Authorization

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How to contact Acentra Health

Contact Acentra Health by Atrezzo provider portal, fax, phone or U.S. Postal Service as follows:

Acentra Health website:	mhcp.kepro.com.	Contact Acentra Health for access to the Atrezzo provider portal.
Mail:	Acentra Health Attention MN Medicaid 6802 Paragon Place, Suite 440 Richmond, VA 23230	

For authorization requests:		**For EMA Care Plan Certification requests**	
Phone:	866-433-3658	**Phone:**	844-810-1472
Fax:	866-889-6512	**Fax:**	844-472-3779

How to use Acentra's Atrezzo provider portal

Enrolled providers may access the secure web-based Atrezzo provider portal from the Acentra website at mhcp.kepro.com. Use the Atrezzo provider portal to upload the following documents:

- Completed and signed authorization forms and supporting documentation to Acentra
- EMA Care Plan Certification (CPC) requests and supporting documentation to Acentra
- The MN–ITS response page and supporting documentation to Acentra (if you submitted the initial request using the MN–ITS (278) Authorization Request).

Note: When you use the Atrezzo provider portal to submit the initial authorization request, you do not have to submit using MN–ITS.

How to submit authorization requests to the medical review agent

Depending on the type of services, submit authorization requests to the medical review agent using one of the options listed in the following table:

Type of request	How to submit
Medical	1. **Atrezzo provider portal (preferred)**: Enter the authorization request into the Atrezzo provider portal, and then electronically upload the required clinical support documentation.
	2. **278 transaction in MN–ITS**: Write the 11-digit number assigned by the response page on each page of your documentation and then fax or mail

	3. the required clinical support documentation.
	4. **U.S. Postal Service**: Mail the appropriate DHS authorization form with all required clinical support documentation.
Dental	1. **Atrezzo provider portal (preferred)**: Enter the authorization request into the Atrezzo provider portal, and then electronically upload the required clinical support documentation including current digital X-rays. For non-digital X-rays, mail a current copy of the X-rays with the Atrezzo case number listed to ensure accurate processing.
	2. **278 transaction in MN–ITS**: Write the 11-digit number assigned by the response page on each page of your documentation and on the X-rays and then fax required clinical support documentation and mail a current copy of X-rays.
	3. **U.S. Postal Service**: Mail the appropriate ADA Dental Claim form along with all required clinical support **documentation** and a current copy of the X-rays.
Medical supply	1. **Atrezzo provider portal (preferred)**: Enter the authorization request into the Atrezzo provider portal, and then electronically upload the required clinical support documentation.
	2. **278 transaction in MN–ITS**: Use the 278 transaction in MN–ITS. Write the 11-digit number assigned by the response page on each page of your documentation and then fax or mail the required clinical support documentation.
	3. **U.S. Postal Service**: Mail the appropriate DHS authorization form along with all required clinical support documentation.
Inpatient hospital	1. **Atrezzo provider portal (preferred)**: Enter the authorization request into the Atrezzo provider portal, and then electronically upload the required clinical support documentation.
	2. **Phone**: Initiate the request by phone, then fax or mail the required clinical support documentation.
	3. **U.S. Postal Service**: Mail the appropriate DHS authorization form along with all required clinical support documentation.
Early Intensive Developmental and Behavioral Intervention (EIDBI) services	**Atrezzo provider portal (required)**: Enter the authorization request into the Atrezzo provider portal. The required information is in the EIDBI service authorization request section of the Individual Treatment Plan (ITP) form. Electronically upload the completed Comprehensive Multi-Disciplinary Evaluation (DHS-7108) (PDF) and Individual Treatment Plan (DHS-7109) (PDF)
Emergency Medical Assistance (EMA) Care Plan Certification (CPC) request	1. **Atrezzo provider portal (preferred)**: Enter the EMA CPC request into the Atrezzo provider portal, then electronically upload the required clinical supporting documentation.
	2. **Fax**: Fax the EMA CPC request and clinical supporting documentation using the EMA dedicated fax line, 844-472-3779
	3. **U.S. Postal Service**: Mail the EMA CPC request and clinical supporting documentation.
Home Care (except PCA and home care for persons on a waiver)	1. **Atrezzo provider portal (preferred)**: Enter the authorization request into the Atrezzo provider portal, and then electronically upload the required clinical support documentation.
	2. **278 transaction in MN–ITS**: Use the 278 transaction in MN–ITS. Write the 11-digit number assigned by the response page on each page of your documentation and then fax or mail the required clinical support documentation.

Substance Use Disorder (SUD) services for Nonresidential (outpatient) group and individual treatment	1. **Atrezzo provider portal (preferred)**: Enter the authorization request into the Atrezzo provider portal, and then electronically upload the required clinical support documentation.
	2. **278 transaction in MN–ITS**: Use the 278 transaction in MN–ITS. Write the 11-digit number assigned by the response page on each page of your documentation and then fax or mail the required clinical support documentation
	3. **U.S. Postal Service**: Mail the appropriate DHS authorization form along with all required clinical support documentation.

Early Intensive Developmental and Behavioral Intervention (EIDBI) Authorization Requests

Kepro is the authorization review agent for all EIDBI authorization requests for the following services:

- EIDBI intervention (individual, group, or higher intensity)
- EIDBI observation and direction
- Family or caregiver training and counseling (individual or group)
- Individual treatment plan (ITP) progress monitoring
- Travel time

Use the secure web-based Atrezzo provider portal from the Acentra Health website at **mhcp.kepro.com** to submit the completed Comprehensive-Multi-Disciplinary Evaluation (CMDE) Medical Necessity Summary Information (DHS-7108) (PDF) and Individual Treatment Plan (ITP) and Progress Monitoring (DHS-7109) (PDF). You will need to use your MN–ITS username and password to log in to access these forms. Training is available on the Acentra website about how to complete an authorization request and upload documents using the Atrezzo provider portal. For additional information, refer to Service Authorization in the EIDBI section of the MHCP Provider Manual.

The medical review agent will take initial action (approve, deny, or pend for additional information) on a CMDE within five business days of receipt, and on an ITP within 10 business days of receipt. If additional information is required, the medical review agent will place the case in pending status for at least 15 business days. If the medical review agent pends a case, the medical review agent will take final action within three business days after the medical review agent has received all requested information, or 15 business days after pending the case, if the medical review agent receives no response.

Emergency Medical Assistance (EMA) Care Plan Certification (CPC) Requests

Acentra Health is the medical review agent for all EMA CPC requests.

Use the secure web-based Atrezzo provider portal from the Acentra website (**mhcp.kepro.com**) to upload and submit the EMA CPC request and required clinical supporting documentation. Training is available on the Acentra website about how to upload documents using the Atrezzo provider portal.

Fax CPC requests and documentation to the dedicated EMA fax number if you do not have access through the secure web-based Atrezzo provider portal.

The medical review agent will take initial action (approve, deny, or pend for additional information) on a CPC request within 20 business days. The medical review agent will take initial action on an expedited review for a member awaiting discharge from an inpatient hospital or nursing facility within two business days. If additional information is required, the medical review agent will place the case in pending status for at least 20 business days. If the medical review agent pends a case, the medical review agent will take final action within two business days after the medical review agent receives all

requested information, or 20 business days after pending the case, if the medical review agent receives no response.

EMA Kidney Transplants

EMA provides coverage for kidney transplants to eligible members who are currently receiving dialysis through an approved EMA CPC. The following are also required:

- A prior authorization is required for the kidney transplant evaluation
- An inpatient hospital authorization is required for the kidney transplant

Detailed information on these requirements is available in the EMA Kidney Transplant Services section of this manual.

Home Care Authorization Requests

Kepro is the authorization review agent for all temporary and long-term authorization requests for the following home care services:

- Skilled nursing visits
- Home health aide services
- Home care nursing services

Use the secure web-based Atrezzo provider portal from the Acentra website (**mhcp.kepro.com**) to upload documentation and submit requests. Training is available on the Acentra website about how to upload documents using the portal.

Submit requests using the MN–ITS DDE Authorization Request (278) transaction **only** if unable to use the Atrezzo provider portal. Use the Authorization Requests (278) – Home Care MN–ITS User Guide for instructions.

Fax or mail documentation if you do not have access through the secure web-based portal.

Submit all documentation for long-term home care authorizations directly to the medical review agent. Do not send requests to DHS. MHCP will not process or forward any documentation requests. MHCP will continue to process PCA requests and technical change requests for home care services.

The medical review agent will take initial action (approve, deny, or pend for additional information) on a prospective authorization request within 10 business days. The medical review agent will take initial action on a Home Care Temporary Start request within two business days. If additional information is required, the medical review agent will place the case in pending status for at least 20 business days. If the medical review agent pends a case, the medical review agent will take final action within three business days after the medical review agent receives all requested information, or 15 business days after pending the case, if the medical review agent receives no response.

Out-of-State Services

Except for emergency services, providers rendering health care services to MHCP members outside Minnesota or its local trade area must obtain authorization before providing MHCP-covered services. Out-of-state providers who do not see the member but provide health care service (such as lab or medical supply) do not need to obtain authorization unless the services would otherwise require authorization.

MHCP will cover services provided to a Minnesota member at a location outside of Minnesota or its local trade area by an out-of-state provider under the following circumstances:

- The provider enrolls in MHCP and follows all program guidelines

- The services are medically necessary
- The services meet one of the following criteria:
- The services are provided in response to an emergency while the member is out of Minnesota or its local trade area
- The services are not available in Minnesota or its local trade area, and the attending physician has determined medical necessity and obtained prior authorization from the medical review agent. The county is responsible for travel expenses associated with obtaining the out-of-state services
- The services are required because the member's health would be endangered if the member were required to return to Minnesota for treatment

Substance Use Disorder Request for Nonresidential (outpatient) Group and Individual Treatment

Review the information under the Authorization heading, SUD authorization request for Nonresidential (outpatient) group and individual treatment for more than six hours a day or 30 hours per week, in the Substance Use Disorder Services section of the MHCP Provider Manual for more details.

Use the secure web-based Atrezzo provider portal from the Acentra website to upload and submit the supporting documentation. Training about how to upload documents using the Atrezzo provider portal is available on the Acentra Training webpage in the substance use disorder section.

The Notice of Action will be communicated in the provider portal and your MN–ITS Mailbox Miscellaneous Received file type: PAL after your Authorization Request is approved or denied. Refer to the MN–ITS Mailbox user guide for step-by-step instructions.

Services Related to Investigational Drugs

MHCP does not cover costs incidental to, associated with, or resulting from the use of investigational drugs, biological products, or devices as defined in the Minnesota Right to Try Act. Authorization is not available for these services.

Authorization of Services for Continuity of Care

MHCP will approve authorization requests without medical review for medical, dental, or medical supply services which have been approved by an MCO when:

- The provider is an MHCP-enrolled provider who is eligible to provide the service,
- The authorization was approved while the member was enrolled in the MCO,
- The member is covered by fee-for-service MHCP on the date of service, and
- MHCP covers the service.

Submit an authorization request to the medical review agent as described in the How to submit authorization requests to the Medical Review Agent table, and upload, fax, or mail the MCO approval, with a statement requesting administrative approval for continuity of care.

MN–ITS Authorization Requests

To submit authorization requests using MN–ITS, follow these steps:

- Complete and submit the Authorizations (278) transaction. After you submit your authorization request, you will receive an Authorization Response (278) with a unique number.
- Print the response.
- Write the unique number assigned from the Authorization Response on each document you will submit as supporting documentation, including any other authorization forms you may need to submit.

- Fax the supporting documentation (and additional authorization forms, as appropriate) to the medical review agent.

The medical review agent will take initial action (approve, deny, or pend for additional information) on a prospective prior authorization request within 10 business days. The medical review agent will take initial action on a retrospective or retroactive authorization request within 20 business days. If additional information is required, the medical review agent will place the case in pending status for at least 15 business days. If the medical review agent has pended a case, the medical review agent will take final action within three business days from when the medical review agent has received all requested information, or 15 business days after pending the case, if the medical review agent receives no response.

The MHCP Resource Center cannot determine status of pending authorizations.

General Authorization Criteria

MHCP requires authorization as a condition of MHCP payment if a health service, including a drug, meets one of the following:

- The health service could be considered, under some circumstances, to be of questionable medical necessity
- Use of the health service requires monitoring to control the expenditure of MHCP funds
- A less costly, appropriate alternative health service is available
- The health service is investigative or experimental
- The health service is newly developed or modified
- The health service is of a continuing nature and requires monitoring to prevent its continuation when it ceases to be beneficial
- The health service is comparable to a service provided in a skilled nursing facility or hospital but is provided in a member's home
- The health service could be considered cosmetic

Documentation Requirements

Authorization review agents use the following criteria processing authorization requests. Submit documentation demonstrating the requested service is:

- Medically necessary, as determined by prevailing medical community standards or customary practice and usage
- Appropriate and effective for the member's medical needs
- Timely, considering the nature and present medical condition of the member
- Provided by a provider with appropriate credentials
- The least expensive, appropriate alternative available
- An effective and appropriate use of MHCP funds

Documentation must be timely, showing the member’s medical condition on the proposed date of service. For most authorizations, documentation that is more than 4 – 6 months old will not be timely.

Some services and procedures require additional documentation. Refer to the appropriate provider type section(s) for more information about specific documentation requirements, or contact the medical review agent or drug review agent, as appropriate.

If a modifier is required for a particular procedure code, include the appropriate modifier in the authorization request.

Information on the authorization request, including the procedure code(s) and the modifier(s), must match the information on the claim you submit for the service(s), or MHCP will deny the claim.

Bill services with approved authorization on a separate claim from services not authorized.

Authorization Requests and Medicare or Third-Party Liability (TPL) Coverage

Except for home care and EIDBI authorization requests, MHCP will not consider a request for authorization of a service or item for a member with Medicare or TPL unless the provider has made a good faith effort to receive authorization or payment from the primary payer(s).

For services or items, document and submit to the review agent the good faith effort with any of the following:

- An explanation of benefits (EOB) showing determination of payment by the primary payer(s)
- A determination of authorization or denial of authorization by the primary payer(s)
- Written communication from the primary payer(s) showing that the service is not covered for the member
- Documentation by the provider of a phone call to the primary payer(s) and the statements made by the primary payer about coverage of the service or item for the member.
- Documentation by the provider that, because of recent claim experiences with Medicare, coverage is not available for the service or item

If a MN–ITS Authorization Response shows TPL include a printout of the Authorization Response with submitted documentation.

Except for home care services, authorization is not required if a third party payer has made payment that is equal to or greater than 60 percent of the MHCP maximum allowed amount for the service or item. Submit the claim to MHCP and attach the EOB from the other payer(s) to the claim. See also Medicare and Other Insurance.

Medical Necessity Review

If there is concern about TPL ending before treatment is complete, submit an authorization request and include documentation of a good faith effort as outlined in the previous section, and a statement indicating that the request is for medical necessity review in case of loss of insurance.

If the medical necessity review is:

- Approved: the provider should bill MHCP as a secondary payer with TPL as the primary payer until the TPL ends, then providers should bill MHCP as the primary payer.
- Denied: Providers may obtain a signed Advance Recipient Notice of Noncovered Service/Item (DHS-3640) (PDF) and receive payment from the member for the service or cost sharing. If the member chooses not to sign the Advance Recipient Notice, the provider may decline to provide the service, and must not bill the member or MHCP for any service cost, including cost sharing as secondary payer.

Retroactive Medical Necessity Review

If the service has begun without an MHCP medical necessity determination and TPL coverage ends, MHCP will pay for the remainder of the service only if the applicable authorization criteria would have been met when the service began. Request a retroactive authorization review.

If the retroactive authorization review is:

- Approved: the provider may bill MHCP as the primary payer after the last TPL payment is made.

- Denied: The provider must not bill the member or MHCP for any service cost, including cost sharing.

MHCP Authorization Forms

The review agent accepts the following paper forms for authorization requests (some forms are in addition to the MHCP Authorization Form; refer to the instructions on the forms):

- ADA dental claim form for dental authorization requests
- ARMHS and Day Treatment Authorization Form (DHS-4159A) (PDF)
- Augmentative Communication Devices and Accessories Authorization Form (DHS-4535) (PDF)
- Authorization Form (DHS-4695) (PDF)
- Bath/Shower/Toileting Equipment Authorization Form (DHS-6008) (PDF)
- CTSS Authorization Form (DHS-4159) (PDF)
- Chiropractic Authorization Form (DHS-4878) (PDF)
- Dental Implants Authorization Form (DHS-3538) (PDF)
- Dialectical Behavior Therapy (DBT) – Additional – Authorization Form (DHS-6322A) (PDF)
- Dialectical Behavior Therapy (DBT) – Initial – Authorization Form (DHS-6322) (PDF)
- Enteral/Nutritional Authorization Form (DHS-3971) (PDF)
- Enclosed Medical Beds Authorization Form (DHS-4370) (PDF)
- MHCP Inpatient Hospital Authorization Form (DHS-4676) (PDF)
- Mobility Devices Authorization Form (DHS-4315) (PDF)
- Prosthetics and Orthotics Authorization Form (DHS-4437) (PDF)
- Specialized Wound Therapy Authorization Form (DHS-4045) (PDF)
- Standers and Accessories Authorization Form (DHS-4075) (PDF)
- TMD Treatment Authorization Form (DHS-6119) (PDF)
- Vision Therapy Authorization Form (DHS-4879) (PDF)

Notice of Action Taken

The review agent or MHCP will send written notification to the provider and member of action taken on an authorization request. The review agent will notify the provider if they need additional information to decide medical necessity. If the review agent denies a request, the member will receive a notice of member's right to appeal.

Requests for Reconsideration

If the review agent denies a request for authorization, the provider may submit a request for reconsideration. When requesting reconsideration, include the following:

- Additional documentation or an explanation why an exception should be made
- The original denial notice – it is not necessary to submit a new authorization request

If the review agent denies a request for reconsideration, the provider may submit a request for a Level Two reconsideration by requesting a Peer-to-Peer reconsideration or a Peer Review Panel in writing within 30 calendar days of a denied Request for Reconsideration.

Submit the reconsideration request(s) via the medical review agent’s provider portal, fax, or mail.

Fair Hearings

If the review agent or MHCP deny or reduce an authorization, the member may appeal (refer to Your Appeal Rights [DHS-1941] [PDF]) the decision within 30 days, or within 90 days with good cause, and receive a hearing before a referee from DHS. To request a hearing, the member must contact the county agency or the Appeals Unit at DHS.

Providers do not have the right to appeal a denied authorization request under the MHCP fair hearing process. Providers may submit additional documentation and ask the medical review agent for a reconsideration of a decision.

Legal References

Minnesota Statutes, 151.375 (Right to Try Act)
Minnesota Statutes, 254B.05, subdivision 5(h) (Authorization for Substance Use Disorder nonresidential (outpatient) individual or group services therapy that exceeds 6 hours per day or 30 hours per week)
Minnesota Statutes, 256B.02 (Definitions)
Minnesota Statutes, 256B.04 (Duties of State Agency)
Minnesota Statutes, 256B.0625 (Covered Services)
Minnesota Statutes, 256B.0625, subdivision 25b (Authorization with third-party liability)
Minnesota Statutes, 256B.0625, subdivision 64 (Investigational drugs, biological products, devices, and clinical trials)
Minnesota Rules, 9505.0175 (Definitions)
Minnesota Rules, 9505.0215 (Covered Services; Out-of-State Providers)
Minnesota Rules, 9505.0501 to 9505.0545 (House Admissions Certification; establish admission certification standards and procedures)
Minnesota Rules, 9505.5000 to 9505.5105 (Conditions for Medical Assistance and General Assistance Medical Care Payment; establish authorization procedures)