A Guide to a Successful Prior Authorization

Acentra Provider Relations

2024 IHCP Roadshow

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What Acentra Does

- Utilization Management (UM) contractor for traditional Medicaid/Fee-For-Service (FFS). Acentra performs UM reviews for medical services, behavioral health services, and pharmacy services covered under the medical benefit
- Utilization management (UM) team:
  - Review and evaluate each authorization request for medical necessity and appropriateness utilizing both state and nationally recognized criteria
  - Review for prior authorization (PA), concurrent, and retrospective services

Why PA is necessary

To determine:

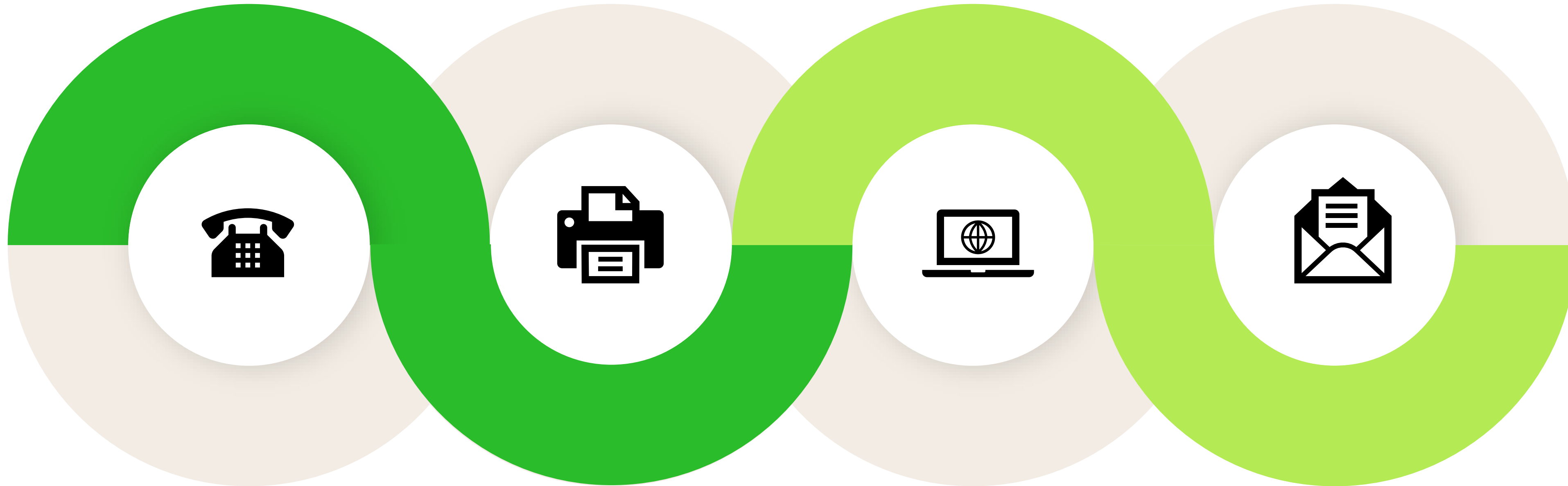
- Medical necessity for services or continued services when normal limits are exhausted
- To make sure services are covered under the member's plan

To ensure Indiana Medicaid funding is utilized for appropriate services:

- Medically necessary, appropriate, cost effective

Note: PA is not a guarantee of payment

How to contact the Acentra Team



Customer Service Phone	Customer Service Fax	Atrezzo Portal	Provider Assistance Email
866-725-9991	**800-261-2774**	https://portal.kepro.com/	INPriorAuthIssues@Acentra.com

Important Factors for Atrezzo Submissions

Servicing Provider

Be sure to use a billing or group National Provider Identifier (NPI) in the servicing provider section. The system will give the user a warning and block the submission if a rendering NPI is used.

Extensions

For an extension on a currently authorized date of service (DOS) span, users should not enter a new case into the system. This would cause issues due to being a duplicate of the same authorization and can cause claims issues.

Fee Schedules

Users should use the Fee schedules to determine if codes require a PA. If they do not, an error message saying “One or More Procedure Codes Not Appropriate For Service Type” will pop up.

Documentation

When submitting a case, ensure that all required documentation has been uploaded. Documents should be appropriately labeled to allow the clinician review the case as expeditiously as possible

Important Tips for Fax Submissions

- **Do not submit the same request via multiple submission avenues, this slows the process and creates duplication of cases.**
- **Include all required forms and necessary clinical documentation.**
- **Ensure that faxed requests contain legible, clean copies of all documents necessary to establish medical necessity.**
- **Ensure all required forms are filled out correctly, including the appropriate NPI, Codes, dates of service, and Member information.**

Important Information to Know After Submission

Locating the Case in Atrezzo

How to search

When attempting to locate cases, ensure the user is trying to view the case under the correct provider context.

Cases can be searched using the search box with the case number, by pulling up the member, or by filtering the provider cases list.

Messaging

When is messaging appropriate

Sending messages on a completed case will not alert the clinical reviewers that something needs to be reviewed. Do not enter clinical into a message.

Discharge

When to enter a discharge

A discharge should be entered on a PA when a member is discharged or is no longer receiving care from a provider. This is for any specialty. Hospice providers need only upload the Hospice Discharge Form as the clinicians must complete that.

Process for Requesting Additional Units

Using the Actions drop down

View Procedures

Copy

Extend

Add Additional Clinical Information

Reconsideration

Request Authorization Revision

Request Peer To Peer Review

Denied: 1

Appeal: 1

View Procedures

Approved: 1

View Procedures

No letters available

Actions

Using the extend button within the case

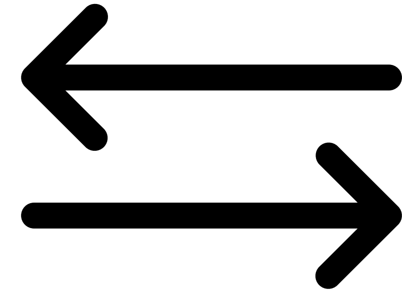
ACTIONS

COPY

EXTEND

EXPAND ALL

Process for Requesting Additional Units, Cont.



Update the start date on the extension

Delete codes that do not require additional units

Request to move unused units from original request line

Acentra HEALTH

Home | Cases | Create Case | Members | Setup | Message Center 0 | Reports | More ↓ | Search by #

Change Context | Doctor Test, Indiana Medicaid

HOME

0 **Messages**
for review or action

Go to Message Center

WORK-IN-PROGRESS	NOT SUBMITTED	SUBMITTED
11	0	11

Request Saved But Not Submitted

CONTRACT	CASE TYPE	MEMBER ID	MEMBER NAME	DATE OF BIRTH	LAST MODIFIED	

No records found.

“Authorization Revision” Action

- When to use “Authorization Revision” Action:
  - Requests to only move units from one code to another

- If no additional units are needed but the end date needs to be extended, this would also be an Authorization Revision Request.

Once Submitted for Review

1. Turn around times: 5 business days for Standard, 48 hours for Expedited and 30 days for Retrospective.
2. All documentation and criteria/requirements are reviewed.
3. The clinician determines if they can approve request or refers the case for a Medical Director's review and decision is entered.
4. The extract file is sent to Gainwell and an authorization number is generated.
5. If submitted via portal, an email notice of case status change is sent to the user who made the submission.
6. The provider can view/download the authorization letter within case (under Attachments-Letters). Letters are also mailed.

Assuming a PA From Another Provider

How to assume a PA

- Call Customer Service or Fax a request
- Provide all relevant information including but not limited to:
  - ✓ Member information
  - ✓ Originating provider information
  - ✓ Authorization if available
  - ✓ Procedures on the PA request
  - ✓ Date PA will be assumed

Hospice providers are required to submit a completed Hospice Provider Request Between Indiana Hospice Providers Form and a new case will be created.

Requesting PA Administrative Review (Reconsideration)

If the provider disagrees with an adverse determination, a request can be made in writing within 7 business days plus 3 calendar days of receipt of notification of modification or denial (date on decision letter)

- Provider must include the following information with the request:
  - Documentation of medical necessity
    - Pertinent to case, supports medical necessity
    - No need to duplicate documents already provided

- If submitted via portal:
  - Enter pertinent reasons for medical necessity in note box
  - Attach other supporting documents (no form letter)

- Once review is processed, provider and member notified of outcome by letter

Ways to Submit an Administrative Review

- Atrezzo Provider Portal, under the Actions tab
  - ✓ Select Reconsideration
  - ✓ Enter a note and add documents
- Fax to 800-261-2774
- Mail to:

  Acentra

  6802 Paragon Place, STE 440

  Richmond, VA 23230

Note: Submitting via other avenues can delay the process.

Common Denials/Case Void Reasons

- **Medical Necessity Denial**

  The criteria set forth are not met by the provided documentation.

- **Duplicate Void**

  The submitted request duplicates an existing authorization for the same services and timeframe.

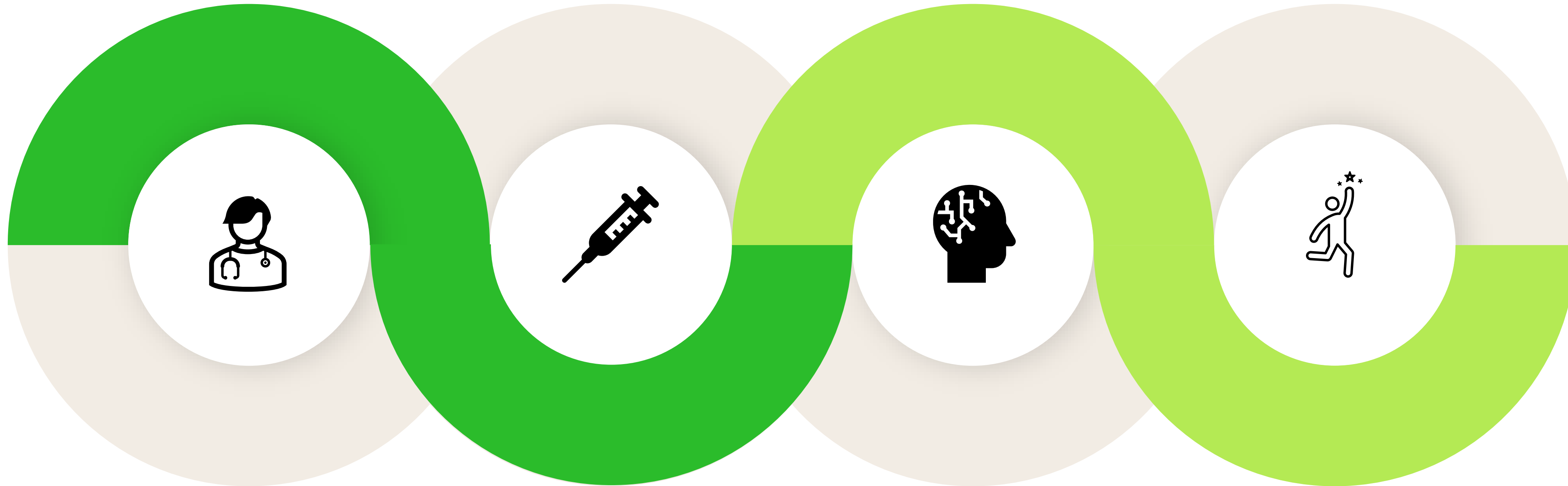
- **Untimely Denial**

  The request is not received from the provider in a timely manner.

- **Missing Information Denial**

  The missing documentation is not received within 30 days.

Links



Education

Indiana Medicaid FFS provider education

Atrezzo Portal

Provider Portal

Questions?

Acentra
HEALTH

Accelerating
Better Outcomes

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