FREQUENTLY ASKED QUESTIONS

1) **If a client is admitted to a medical facility with a combination of medical and psych diagnoses would that be considered a medical admission?**
   a) The client's admission will be based on the reason for admission and treatment needed.
2) **Should the provider add an attending physician for a Private Duty Nurse request to indicate the MD that signed the plan of care as a servicing provider?**
   a) They can add the physician's name, but it is not necessary. Acentra Health will not contact the physician for any information, we will only contact the provider.
3) **Does the Peer-to-Peer process require MD to MD consultation and if so, how would be provide their contact information?**
   a) Yes, a Peer to Peer is a consultation between physicians that can be requested after receiving an adverse determination. When submitting a request, the provider must include the MD's name, contact telephone number, and at least three different dates/times of availability.
4) **How would a provider search for a code type?**
   a) CPT drop down box will provide you with the applicable code type.
5) **Where would a provider find the "Action" button?**
   a) During case submission, the provider should see the "Action" button.
6) **Does this questionnaire "time out" if a provider gets interrupted during this process?**
   a) Yes, ATREZZO will time out, but will save your progress if the case creation process has begun.
7) **How can a provider attach documentation in ATREZZO or an extension?**
   a) Providers will need to select case -> actions -> extend -> add documentation and attach the document to the note section.
8) **Will acute care facilities be able to search for authorizations submitted by the provider on this website?**
   a) Yes, if they are the servicing facility. They must be linked to the case to view the request, to ensure our system is HIPPA compliant. The requesting provider and the servicing provider can see the case in ATREZZO.

9) **Is there a size limit for uploading supporting documentation?**
   a) The live site can hold large uploads, however, if you see this is an issue the size can be customized to the provider's needs. The provider would need to contact us at Acentra Health Customer Services: vaproviderissues@kepro.com or call Customer Services 888-827-2884 or 804-287-2884.
10) **Do providers have to enter the diagnostic codes when submitting for the same individual?** a) Yes, the diagnostic code will have to be submitted.
11) **Can providers check the case status of submissions in the ATREZZO portal?**
   a) Yes, the case status can be checked by the provider who made the submission, the servicing facility/provider, and the administrator on the account.
12) **Will a provider be able to submit "Retro Requests".**
   a) Yes, a provider will be able to submit a Retro Request in ATREZZO. When the provider chooses the request type as retrospective from the dropdown.
13) **What is the difference between quantity and duration?**
   a) Quantity refers to units and duration is length of stay or how long the service authorization will be valid.
14) **When choosing the diagnosis codes, how would a provider change a code to become the primary code if you have more than one?**
   a) The first code entered will be the primary code. Once all the codes have been added, the providers can drag the diagnosis into the appropriate order.
15) **Is there a way to print/download the service authorization submission?**
   a) Yes, providers will select a case summary, to get printer friendly view, which will appear as a tiny icon in upper right corner, and print.
16) **How does a provider initiate a reconsideration of an initial determination?** a) A provider must exhaust Acentra Health's internal reconsideration process for all services prior to submitting toDMAS Appeals. If a provider wants to have Acentra Health reconsider the initial determination, they must submit a reconsideration through the Atrezzo Next Generation (ANG) portal: https://portal.kepro.com within 30 calendar days from the date of the initial determination letter. Providers must submit in ANG via the dropdown option to choose a 'reconsideration' task and/or attach or document within the note section with the additional information that is needed to show that the member meets criteria for the care that was denied or reduced. Please ensure you include any additional information or documentation that evidences that the member meets the criteria for the requested level of care.