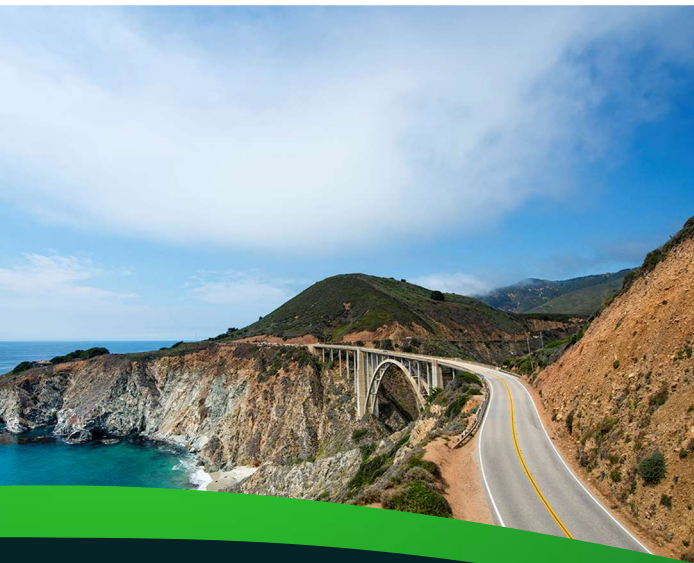




Psychiatric Inpatient Concurrent Review Manual

In Partnership with

**California Mental Health
Services Authority (CalMHSA)**

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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](tel: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.

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.

● 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

Vital Partner Advancing Health Outcomes

Modernizing the healthcare experience for priority populations requires a broader lens. Acentra Health's diverse team of experienced leaders, clinicians, technologists, and industry professionals are redefining industry standards and expectations to support your program's needs.

- ✓ 30+ years of public sector health experience
- ✓ Innovative excellence in healthcare technology solutions and clinical expertise
- ✓ Best-in-class client experience: subject-matter experts, health care advisory board, board of directors, and client focus groups



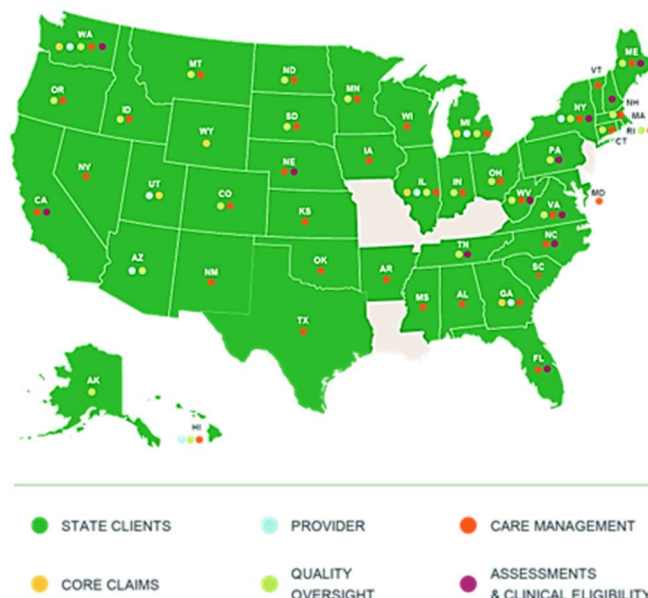


Acentra Health's extensive experience developing innovative, collaborative models of utilization management, care management, provider relations and quality improvement emphasizes community partnerships, training, and technical assistance. Acentra Health has been highly successful in improving collaboration 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.



MELISSA LEIGH
Chief Legal & Compliance Officer

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:** CARreviews@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

Kelly Parnell, LCSW
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California Leadership Team



Program Manager

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Clinical Manager

Keshia Ingram, LMFT
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Clinical Supervisor

Ani Hacopian, LMFT
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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

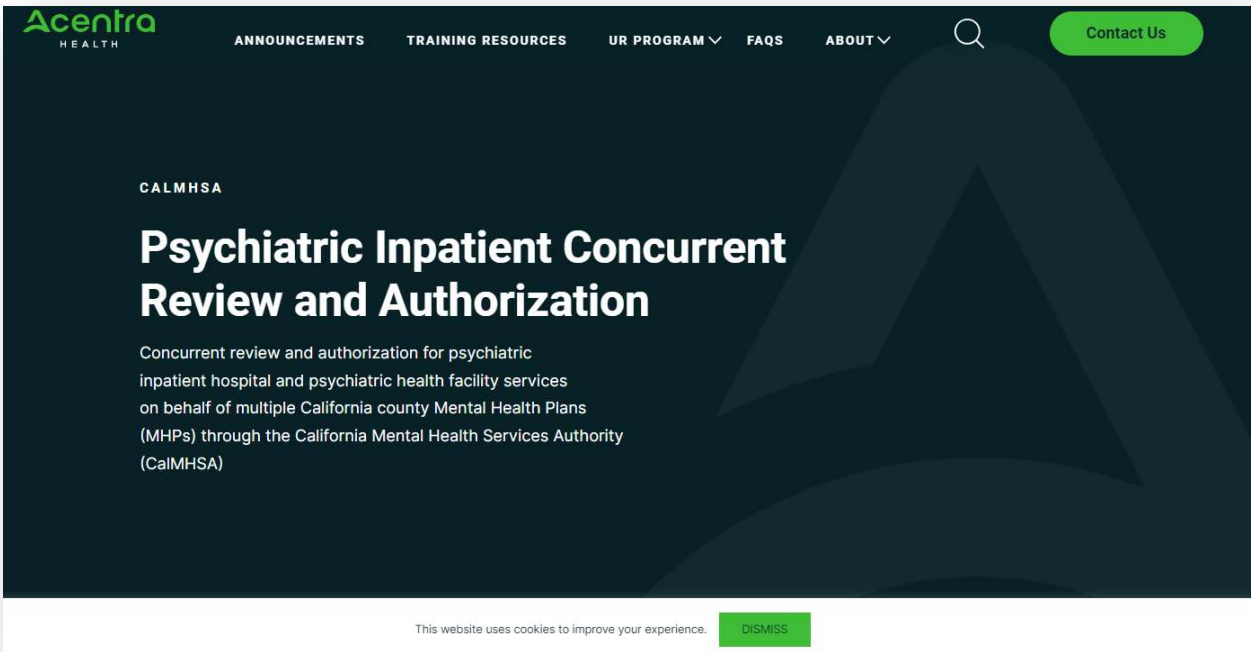
Atrezzo	Members & Appeals	Clinical Questions	Training & Reporting
CARreviews@acentra.com (866) 449-2737	AppealsCA@acentra.com (866) 449-2737	CARreviews@acentra.com (866) 449-2737	CARreviews@acentra.com (866) 449-2737
Crystal Zapata, Lead CSR crystal.zapata@acentra.com	Jade Rivera, Appeals Spec jade.rivera@acentra.com	Ani Hacopian, Clinical Sup. ani.hacopian@acentra.com	Crystal Zapata, Lead CSR crystal.zapata@acentra.com
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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

Psychiatric Inpatient Concurrent Review Manual

In Partnership with the
California Mental Health Services Authority (CalMHSA)



Version: January 2025



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

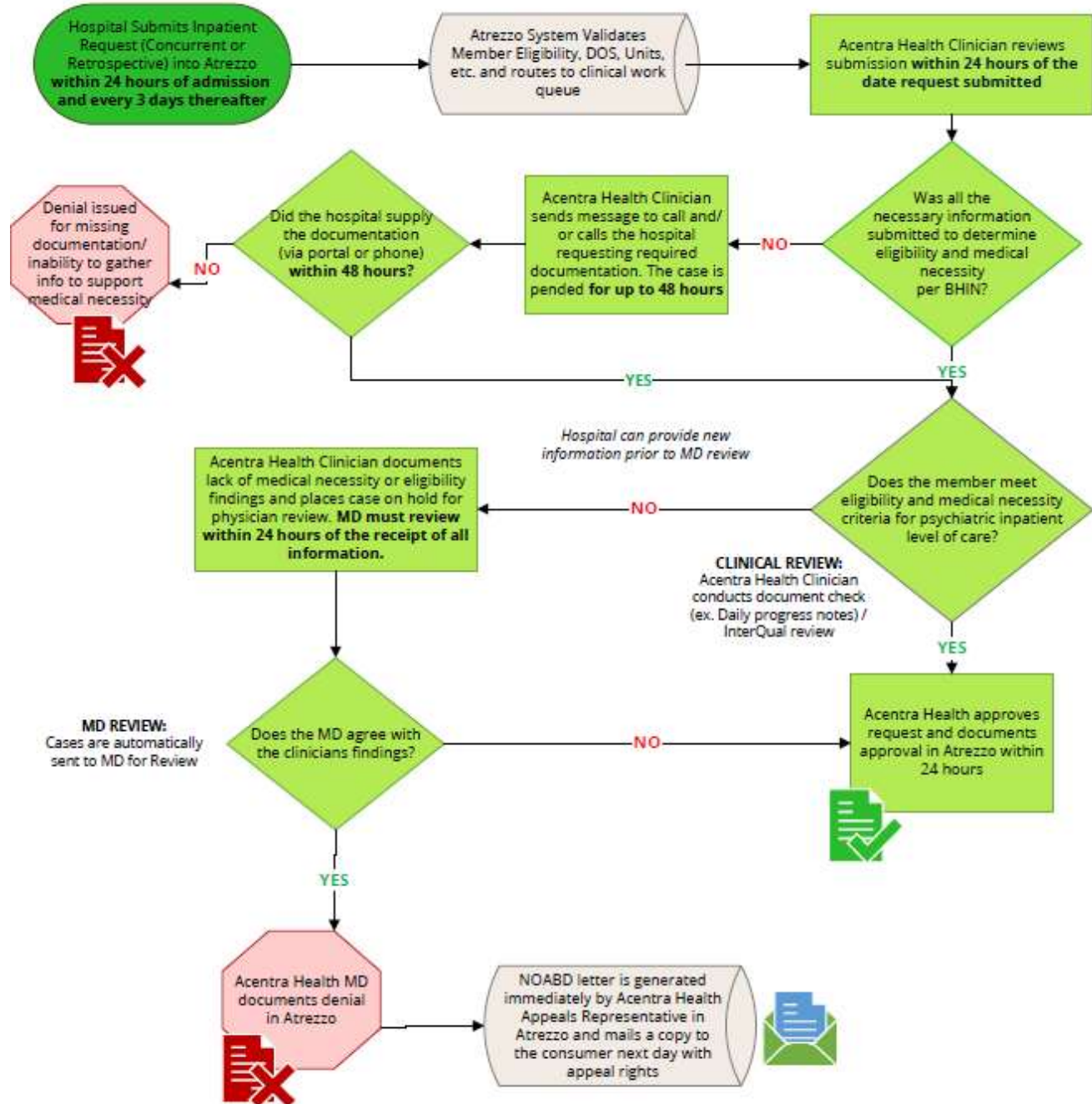
- **Submission Timeline:**

- 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

Plan of Care Requirements

When a Clinical Reviewer (CR) questions the medical necessity of a Length of Stay (LOS) request in Atrezzo, the case is referred for physician review. Simultaneously, a message is sent to the provider notifying them of the potential denial due to lack of medical necessity and informing them that the Mental Health Plan (MHP) is available to assist with discharge planning and the development of a Plan of Care.

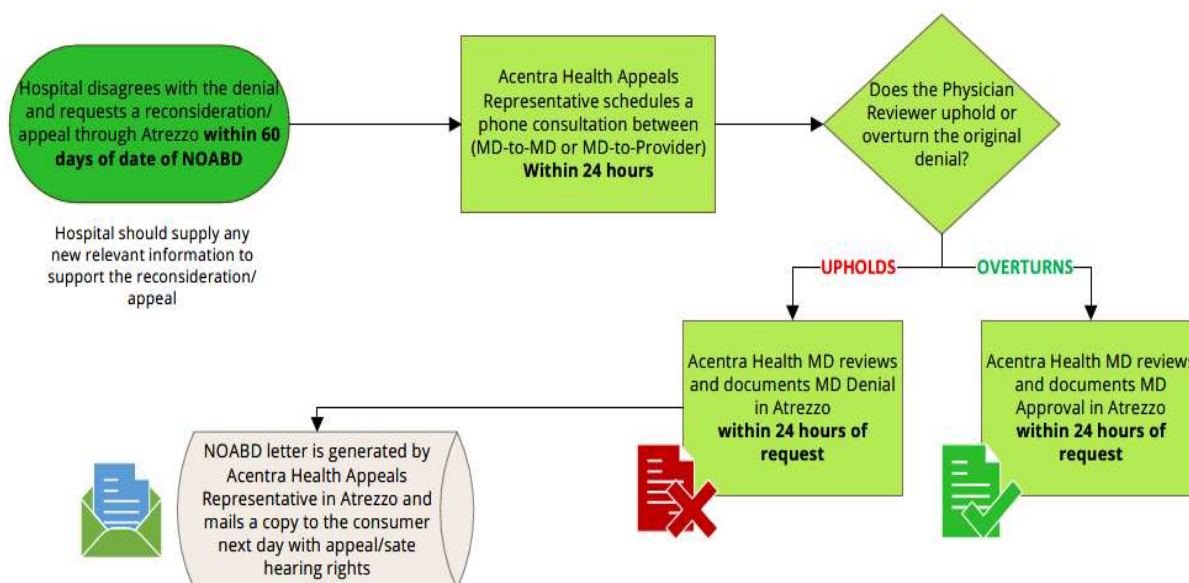
If the request is denied, a Notice of Adverse Benefit Determination (NOABD) is sent to the provider, along with a message in Atrezzo indicating that the denial was due to not meeting medical necessity criteria. A Plan of Care must then be submitted for MHP review. Providers may request a peer-to-peer review of the denial and/or appeal the decision.



All communications are documented in the Atrezzo case. It is the responsibility of the fiscally responsible county (MHP) to determine the appropriateness of the Plan of Care. Once uploaded, Acentra notifies the county point of contact that the Plan of Care is available for review. The county is responsible for communicating the outcome to both the provider and Acentra Health.

Clinical Reviewers do not approve or deny requests based on the inclusion of a Plan of Care.

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 are available for download directly through the Atrezzo system. These reports include a variety of parameters and options, allowing both **hospitals** and **counties** to run, view, and export data independently.
- 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 additional guidance on managing and accessing reports, please refer to provider reference guide "How to Manage Reports."
- In addition, users can set up a Report Subscription to have reports automatically generated and delivered to a specific group or list of individuals at a preferred date and time.

Available Reports:

- **CalMHSA Billing – Admin Report:** The Billing-Admin Report provides an overview of an individual beneficiary's treatment episode, encompassing the duration of stay (total days), the number of approved days in contrast to denied days, and whether the beneficiary qualifies as a short Doyle or foster youth. Additionally, it details the date on which the Treatment Authorization Request (TAR) was submitted, the associated TAR control number, and specifies whether the TAR was directed to the Fiscal Intermediary (FI) or the County.
- **CalMHSA Appeals Report:** The Appeals Report provides the status and details of appeal cases submitted to Acentra Health. This report provides information surrounding the specified case, appeal submission date, appeal results, completions date, and receipt date to facilitate tracking of the appeals process.
- **CalMHSA Hospital Census Report:** The Hospital Census Report presents an in-depth analysis of all types of requests, including those that are submitted, approved, pending, denied, and rejected. This report is inclusive of detailed TAR information as well as a summary



- **CalMHSA Length of Stay Report:** The Length of Stay Report provides an insight into patient stay durations within inpatient behavioral health facilities. This report is designed to assist providers and partner agencies in identifying patients who have reached a specific length of stay milestones (e.g., 14, 30, 45, and 60 days). By tracking these thresholds, users can ensure appropriate clinical and administrative actions are taken to support care coordination, compliance, and quality management.
- **CalMHSA NOABD Report:** The NOABD Report outlines the status of all denied cases accompanied by a Notice of Action and Benefit Determination (NOABD) letter. The reasons for denial may include, but are not limited to, the failure to submit the TAR within the required 14-day period, determination of medical necessity, or absence of requisite documentation.
- **CalMHSA Readmission Report:** The Readmission Report monitors the discharge of beneficiaries from a facility and records instances of readmission to either the same or a different hospital/facility within specified intervals of 30, 60, or 180 days.

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).
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 First Name	First name of the beneficiary receiving the service.

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Beneficiary Gender	Gender of the beneficiary as reported on their insurance or identification documents.
Beneficiary Last Name	Last name of the beneficiary receiving the service.
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.

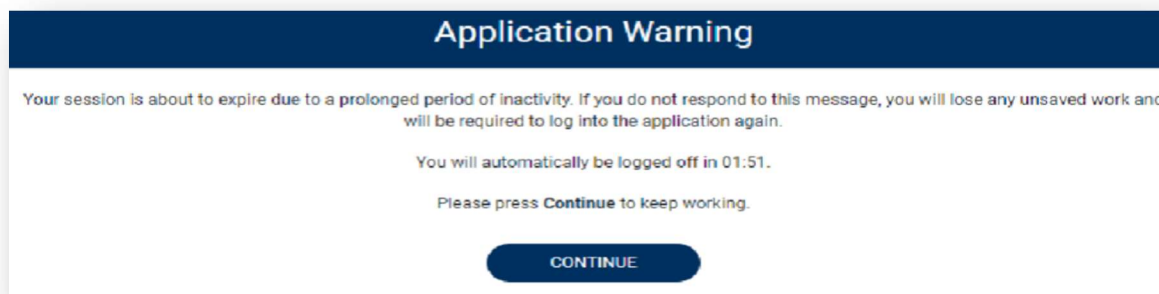
The purpose of this user guide is to provide an overview of the Provider Portal with Utilization Management functions. This user guide was designed to be easy-to-use for users familiar with a basic PC and internet environment.

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.

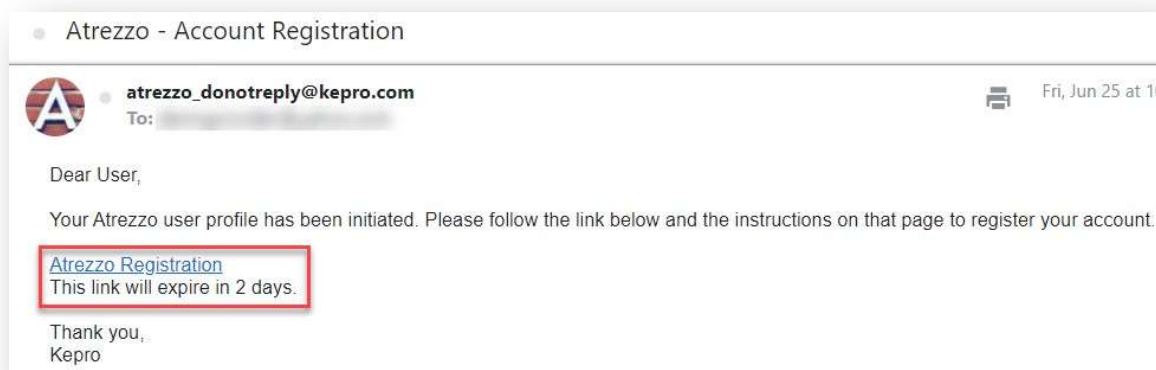




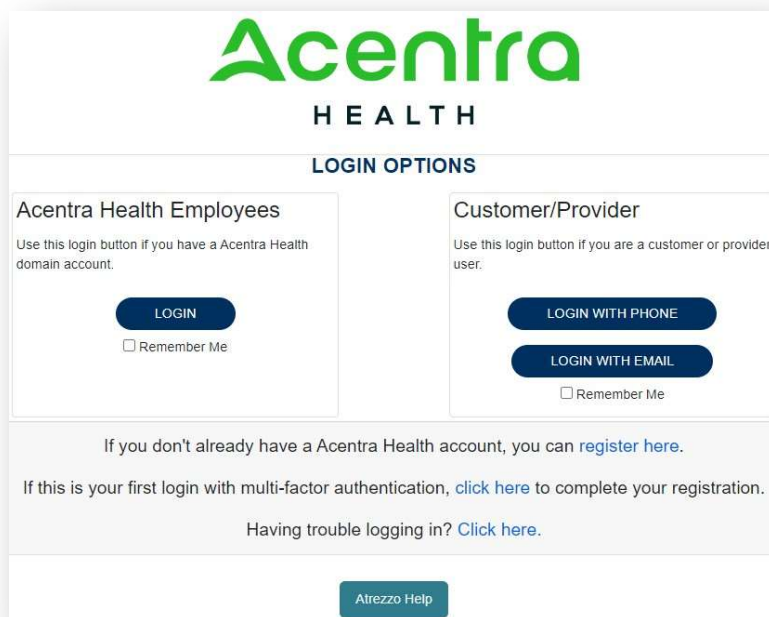
Getting Started

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.



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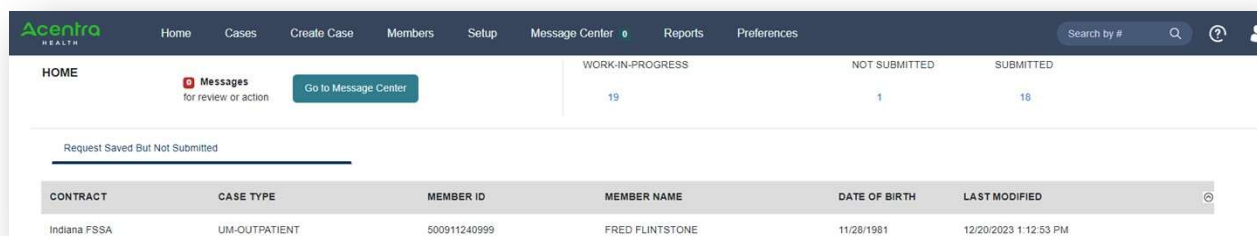


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System Navigation

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.

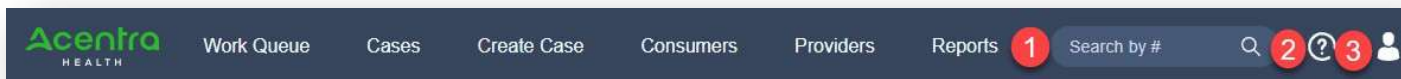


The legend below gives a brief overview of each area within Atrezzo. For a more detailed description, and for all available workflows, click the hyperlink.

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.

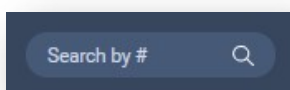
General System Features

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



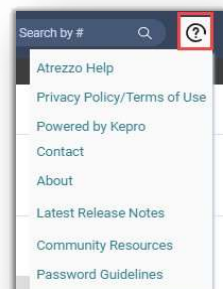
Button 1 - Search

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).



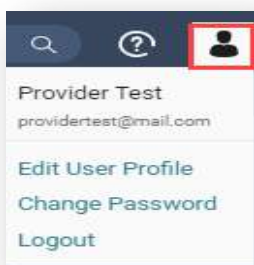
Button 2 - Help

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.



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Home Screen View

Once successfully logged in, you will be taken to the Atrrezzo 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.

HOME

0 Messages for review or action [Go to Message Center](#)

WORK-IN-PROCESS 19 NOT SUBMITTED 1 SUBMITTED 18

[Request Saved But Not Submitted](#)

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

Displaying records 1 to 1 of 1 records

Previous 1 Next Show 10 Entries

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

HOME

0 NEW MESSAGES [Go to Message Center](#)

WORK-IN-PROCESS 38 NOT SUBMITTED 10 SUBMITTED 28

[Request Saved But Not Submitted](#)

CONTRACT	CASE TYPE	CONSUMER ID	CONSUMER NAME	DATE OF BIRTH	LAST MODIFIED
CO UM	UM-OUTPATIENT	0933446	SARA ALOBAIDI	04/10/2006	10/1/2021 8:39:46 AM
CO UM	UM-OUTPATIENT	0933446	SARA ALOBAIDI	04/10/2006	10/1/2021 8:30:09 AM
CO UM	UM-OUTPATIENT	0933446	SARA ALOBAIDI	04/10/2006	9/30/2021 9:02:42 AM

Displaying records 1 to 3 of 3 records

Previous 1 Next Show 10 Entries

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.

HOME

0 NEW MESSAGES [Go to Message Center](#)

WORK-IN-PROCESS 38 NOT SUBMITTED 10 SUBMITTED 28

Displaying records 1 to 3 of 3 records

Previous 1 Next Show 10 Entries



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.

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Request	Member	Status	Submit Date	Category	Discharge Date	Service Type	Service Dates	Procedures	Letters	Actions
- Case Level Member ID / CaseID: / 223630004										
Request 01	TEMP001762021073000000 ANG Test 12/15/1960 West Virginia	Submitted	12/29/2022	Outpatient	N/A	Radiology	12/29/2022 - 12/29/2022	View Procedures	No letters available	Actions

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.

CASE / SEARCH - BY CONSUMER

CASES

BY CASE BY CONSUMER

CONSUMER ID LAST NAME DATE OF BIRTH SEARCH CONTEXT

MM/DD/YYYY

All Related Submitting Providers

*Combination of DOB and Last Name or Consumer ID is required

SEARCH

Search results will render below.

NAME	DATE OF BIRTH	ADDRESS	CONSUMER ID	CONTRACT	CASE COUNT
ANG Test	12/15/1960	1111 33rd Somewhere,JA	TEMP001982021011200000	Colorado	0

Displaying records 1 to 1 of 1 records

Previous 1 Next

Show 10 Entries

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

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CONSUMERS / Aimee Train

CONSUMER NAME	DATE OF BIRTH	ADDRESS	COUNTRY	MEMBER ID
Aimee Train	12/15/1960	123 Slopes Court	United States	TEMP001982021032400000

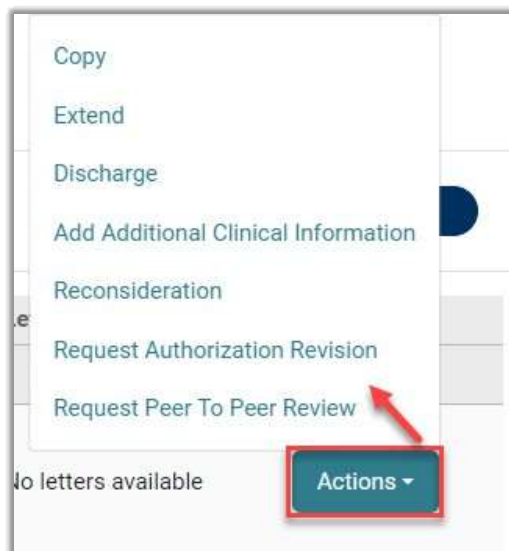
CREATE CASE >

UM CASE (10)

Submitted Requests Servicing Requests

Request	Status	Submit Date	Category	Discharge Date	Service Type	Service Dates	Procedures	Letters	Actions
- Case: 210830010									
Request 01	Submitted	3/24/2021	Outpatient	N/A	117b - Imaging Studies	3/25/2021 - 3/25/2021	Approved: 1 View Procedures	1 Letter View Letters	Actions
- Case: 210830015									
Request 01	Submitted	3/24/2021	Outpatient	N/A	113 - Speech Therapy	3/29/2021 - 5/27/2021	Denied: 1 View Procedures	No letters available	Actions

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.

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CONSUMERS / Aimee Train									
CONSUMER NAME	DATE OF BIRTH	ADDRESS	COUNTRY	MEMBER ID					
Aimee Train	12/15/1960	123 Slopes Court	United States	TEMP001982021032400000					
CREATE CASE									
UM CASE (10)									
Submitted Requests									
Servicing Requests									
Request	Status	Submit Date	Category	Discharge Date	Service Type	Service Dates	Procedures	Letters	Actions
- Case: 210830010									
Request 01	Submitted	3/24/2021	Outpatient	N/A	117b - Imaging Studies	3/25/2021 - 3/25/2021	Approved: 1 View Procedures	1 Letter View Letters	Actions

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.

CONSUMER NAME	GENDER	DATE OF BIRTH	MEMBER ID	CONTRACT
AIMEE TRAIN	F	12/15/1960 (62 Yrs)	TEMP001982021032400000	Colorado
ACTIVE REVIEW				
CASE ID	CATEGORY	CASE CONTRACT	CASE SUBMIT DATE	SRV AUTH
210830015	Outpatient	CO UM	03/24/2021	

Searching by Case

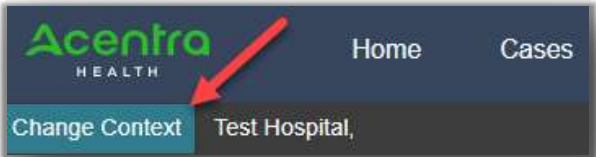
To search directly for a case, enter the Case ID in the search by # box on the top right of any page, then hit enter on your keyboard or click anywhere outside of the search box.

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.

CHANGE PROVIDER CONTEXT			
Name	NPI	Type	Address
Provider Demo	9999999999	0 - Provider	222 Main St Indianapolis IN 46077
NAME	NPI	TYPE	ADDRESS
Demo Facility	9999999999	0 - Acute Hospital	111 Main St Indianapolis IN 46077

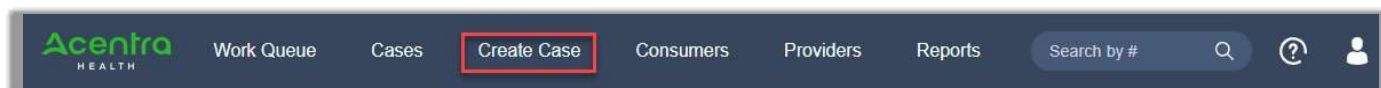
The selected provider will be displayed in the banner at the top left of the screen.





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.

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



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

New UM Case | **Denver Provider** | **CO UM**

Requesting Provider | Inpatient

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

Consumer Information/ Search Consumer/ Results

CONSUMER ID | LAST NAME | FIRST NAME (MIN 1ST LETTER) | DATE OF BIRTH

test | 12/15/1960

*Combination of DOB and Last Name or Member ID

Cancel | Search

Name	DOB	Address	Consumer ID	Contract
ANG Test	12/15/1960	1111 33rd Somewhere, JA	TEMP001982021011200000	Colorado

Showing 10 of 1

Not finding what you're looking for

Back | **Add temporary consumer**

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.

CONTRACT INFORMATION

CONTRACT * | PLAN *

Colorado | Colorado

CONSUMER DETAILS

PREFIX | FIRST NAME * | MIDDLE NAME | LAST NAME * | SUFFIX

Select One | | | test | Select One

GENDER *

☐ Male ☐ Female

DATE OF BIRTH * | LANGUAGE

12/15/1960 | Select One

CONTACT INFORMATION

☐ Use Facility Address

ADDRESS LINE 1 * | ADDRESS LINE 2 | CITY * | COUNTRY *

| | | ☐ Canada ☐ United States

STATE/PROVINCE * | COUNTY * | POSTAL CODE *

Select One | Select One |

PHONE NUMBER

OTHER INFORMATION

SSN (XXX-XX-XXXX) | SELF PAY | MEDICAID ID/SUBSCRIBER ID

| | |

PRIVATE INSURANCE | OTHER ID

| |

MEDICARE HICN | MEDICARE MBI

| |

Cancel | **Create Temporary Consumer**



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.

The screenshot shows the 'Submitted Requests' tab selected. The table lists two cases:

Request	Status	Submit Date	Category	Discharge Date	Service Type	Service Dates	Procedures	Letters	Actions
- Case: 210820018									
Request 01	Submitted	3/23/2021	Outpatient	N/A	117b - Imaging Studies	3/25/2021 - 3/25/2021	Denied: 1 View Procedures	No letters available	Actions
- Case: 210830017									
Request 01	Submitted	3/24/2021	Outpatient	N/A	216 - Reconstructive Surgery	4/1/2021 - 4/1/2021	Denied: 1 View Procedures	1 Letter View Letters	Actions

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

The screenshot shows the 'Servicing Requests' tab selected. The table lists two cases:

Request	Status	Submit Date	Category	Discharge Date	Service Type	Service Dates	Procedures	Letters	Actions
- Case: 211020028									
Request 01	Submitted	4/12/2021	Outpatient	N/A	113 - Speech Therapy	4/14/2021 - 4/22/2022	Approved: 3 View Procedures	1 Letter View Letters	Actions
- Case: 211020026									
Request 01	Submitted	4/12/2021	Outpatient	N/A	112 - Occupational Therapy	4/14/2021 - 4/28/2022	Denied: 3 View Procedures	3 Letters View Letters	Actions

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

This screenshot is similar to the previous one but highlights the 'Request 01' hyperlinks in the first column of the table rows, indicating where users can click to view details.

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

The screenshot shows the bottom of the interface with the 'Submitted Requests' tab selected. At the bottom right, there are two buttons: 'Cancel' and 'Create Case'. The 'Create Case' button is highlighted with a red box and a red arrow pointing to it.



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.

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	
Servicing	Denver Provider	9999999		9999999999	123 Temporary Road , Denver, CO US 99999		(999) 999-9999		Update Remove

[Add a Note](#)

[Go to Service Details](#)

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

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	
Servicing	Denver Provider	9999999		9999999999	123 Temporary Road , Denver, CO US 99999		(999) 999-9999		Update Remove

[Add a Note](#)

[Go to Service Details](#)

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

Add a note

Note Type *

☒ External

Note *

[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.

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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

Selected Providers

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	
Servicing	Denver Provider	9999999		9999999999	123 Temporary Road , Denver, CO US 99999		(999) 999-9999		Update Remove

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

View Notes (1) Cancel 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.

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 Select One

Service Type * Select One

View Notes (1) Cancel Go to Diagnoses

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.

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 * ICD10

Search Select a Diagnosis Code

Order Rank Please enter 3 or more characters

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

Showing 10 of 1

Add a Note Cancel 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.

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 * Prior Auth

FIPS Code

Notification Date * 01/20/2023

Notification Time * 01:10 PM

Add a Note Cancel Go to Procedures



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.

Psychiatric Inpatient Concurrent Review Manual



In Partnership with the
California Mental Health Services Authority (CalMHSA)

Version: January 2025

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 * CPT Search by code or description

LOS (Un-Submitted) N/A - N/A

LOS Length of Stay

Unit Qualifier Select One

Requested

Requested Start Date * 03/07/2023 Requested End Date * 03/10/2023

Requested Duration * 3

Rates

REQUESTED RATE \$

Add a Note

Jump to Submit Cancel Go to Questionnaires

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

Request 01 Un-Submitted 1/0

LOS (Un-Submitted) 07/18/2023 - 07/22/2023

LOS Length of Stay

Unit Qualifier Select One

Requested

Requested Start Date * 07/18/2023 Requested End Date * 07/22/2023

Requested Duration * 5

Rates

Requested Rate \$

Add a Note

Jump to Submit Cancel Go to Questionnaires

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

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	Kepro	01/19/2023 08:03:51 AM			0	Take

Showing 10 of 1

Add a Note

Jump to Submit Cancel Go to Attachments

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.

Case 203350007 | JOHN DOE (M) | WV Medical | WXMBR0000598487 | Create Questionnaire / ST

01/29/1965 (58 Yrs) | UM | Member ID

ST

Medical Necessity

Medical History

Medical Necessity

1. Are Physician's Order Attached

☐ Yes ☒ No

2. If member is under age 21, does member have an Individual Education Plan (IEP) that includes these services?

Select One

Questionnaire Disclaimers

☐

[RETURN TO CASE](#) [NEXT](#) [MARK AS COMPLETE](#)

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.

Case | ANG Test (F) | CO UM | TEMP001982021011200000 | Create Questionnaire / Wheelchair and CRT

12/15/1960 (62 Yrs) | UM | Member ID

Wheelchair and CRT

General

1. Are the Procedure Codes entered for review in this request related to a CRT repair?

☒ Yes ☐ No

[RETURN TO CASE](#) [MARK AS COMPLETE](#)

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

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

Questionnaires/ Take Questionnaires

Request	Questionnaire ID	Questionnaire Type	Questionnaire's Name	Created By
R01	3751520	Checklist	* Wheelchair and CRT	Kepto

Showing 10 of 1

[Add a Note](#)

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



Add a note

Note Type *

☒ External

Note *

Notes cannot be modified or deleted after being saved.

Cancel
Add Note

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

Step 3
Create Case

Step 4
Additional Providers

Step 5
Service Details

Step 6
Diagnoses

Step 7
Requests

Step 8
Questionnaires

Step 9
Attachments

Questionnaires/ Take Questionnaires

Request	Questionnaire ID	Questionnaire Type	Questionnaire's Name	Created By
R01	3751520	Checklist	* Wheelchair and CRT	Kepro

Showing 10 of 1

View Notes (1)

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.

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	3751520	Checklist	* Wheelchair and CRT	Kepro	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)
Jump to Submit
Cancel
Go to Attachments

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

Step 3
Create Case

Step 4
Additional Providers

Step 5
Service Details

Attachments/Documents

No documents have been added yet.

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.

Psychiatric Inpatient Concurrent Review Manual



In Partnership with the
California Mental Health Services Authority (CalMHSA)

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

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

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

Cancel **Submit**

Review the disclaimer and click Agree.

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**



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.

CONSUMER NAME	GENDER	DATE OF BIRTH	MEMBER ID
MEMBER TEST	F	09/14/1989 (33 Yrs)	TEMP001302022111400000
CASE ID	CATEGORY	CASE CONTRACT	CASE SUBMIT DATE SRV
SUBMITTED 230260017	Outpatient		01/26/2023
UM-OUTPATIENT			
CASE SUMMARY		ACTIONS - COPY EXTEND EXPAND ALL	
Consumer Details	Location: 123 Somewhere Street Anywhere Minnesota;		
Provider/Facility	Requesting : Provider Test/9999999994 Servicing : ROTECH /1346220969		
Clinical	Service Type : 032 - DME Request Type : Prior Auth Notification Date : 01/26/2023 Notification Time : 12:58 PM		
Questionnaires			
Attachments	Document-4 Letters- 0		
Communications	Most Recent Note date:		

Provider Portal Quick Reference Guides

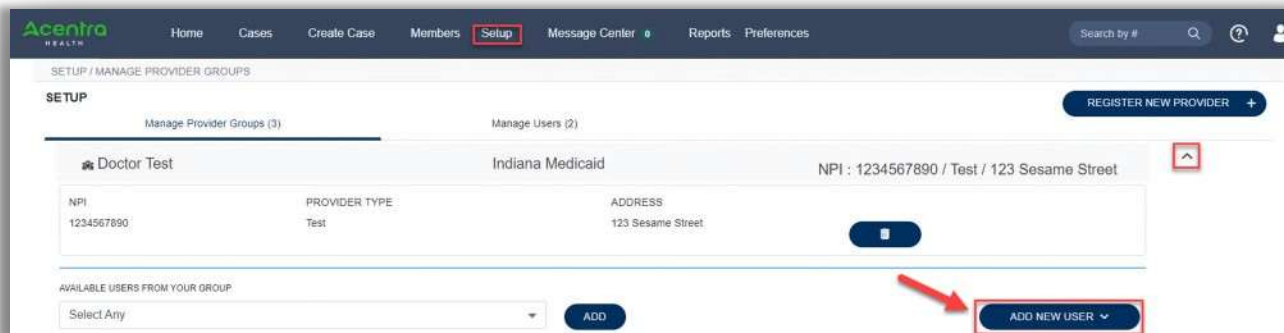
How to Add a User

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

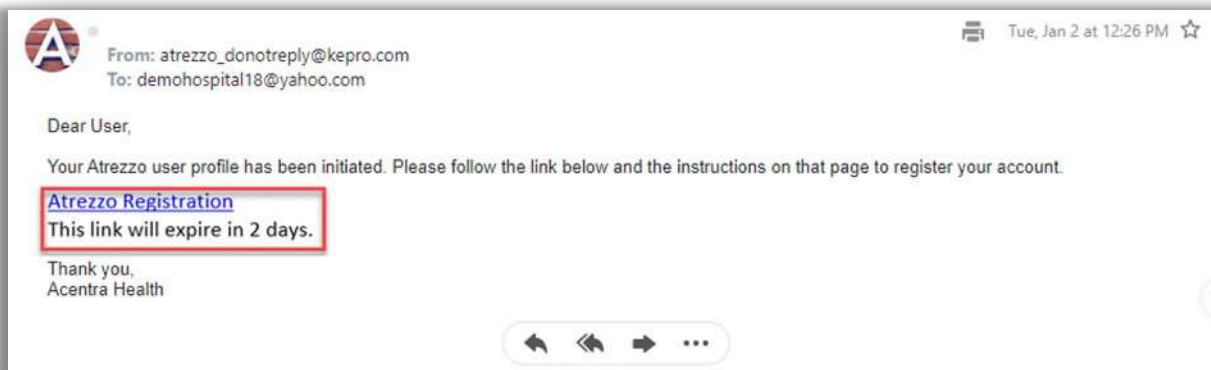
You will create a username and enter the user’s contact information. Then click **CREATE**. A message will display confirming the user was created successfully. User roles default to Provider Staff Account (which is the general user role).

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.



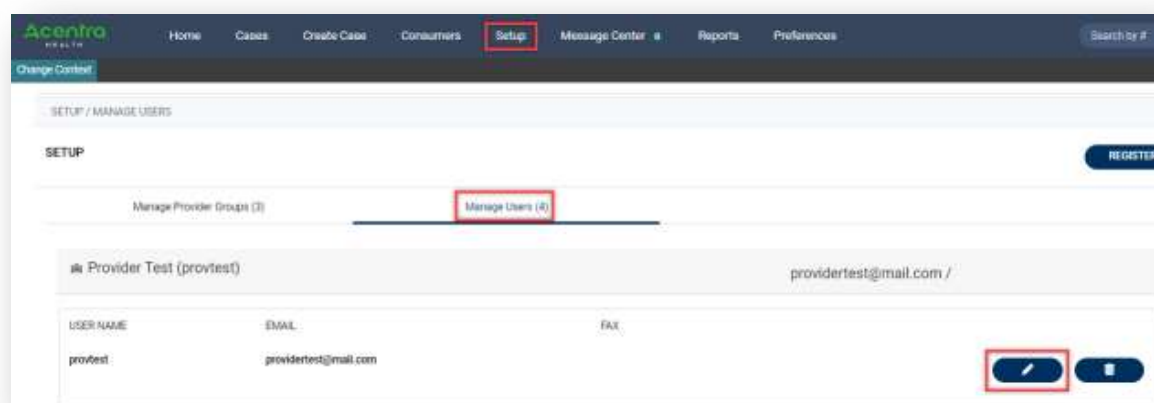


How to Reset User's MFA

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

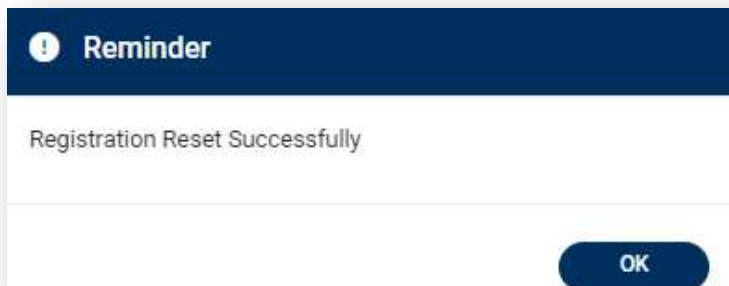
Click the Reset Registration button under the username.



The screenshot shows a web interface for managing users. At the top, there are tabs for 'Manage Provider Groups (3)' and 'Manage Users (4)'. Below the tabs, the user 'Provider Test (protest)' is selected, with an email address 'providertest@mail.com'. The breadcrumb trail is 'SETUP / MANAGE USERS / Provider Test'. The user's account information is displayed, including 'USERNAME' (protest) and 'AZURE USERNAME' (providertest@mail.com). There is a checkbox for 'ACTIVE USER' which is checked. At the bottom, a blue button labeled 'RESET REGISTRATION' is highlighted with a red rectangular box.

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



The screenshot shows the Acentra Health login interface. At the top is the Acentra Health logo. Below it, the text 'Sign in with your email address:' is displayed. There are two input fields: 'Email Address' and 'Password'. A red box highlights the 'Forgot your password?' link located below the password field. At the bottom is a blue 'Sign in' button.

Step 2 - Enter Email Address

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

The screenshot shows the Acentra Health email verification screen. It features the Acentra Health logo at the top. Below the logo is an 'Email Address' input field, which is highlighted with a red border. A red arrow points from this field to a blue 'Send verification code' button. Below this button is a light blue 'Continue' button.

Step 3 - Email Verification

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

The screenshot shows the Acentra Health verification code entry screen. It features the Acentra Health logo at the top. Below the logo, a message states: 'Verification code has been sent to your inbox. Please copy it to the input box below.' There is an input field containing the email 'demohospital18@yahoo.com'. Below this is a 'Verification Code' input field, highlighted with a red border. A red arrow points from this field to a blue 'Verify code' button. Next to it is a blue 'Send new code' button. At the bottom is a light blue 'Continue' button.

The screenshot shows the Acentra Health email verification confirmation screen. It features the Acentra Health logo at the top. Below the logo, a message states: 'E-mail address verified. You can now continue.' There is an input field containing the email 'demohospital18@yahoo.com'. Below this are two blue buttons: 'Change e-mail' and 'Continue'. A red arrow points from the 'Continue' button to the bottom of the screen.

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.



We have the following number on record for you. We can send a code via SMS or phone to authenticate you.

XXX-XXX-9885

Enter your verification code below, or send a new code

Acentra
HEALTH

New Password

Confirm New Password

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 Atrazzo 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.

CHANGE PROVIDER CONTEXT					
Name	NPI	Type	Contract	Address	
Test Hospital	987654321	0 - Demo	Indiana Medicaid	321 Nowhere St Somewhere IN 11111	
NAME	NPI	TYPE	CONTRACT	ADDRESS	
Doctor Test	1234567890	0 - Test	Indiana Medicaid	123 Sesame Street Anywhere IN 11111	➔
OAKLAWN PSYCHIATRIC CENTER INC	1598847212	11 - Behavioral Health Provider	Indiana Medicaid	2601 OAKLAND AVE ELKHART IN 466172311	➔
SILVER CREEK OCCUPATIONAL THERAPY	1437861184	G - Group	Indiana Medicaid	11525 HIGHWAY 31 SELLERSBURG IN 471729618	➔

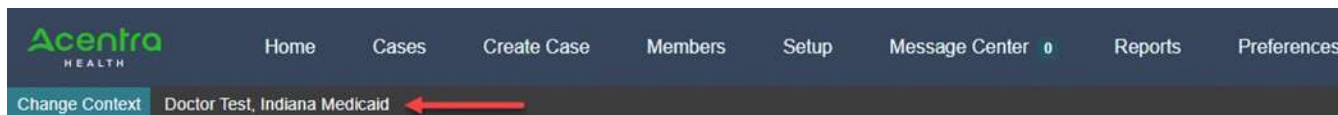
Displaying records 1 to 3 of 3 records

Previous 1 Next Show 10 Entries



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.

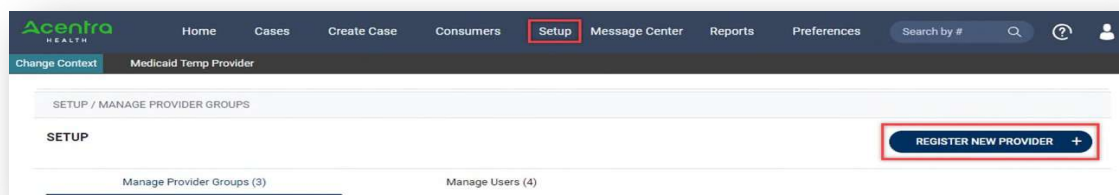


How to Add Additional Providers

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.

Acentra
HEALTH

Register a New Provider

PROVIDER NPI: *

PROVIDER REGISTRATION CODE: *

FIND PROVIDER

SELECT >

Step 3 – Select Correct Provider

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

Acentra
HEALTH

Register a New Provider

PROVIDER NPI: *

9999999949

PROVIDER REGISTRATION CODE: *

d59e20c6-2670-49a4-8c6a-0e255a41dcca

☒ West Virginia - Morgantown BH Demo Provider -- 456 Somewhere Street null - Anywhere WV

FIND PROVIDER

SELECT >

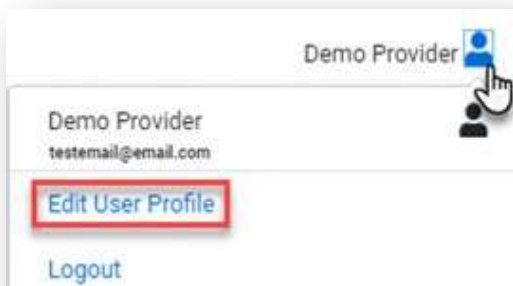
How to Update User Profile

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

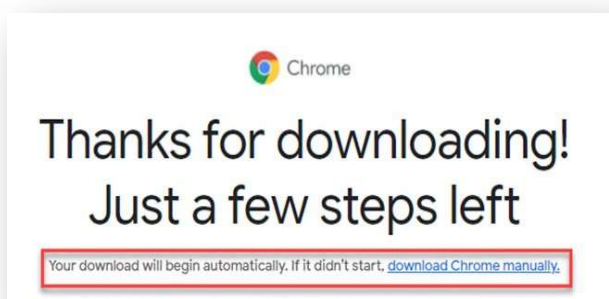
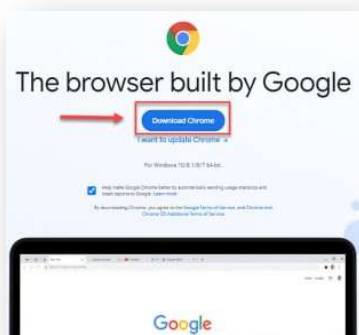
Once the profile screen displays, update the information and include all required fields, then click SAVE.

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.

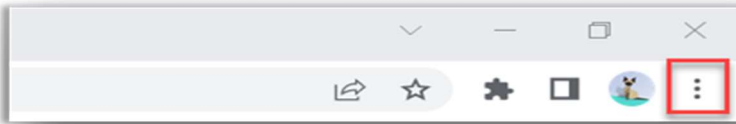


How to Clear Browser History in Chrome

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

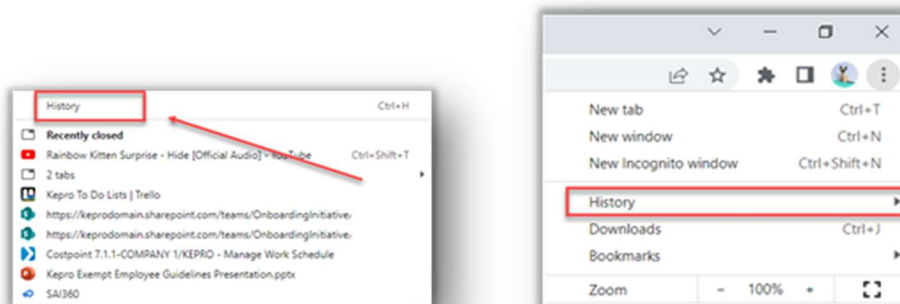
Step 1 - Click the ellipsis on your browser

The ellipsis will be in the top right corner



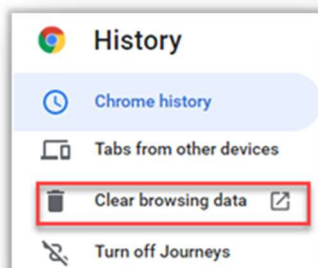
Step 2 - Select History

From the drop-down menu, select history.



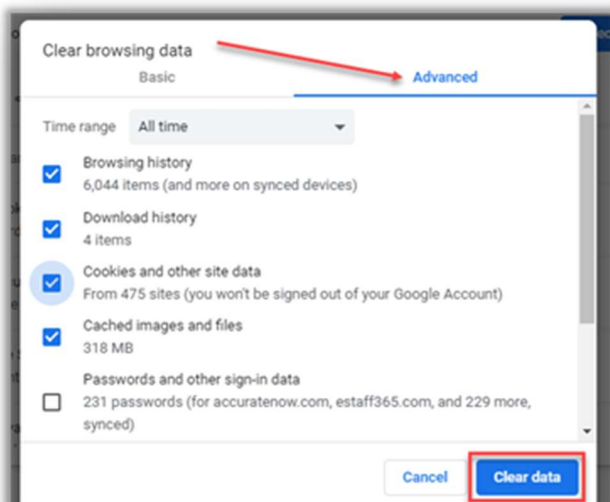
Step 3 - Click Clear Browsing Data

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

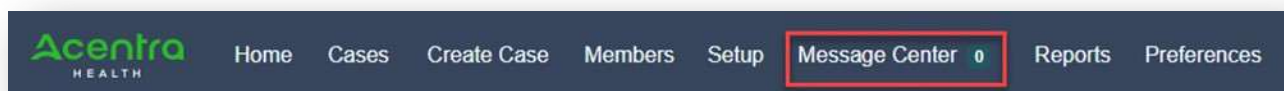


How to View Messages in Message Center

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.



CASE ID	REQUEST	FROM	SUBJECT	TO	SENT ON	
230860012	R01	Kepto	Demo Message	A Provider	3/27/2023 4:12:33 PM	

Message: Enter Note Here

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.

CASE ID	REQUEST	FROM	SUBJECT	TO	SENT ON	
230860012	R01	Kepto	Demo Message	A Provider	3/27/2023 4:12:33 PM	

Message: Enter Note Here

[GO TO CASE >](#)

Reply

SUBJECT *

RE: Demo Message

MESSAGE *

please do not send additional clinical information through these messages. Additional clinical information should be added to the clinical information section of the request.

[CANCEL](#) [SEND >](#)

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.

[Home](#)
[Cases](#)
[Create Case](#)
[Members](#)
[Setup](#)
[Message Center 0](#)
[Reports](#)
[Preferences](#)



Step 2 - Action Button

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

CONSUMER NAME	GENDER	DATE OF BIRTH	MEMBER ID/PLAN	CONTRACT
DANI TEST	F	01/15/1977 (45 Yrs)	TEMP001762021021000001	West Virginia

	CASE ID	CATEGORY	CASE CONTRACT	CASE SUBMIT DATE	SRV AUTH
SUBMITTED	222350001	Outpatient	WV Medical	08/23/2022	

UM-OUTPATIENT

CASE SUMMARY ACTIONS COPY EXTEND

Step 3 - Selecting Add Additional Clinical Information

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

ACTIONS COPY EXTEND

- Add Additional Clinical Information
- Reconsideration
- Request Authorization Revision
- Request Peer To Peer Review

Address: 123 Somewhere Street Anywhere West Virginia

Submission Date: 08/23/2022
Submission Time: 07:20 AM

Comments: 1, Incomplete: 0

Add Additional Clinical Information

REQUEST *

Select One

CANCEL NEXT

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.

Add Additional Clinical Information

Case 222350001 Dani Test (F) WV Medical
Request 01 01/15/1977 Outpatient

Note

Allowed File Types: doc, docx, jpg, jpeg, mdi, pdf, png, ppt, pptx, xls, xlsx, zip.

Document Type

Select One

Drag and Drop or Browse your files.

CANCEL SUBMIT

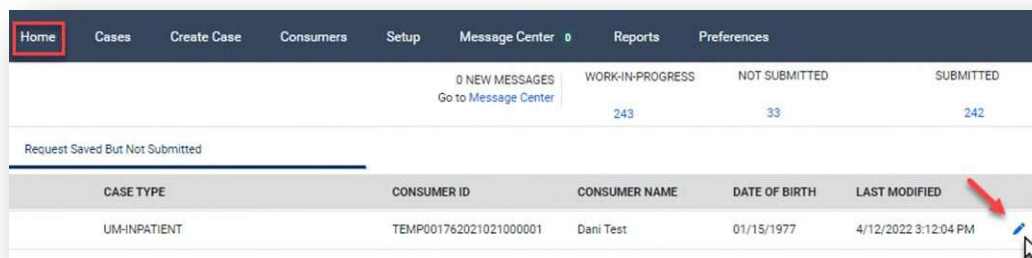


How to Complete a Saved Request

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.



0 NEW MESSAGES Go to Message Center					WORK-IN-PROGRESS 243	NOT SUBMITTED 33	SUBMITTED 242
Request Saved But Not Submitted							
CASE TYPE	CONSUMER ID	CONSUMER NAME	DATE OF BIRTH	LAST MODIFIED			
UM-INPATIENT	TEMP001762021021000001	Dani Test	01/15/1977	4/12/2022 3:12:04 PM			

Step 2 - Add Required Information

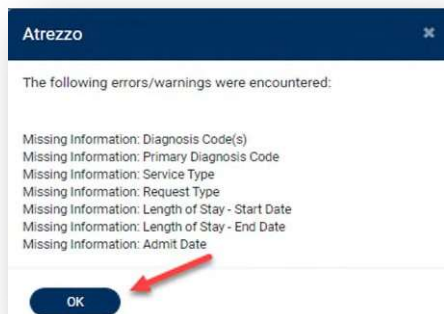
On the case creation page, expand Clinical and review Service Details, Diagnosis, and procedure sections to identify information necessary for submission.



Clinical		
Service Details		
Diagnosis		
Procedures		

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.

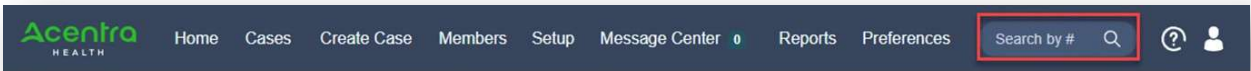


How to View Action Buttons within a Case

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.



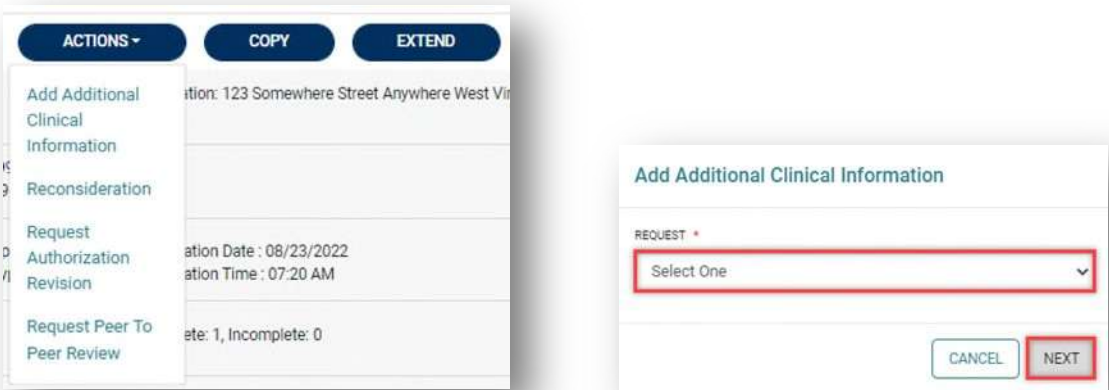
Step 2 - Action Button

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.

CONSUMER NAME	GENDER	DATE OF BIRTH	MEMBER ID/PLAN	CONTRACT
DANI TEST	F	01/15/1977 (45 Yrs)	TEMP001762021021000001	West Virginia

CASE ID	CATEGORY	CASE CONTRACT	CASE SUBMIT DATE	SRV AUTH
SUBMITTED 222350001	Outpatient	WV Medical	08/23/2022	

UM-OUTPATIENT

CASE SUMMARY
ACTIONS
COPY
EXTEND

Step 3 – Selecting Reconsideration or Appeal



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

The screenshot shows the 'ACTIONS' dropdown menu with options: Add Additional Clinical Information, Reconsideration, Request Authorization Revision, Request Peer To Peer Review, and Request Peer Review. The 'Reconsideration' option is highlighted. Below the menu, the 'Reconsideration' form is visible, featuring a 'REQUEST' dropdown menu with 'Select One' as the current selection. The form also includes 'CANCEL' and 'NEXT' buttons.

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.

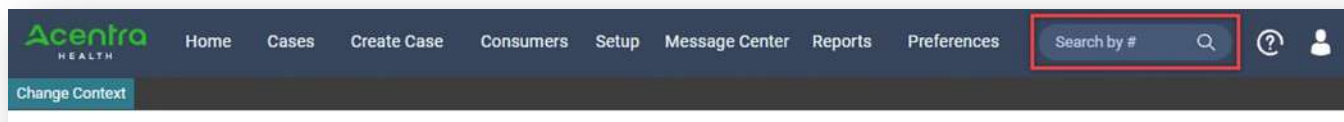
The screenshot shows the 'Reconsideration' form with a 'Note' field and a 'Document Type' dropdown menu. The 'Document Type' dropdown is set to 'Select One'. The form also includes 'CANCEL' and 'SUBMIT' buttons.

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.



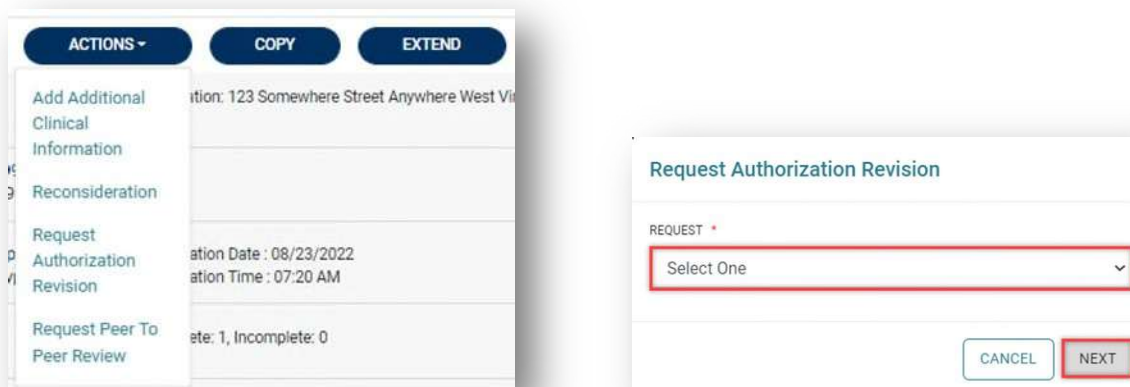
Step 2 - Open Submitted Request

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.



The form is titled "Request Authorization Revision". It contains the following fields and elements:

- Case 22250001, Request 01, Date Test (F) 01/15/1977, WV Medical Outpatient
- Note: A large text area for notes.
- Allowed File Types: doc, docx, jpg, jpeg, mdi, pdf, png, tif, tiff, xls, xlsx, xps.
- Document Type: A dropdown menu with "Select One" selected.
- Drag and Drop: A box with the text "Drag and Drop or Click to Upload your files."
- Buttons: "CANCEL" and "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.

The screenshot shows the Acentra Health search bar. The search bar is located at the top right of the page. It contains the text "221020007" and a magnifying glass icon. The search bar is highlighted with a red box.

Step 2 - Open Case Summary

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

The screenshot shows the Case Summary header. It contains the following information:

- Case 240160006
- Joe Test (M)
- DMAS
- TEMP000052023071800004
-
- SVC Auth #
- Submitted
- ...

Step 3 - Search for Letter

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

Documents				
Request	File Name	Document Type	Received On	Modified On
R01	TEST RX.docx	Rx Order	12/14/2021 3:40:26 PM	12/14/2021 3:40:26 PM
R01	TEST CMN.docx	CMN	12/14/2021 3:40:11 PM	12/14/2021 3:40:11 PM
Letters				
Request	File Name	Fax Status Mailed Date/Time	Date Created Created By	Modified On
R01	CCN_MemberNoticeApproval 2 (348004547).pdf	Not Fax	12/17/2021 4:42:59 PM dbetzary	12/17/2021 4:42:59 PM

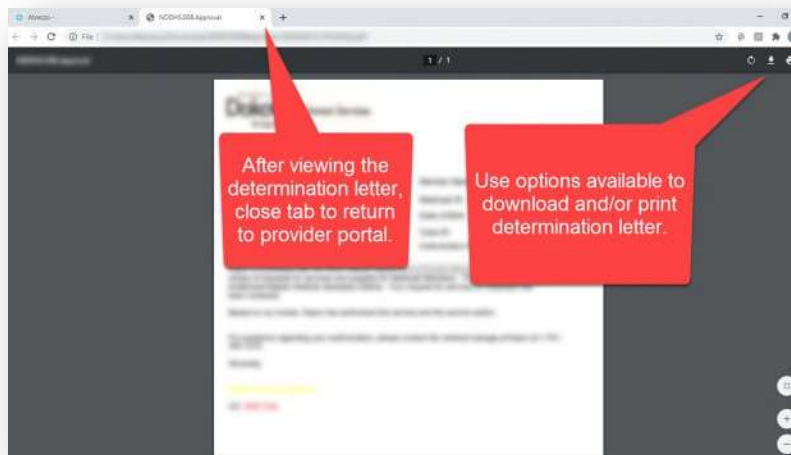
Step 4 - View Letter

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.

Documents				
Request	File Name	Document Type	Received On	Modified On
R01	Test File.pdf	Rx Order	12/17/2021 4:51:16 PM	12/17/2021 4:51:16 PM
R01	Test File.pdf	CMN	12/17/2021 4:51:05 PM	12/17/2021 4:51:05 PM
Letters				
Request	File Name	Fax Status Mailed Date/Time	Date Created Created By	Modified On
Test File.pdf				

Step 5 - Sample Letter

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



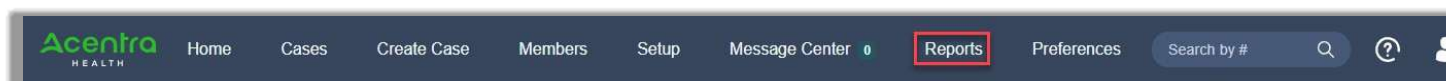


How to Run a Report

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

REPORTS			
CONTRACT NAME	REPORT NAME	REPORT CATEGORY	REPORT DESCRIPTION
Administrative	Fax Activity	Administrative	Fax Activity
Administrative	ReviewerProductivity Clinical Review History	Operational Productivity	ReviewerProductivity Clinical Review History

Displaying records 1 to 2 of 2 records

Previous 1 Next
Show 10 Entries

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.

1=Weekly; 2=Monthly; 3=Quarterly; 4=Yearly; 5 Daily

Start Date: [] End Date: []

Status: [] Time period: [Select a Value]

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.



1=Weekly; 2=Monthly; 3=Quarterly; 4=Yearly; 5 Daily 1

Start Date: 2/27/2023 End Date: 3/5/2023 11:59:59 PM

Status: Approved

Page Width

Requests submitted or certified between 02/27/2023 and 03/05/2023
or appeals completed between 02/27/2023 and 03/05/2023
NPI: 9999999999

Total records: 1

KEPRO Case ID	Submit Date	Member First Name	Member Last Name	Member ID	Request Type	Procedure Code	Procedure Name	Service Start Date	Reason	Modifier	Date of Determination
230600003	3/1/2023	ANG	Test	TEMP00198202 1011200000	Prior Auth	97110	THERAPEUTIC EXERCISES	3/1/2023	Approved - Meets Criteria	96	3/1/2023

Word
Excel
PowerPoint
PDF
TIFF file
MHTML (web archive)
CSV (comma delimited)
XML file with report data
Data Feed

CO HCPF Provider Report

Step 5 – Print the Report

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

1=Weekly; 2=Monthly; 3=Quarterly; 4=Yearly; 5 Daily 1

Start Date: 2/27/2023 End Date: 3/5/2023 11:59:59 PM

Status: Approved

Page Width

Requests submitted or certified between 02/27/2023 and 03/05/2023
or appeals completed between 02/27/2023 and 03/05/2023
NPI: 9999999999

Total records: 1

KEPRO Case ID	Submit Date	Member First Name	Member Last Name	Member ID	Request Type	Service Type	Procedure Code	Procedure Name	Reason	Modifier	Date of Determination
230600003	3/1/2023	ANG	Test	TEMP00198202 1011200000	Prior Auth	Physical Therapy	97110	THERAPEUTIC EXERCISES	Approved - Meets Criteria	96	3/1/2023

CO HCPF Provider Report

Select appropriate options and click Print to print the report.

Print

We'll create a printer-friendly PDF version of your report.

Page size:

Letter (8.5" x 11")

Page orientation:

Portrait

Print Cancel



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!

