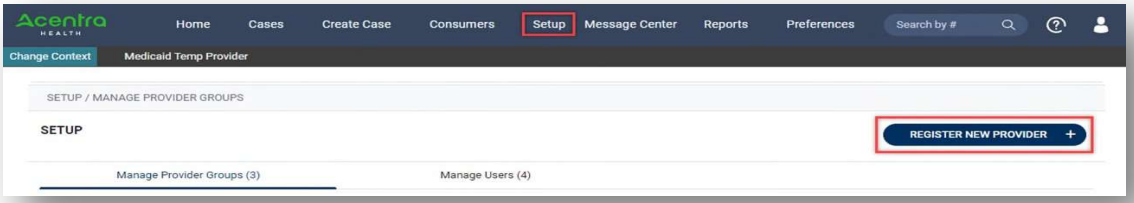


How to Add Additional Providers

Provider Admins exclusively have access to perform this function. For those overseeing multiple provider locations within Atrezzo, the addition of multiple NPI numbers under your login is possible. Follow the outlined steps below to add additional providers.

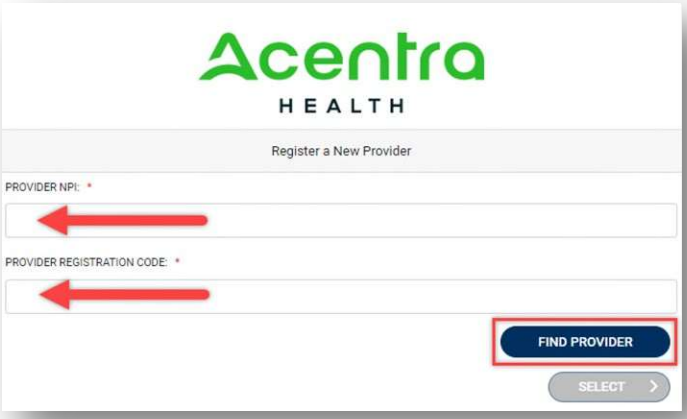
Step 1 - Click Register New Provider

Click Setup from the top navigation pane and click Register New Provider



Step 2 - Enter Provider NPI and Registration Code

Formats for NPI numbers and Registration Codes vary with each contract. Once you enter this information, click Find Provider.



Step 3 – Select Correct Provider

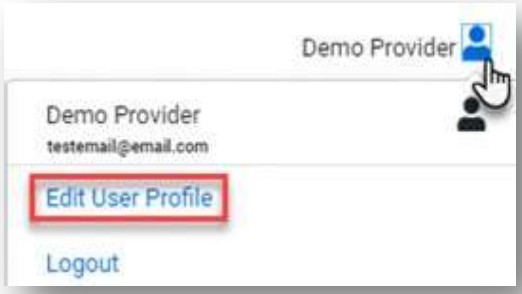
Check the box next to the appropriate provider and click Select. This will add the provider to your group.

How to Update User Profile

Upon finishing registration and multi-factor verification, users can update their profile information and initiate the registration process through an email from the Provider Group Administrator. The instructions below describe how to update profile information.

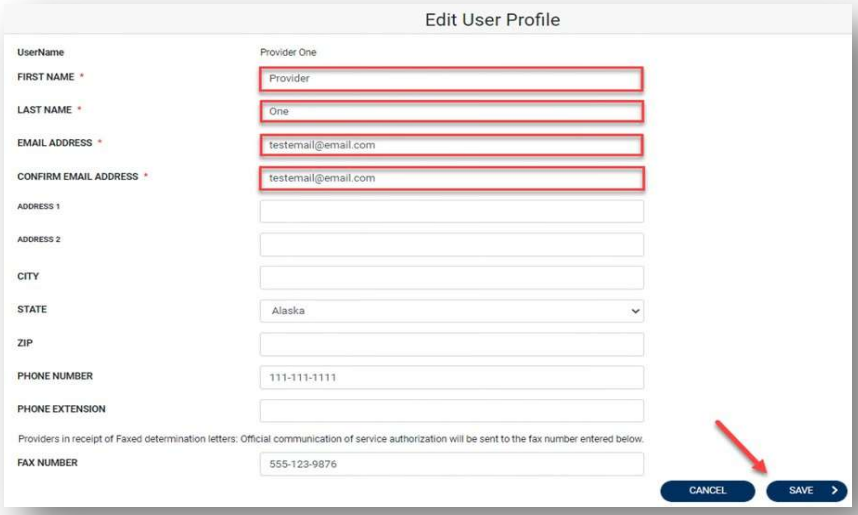
Step 1 - Open Profile Icon

Click on the profile icon in the upper right corner. Once the menu opens, click Edit User Profile.



Step 2 - Update Profile Information

Once the profile screen displays, update the information and include all required fields, then click SAVE.

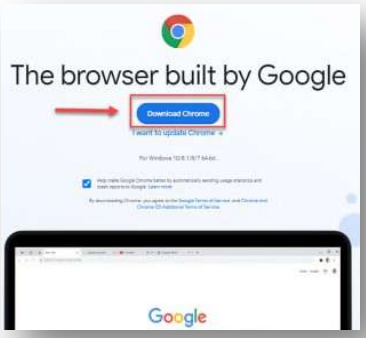


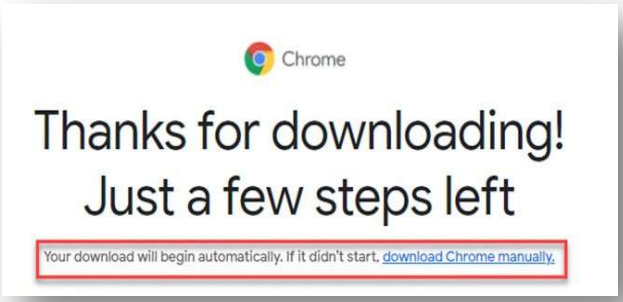
How to Add Chrome Browser

Atrezzo is a web-based care management solution, designed to effortlessly integrate with all internet browsers, including Chrome. The instructions below will highlight the steps to add Chrome to your computer.

Step 1 - Search for Google Chrome

In your current internet browser, do a search for “Google Chrome Download.” Then follow the steps below to complete installation.



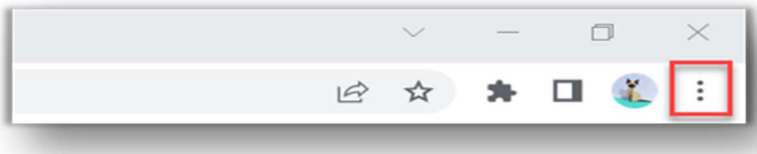


How to Clear Browser History in Chrome

If your internet browser seems slower than usual, you may want to clear your browser history and cookies. The instructions below are for Chrome.

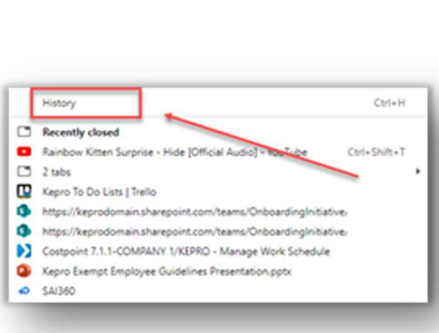
Step 1 - Click the ellipsis on your browser

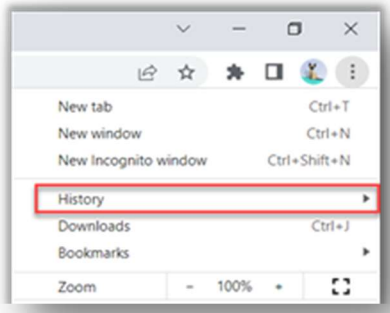
The ellipsis will be in the top right corner



Step 2 - Select History

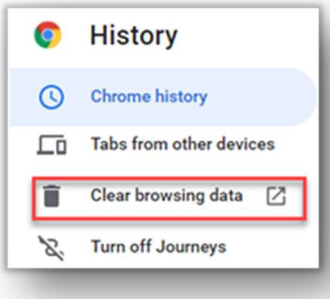
From the drop-down menu, select history.





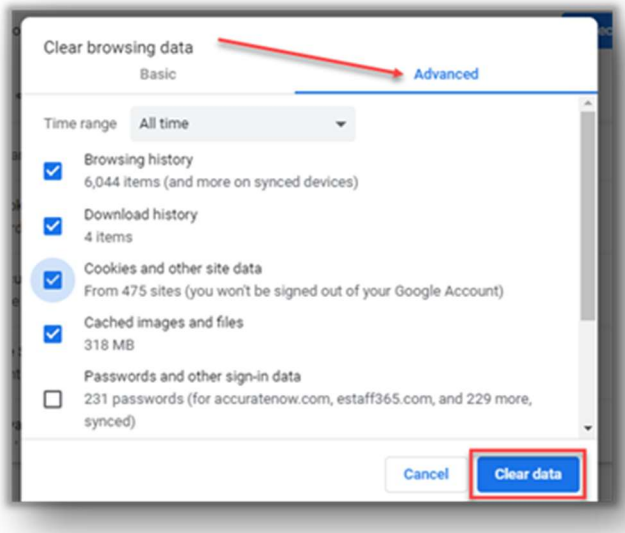
Step 3 - Click Clear Browsing Data

From the drop-down menu, select history.



Step 4 - Click Clear Data

Ensure that Browsing History, Download History, Cookies and other site data, and Cache images and files are selected

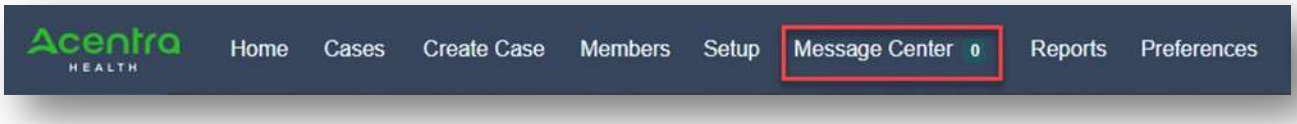


How to View Messages in Message Center

The Message Center will display unread messages, which will provide additional information regarding a current case or request for information. Follow the steps below to enter your Message Center to review and/or respond.

Step 1 - Click Message Center

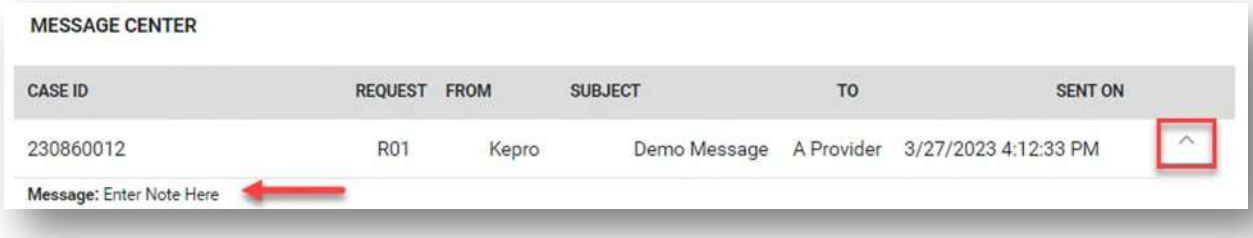
The small teal box will tell you how many messages are waiting for you in your message center.



Step 2 - Expand the Message to Review

Click the caret next to the message to show the full message details.

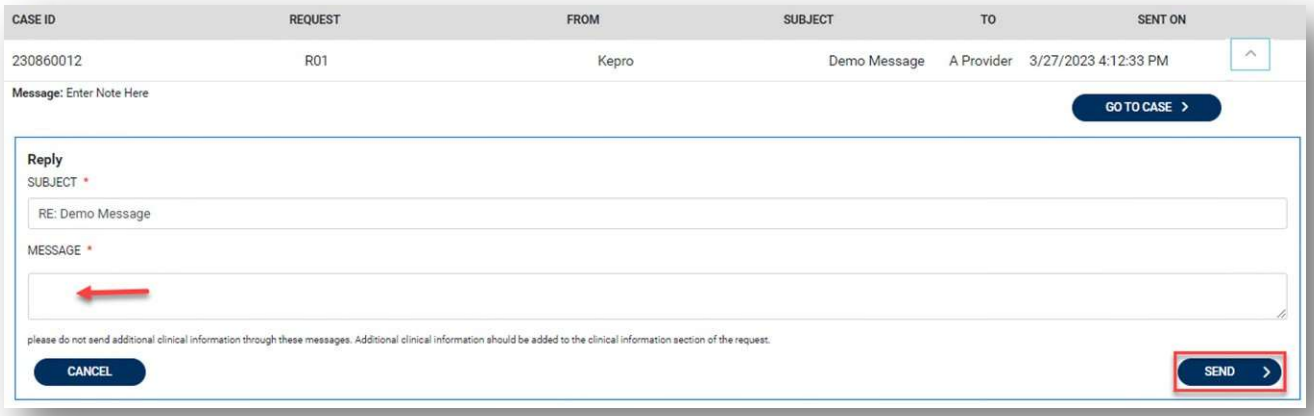
Note: The Message Center will display all messages across all provider locations to ensure messages are not missed based on selected Context.



Step 3 - Reply (if appropriate)

Expanding the message will automatically provide an option to respond. If you wish to, type your message in the MESSAGE field and click SEND.

Important: Upon reading, the message will not be visible in the Message Center but can be found in the Communications ribbon within the case.

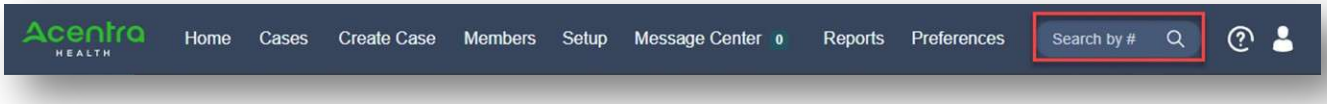


How to Add Additional Clinical Documentation

Utilize the action function to attach extra documentation. Follow the instructions below to begin adding information within the case.

Step 1 - Search for Case ID

Enter the Case ID into the Search Bar. Press enter or click anywhere outside of the box to be navigated to the case.

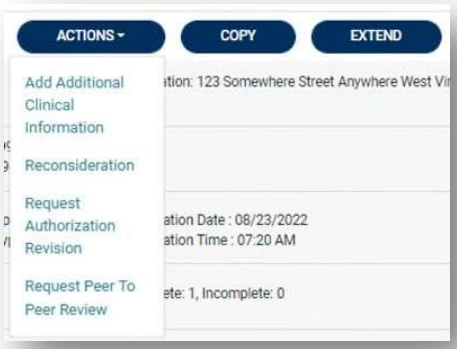


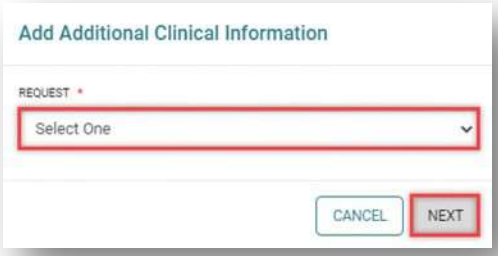
Step 2 - Action Button

Once on the request page, click Actions located at the top.

Step 3 - Selecting Add Additional Clinical Information

Expand actions to view and choose from available options in the dropdown. Select Add Additional Clinical Information.





Step 4 - Complete Information

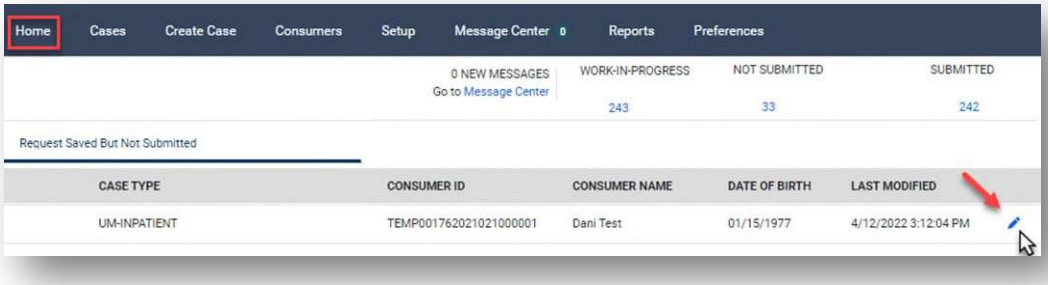
In a new box, choose the request number from the dropdown and click next. To submit the action, attach a note or document, select the document type, and click Submit.

How to Complete a Saved Request

If a request was started but not submitted, it will be listed as a Saved but Not Submitted Request on the home page. The instructions below describe how to complete the request.

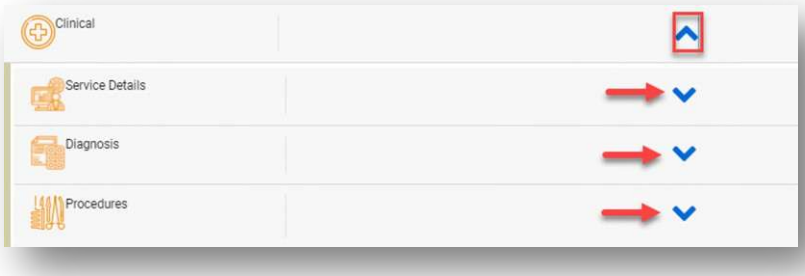
Step 1 - Review Requests on Home Page

Review the requests listed as saved but not submitted. To complete, click the edit icon on the row of the desired request.



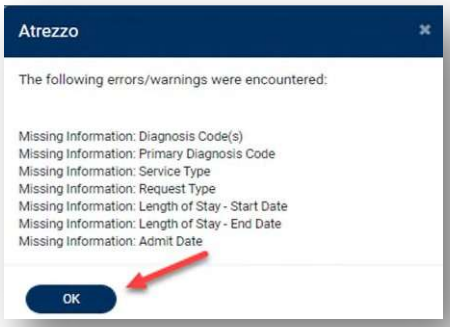
Step 2 - Add Required Information

On the case creation page, expand Clinical and review Service Details, Diagnosis, and procedure sections to identify information necessary for submission.



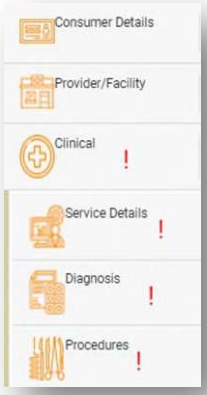
Step 3 - Submit Request

Once all required fields are complete, click Submit. If any required fields are incomplete, a warning message will appear. Click OK to continue.



Step 4 - Review Required Fields

The case creation page will display a red exclamation mark to identify which sections are missing required information. Expand each section with a red exclamation mark displayed. Once required information is added, the red exclamation mark will disappear, and the case can be submitted.

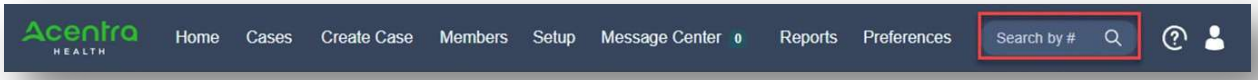


How to View Action Buttons within a Case

Initiate the process of attaching additional documentation, making revisions, and reconsiderations by utilizing the action function within the case. Follow the instructions below to begin creating these actions.

Step 1 - Search for Case ID

Enter the Case ID into the Search Bar. Press enter or click anywhere outside of the box to be navigated to the case.

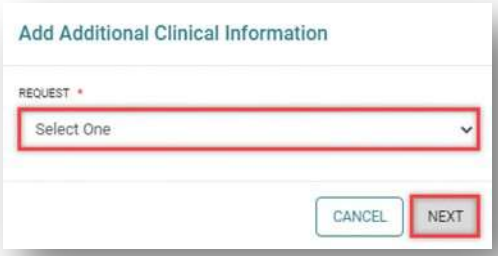


Step 2 - Action Button

Once on the request page, click Actions located at the top.

Step 3 - Selecting an Action

Expand actions to view and choose from available options in the dropdown. Select the appropriate option.



Step 4 - Complete Information

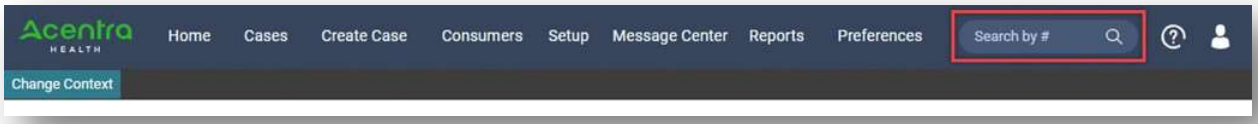
In a new box, choose the request number from the dropdown and click next. To submit the action, attach a note or document, select the document type, and click Submit.

How to Request a Reconsideration or Appeal

Requesting a Reconsideration will need to be made by using the action function. The instructions below describe how to start the process of Requesting a Reconsideration from within the case.

Step 1 - Search for Case ID

Enter the Case ID into the Search Bar. Press enter or click anywhere outside of the box to be navigated to the case.

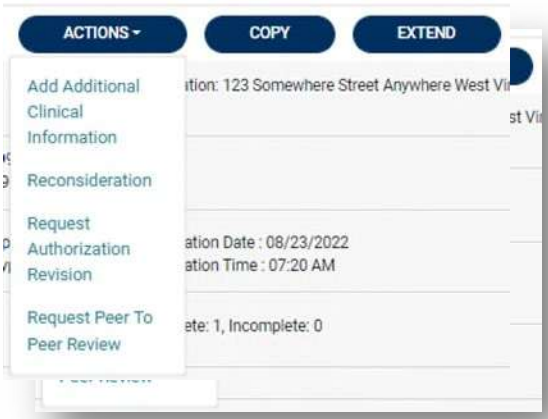


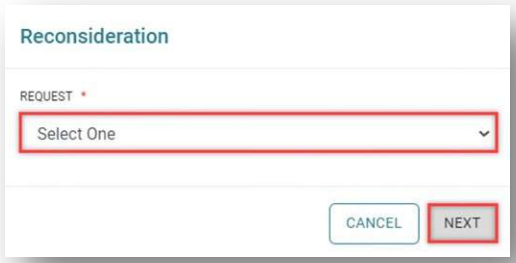
Step 2 – Action Button

Once on the request page, click Actions located at the top.

Step 3 – Selecting Reconsideration or Appeal

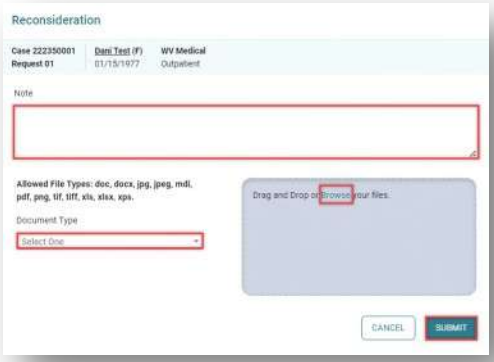
The Actions will expand and show the available actions that can be selected for the case. Select Reconsideration.





Step 4 – Complete Information

A new box will appear. Select the request number from the dropdown and click next. A note or document must be attached to submit the action. Choose the document type and click Submit.

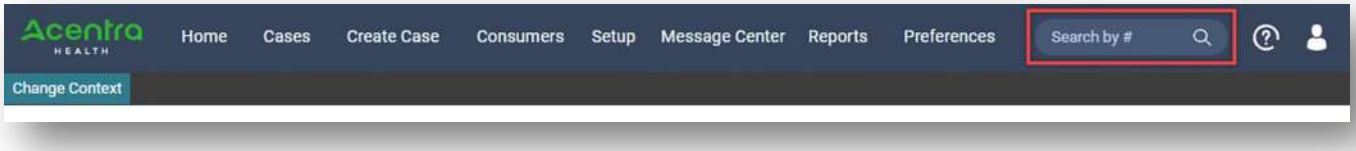


How to Request a Reconsideration or Appeal

Requesting a Reconsideration will need to be made by using the action function. The instructions below describe how to start the process of Requesting a Reconsideration from within the case.

Step 1 - Search for Case ID

Enter the Case ID into the Search Bar. Press enter or click anywhere outside of the box to be navigated to the case.

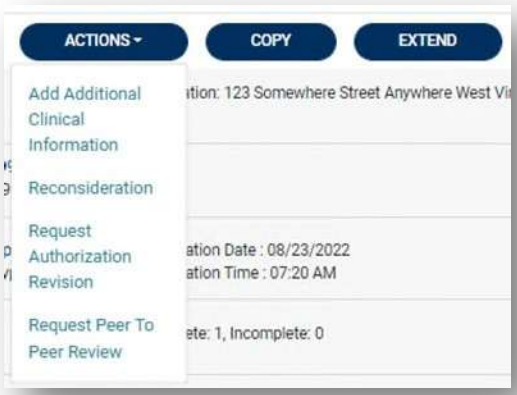


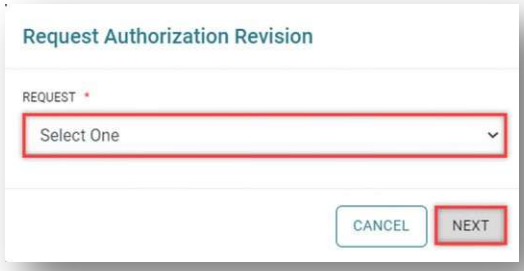
Step 2 - Open Submitted Request

Once on the request page, click Actions located at the top.

Step 3 - Authorization Revision

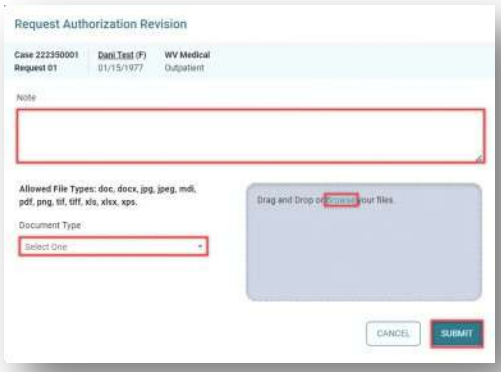
Expand actions to view and choose from available options in the dropdown. Select Request Authorization Revision.





Step 4 - Complete Information

In a new box, select the request number from the dropdown and click next. To submit the action, attach a note or document, select the document type, and click Submit.

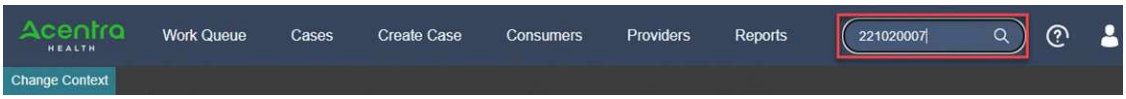


How to View Determination Letter

When a change has been made to the submitted request, you will receive an email notification. The email notification will provide the Case ID to direct you to the specified request. The instructions below will identify the steps to view the determination letter.

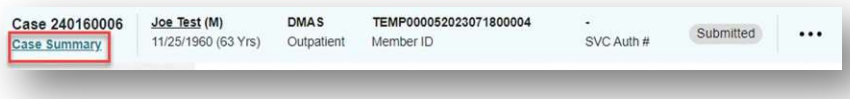
Step 1 - Search for Case ID

Enter the Case ID into the Search Bar. Press enter or click anywhere outside of the box to be navigated to the case.



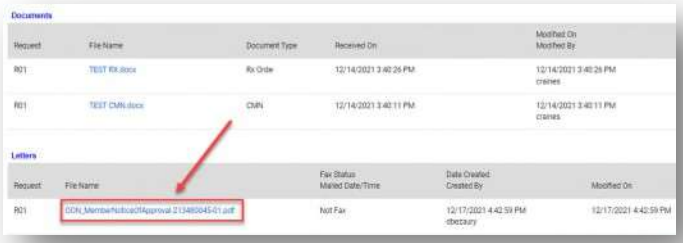
Step 2 - Open Case Summary

Once the case displays, click Case Summary at the top of the page.



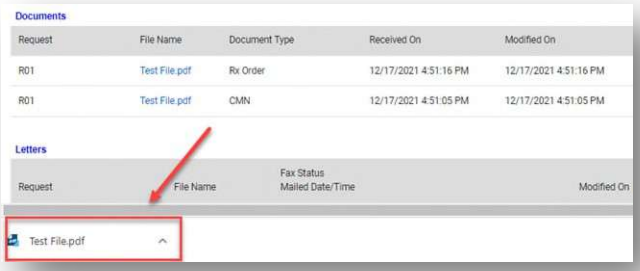
Step 3 - Search for Letter

Scroll to the bottom of the summary to the Letter section. Click the file name hyperlink.



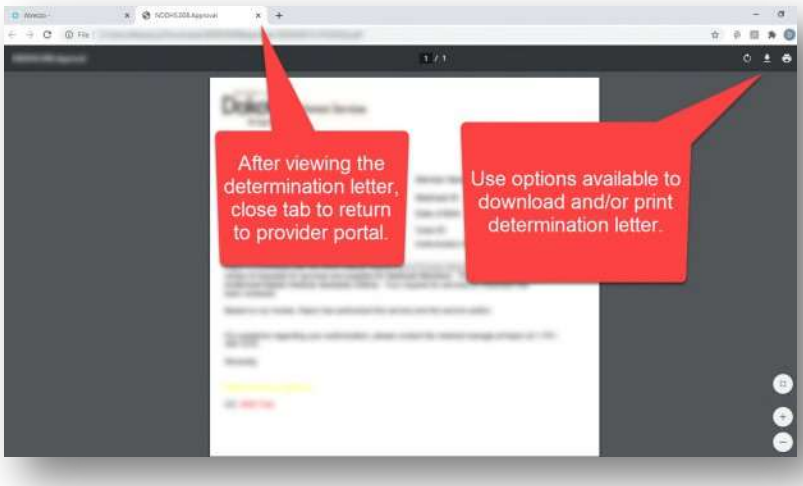
Step 4 - View Letter

Click the file at the bottom of the page once downloaded. The file will open outside of the provider portal for viewing, downloading, saving, and/or printing if needed.



Step 5 - Sample Letter

Once view is complete, close tab to return to the provider portal.

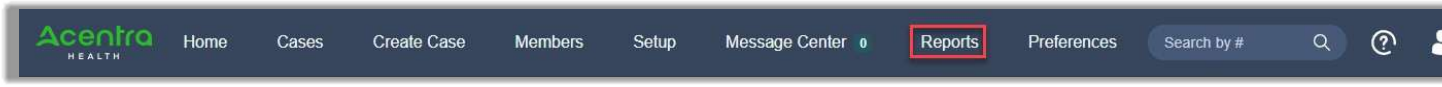


How to Run a Report

Not all users will have access to reports and availability will vary by user role and contract requirements. To view available reports, click Reports. The report name will be a hyperlink and open the desired report in a new tab within the internet browser.

Step 1 – Select Reports

Select Reports from the toolbar

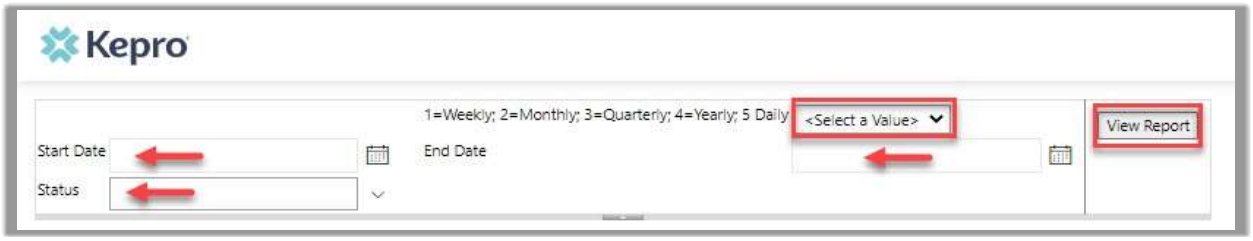


Step 2 – Select the Report Name

Click the report title to open the report viewer

Step 3 – Select the parameters

Some reports will require additional information before they are populated. In the image below, we need to provide the Start Date, Status, Time period, and End Date before clicking View Report.



Step 4 – Save the Report

Once displayed, click the Save icon and select the format you prefer to download a draft, if needed.

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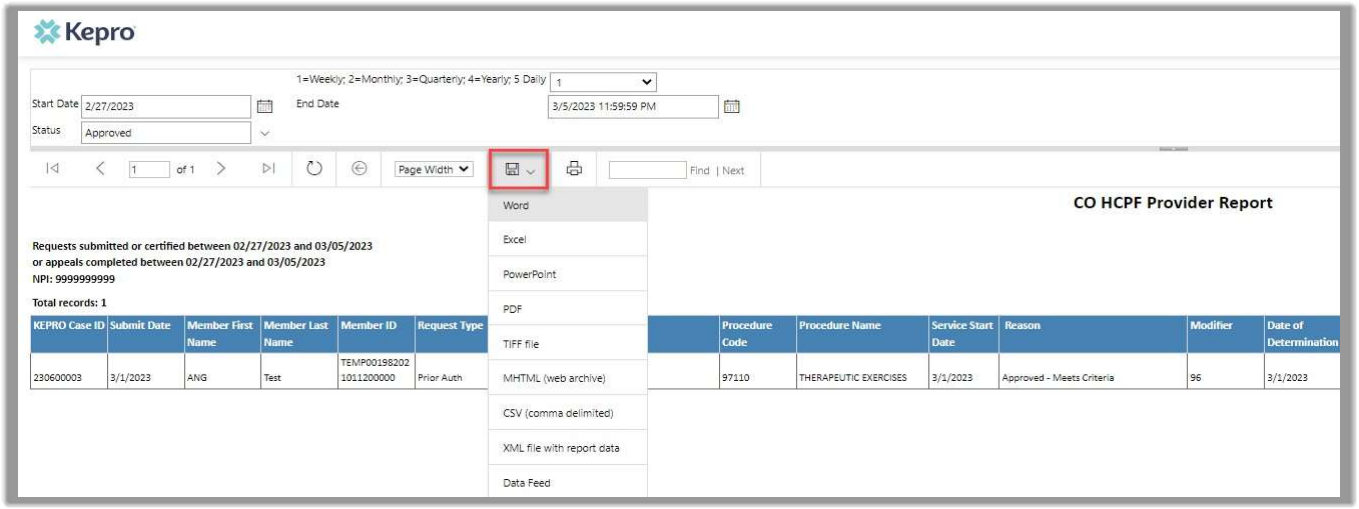
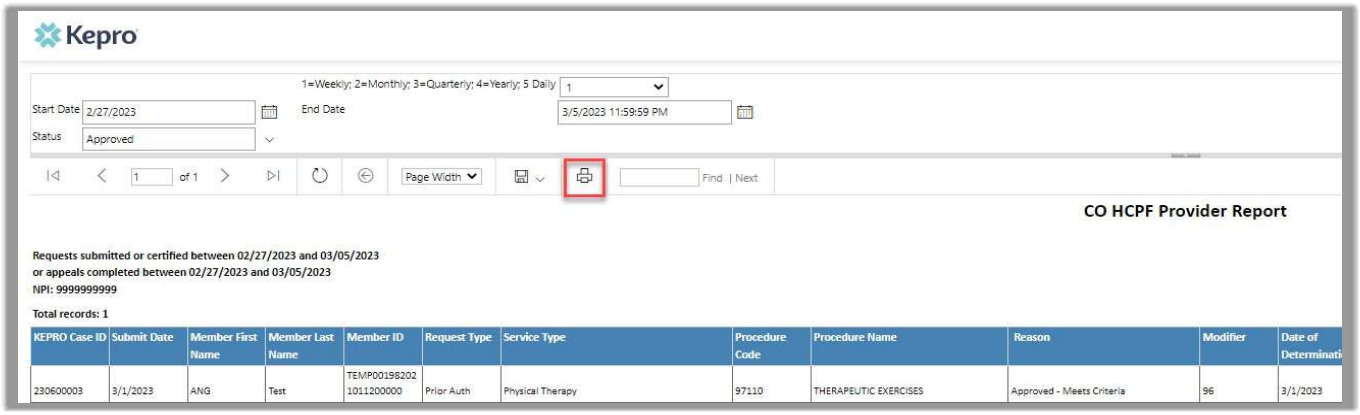
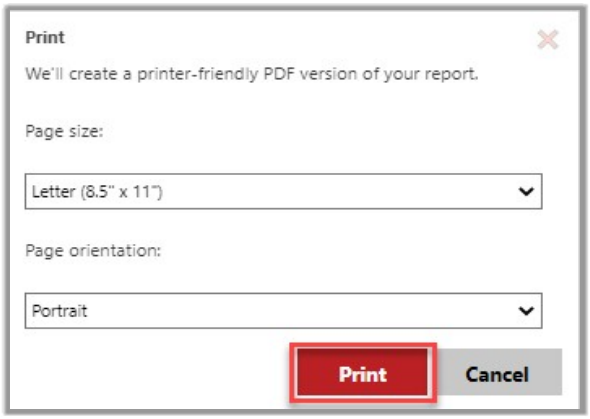


Step 5 – Print the Report

Click the Printer icon to bring up the Page size and Page orientation options.

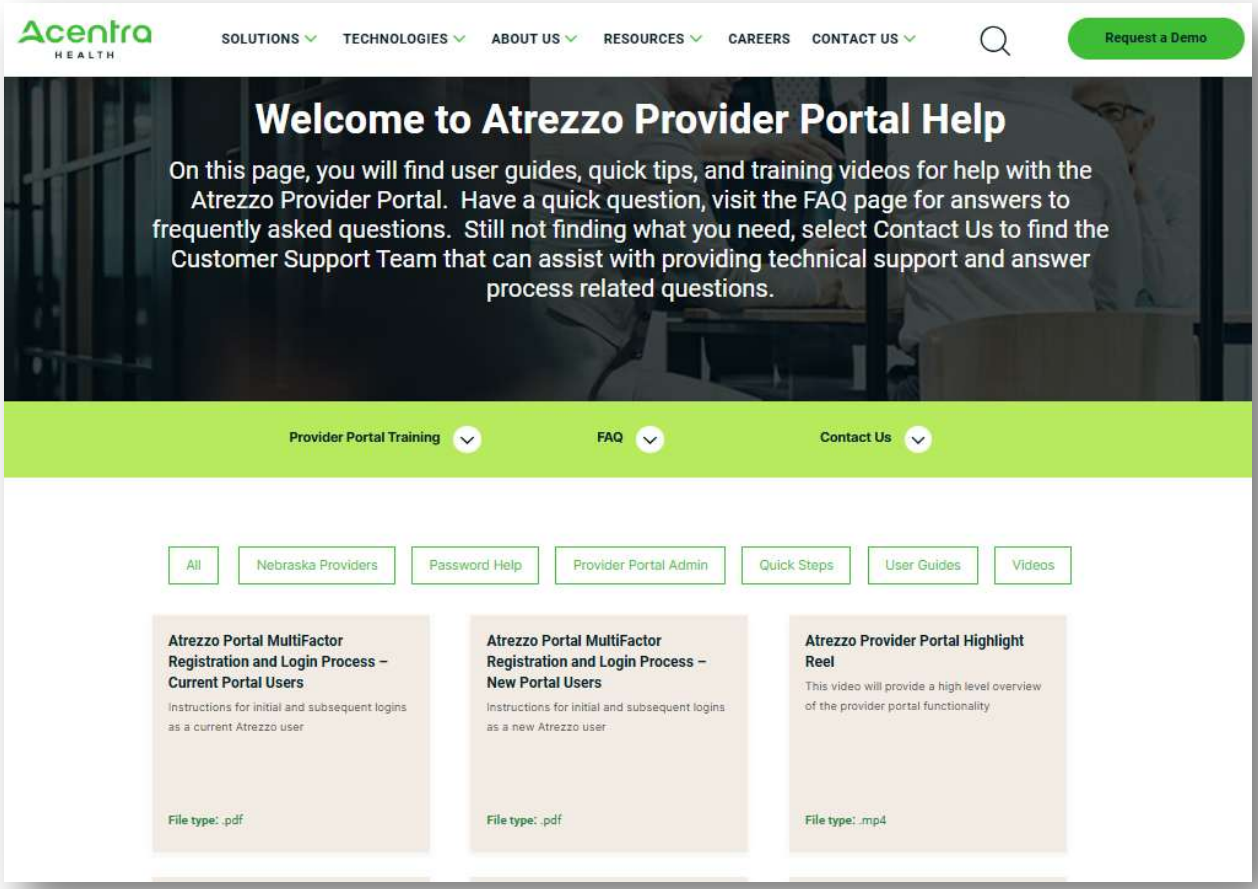


Select appropriate options and click Print to print the report.



Other Atrezzo Resources

For additional tips, tricks, and tutorials to make the most out of Atrezzo, we invite you to visit our dedicated help website at https://acentra.com/atrezzo-help/. This resource is designed to provide users with comprehensive support, including step-by-step guides, troubleshooting tips, and best practices to enhance your experience with the platform. Explore the website today to find the information you need!



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