Acentra HEALTH

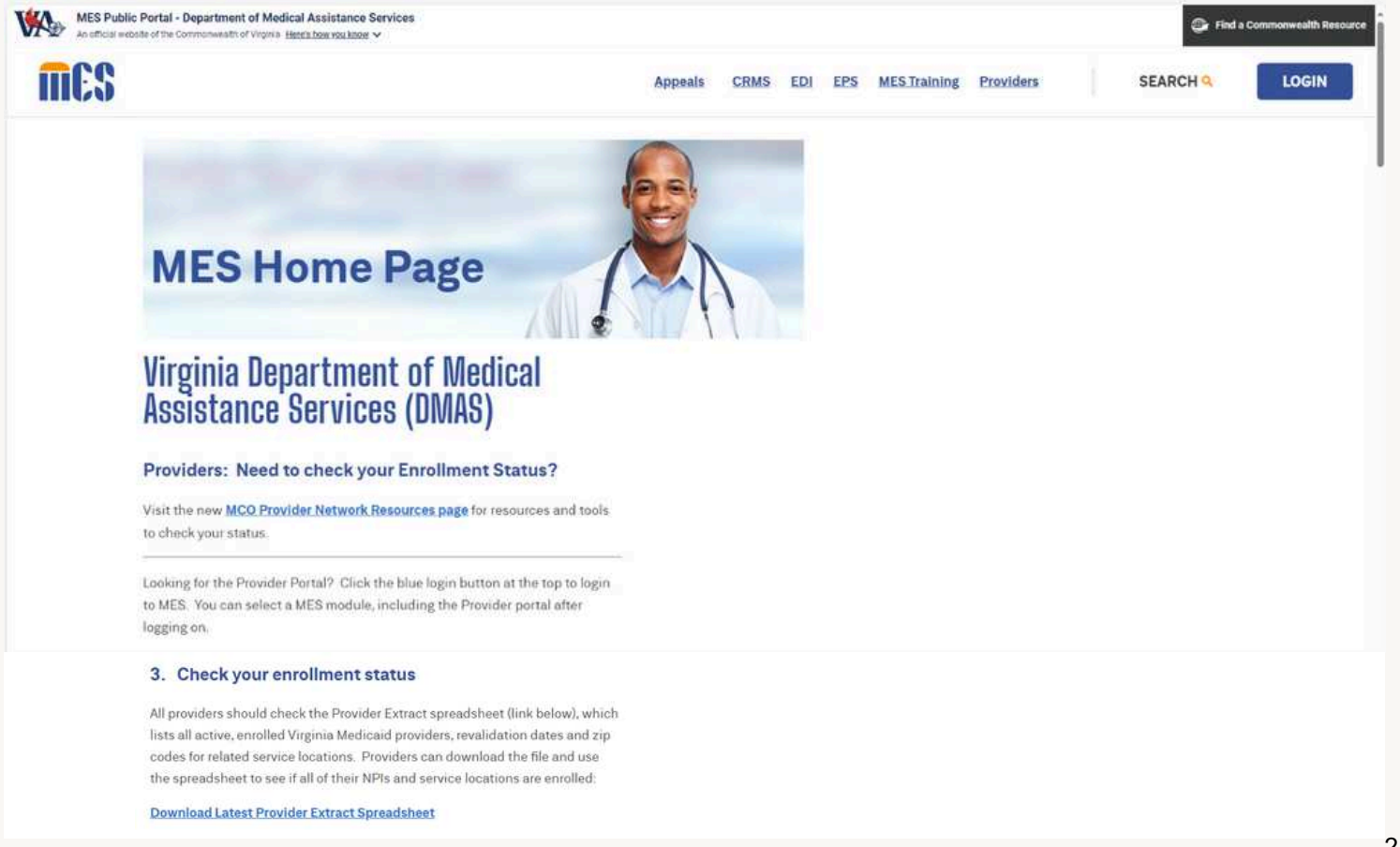
DMAS NEWSLETTER Q3 2024

REVALIDATION

Acentra Health has seen an upward trend of Providers not being enrolled as Medicaid Providers due to not revalidating their information within the PRSS system. Within PRSS there is a revalidation tab where the provider can reference their revalidation dates and complete this process before they are disenrolled from the MES system. Acentra Health advises that providers check this information as it can disrupt service delivery, the approval of authorizations, as well as the remits of payments due to being moved into an inactive status.

**** If you haven't, please go into PRSS system, check your revalidation date, and if needed revalidate accordingly****

There is also a section on the DMAS page where you can check your revalidation dates as well. This information is extracted every Friday and updated on the DMAS page.



WEBSITE UPDATE

In May, 2024, Acentra Health updated its website and integrated its platform into the DMAS website. For access into the Atrezzo portal, as well as any updates and new information from Acentra Health you can access **dmas.kepro.com.**

Registration Codes for New Providers and New Locations

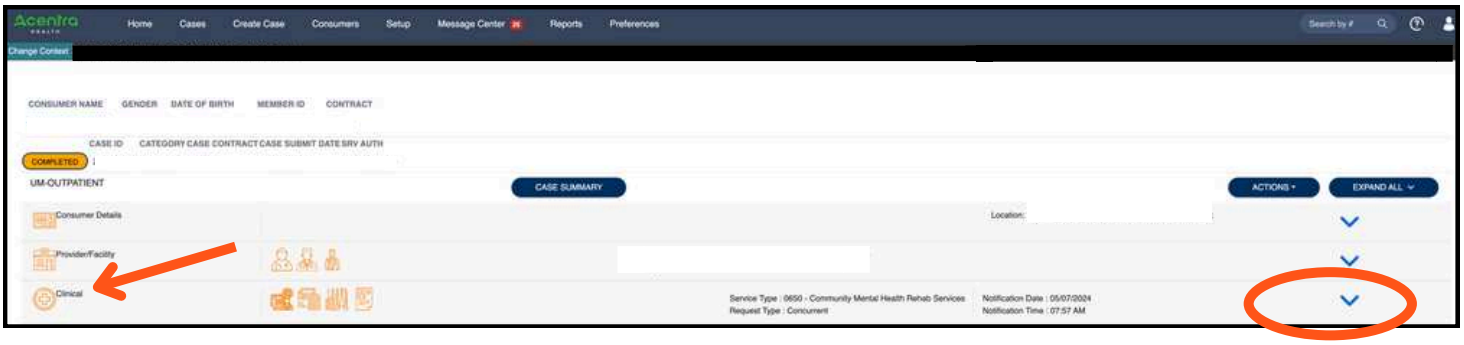
For New Providers of Medicaid Services in Virginia, registration of these locations can be completed through the Atrezzo portal. Providers need to contact he Acentra Help Desk to obtain their Provider Registration Code. Once obtained the provider will be able to register the organization within Atrezzo. The Provider Registration code will either be the first remit date or the Servicing Location ID.

Discharge Function within ANG

Providers are now able to discharge all Behavioral Health services in Atrezzo (ANG). Information needed to complete a discharge includes:

1. **Disposition & Reason**
2. **Living Arrangement**
3. **Employment Status**
4. **Requested End Date**
5. **Requested Discharge Date**
6. **Discharge Note**

To submit a discharge:



1. Log into ANG. **Search by the Case ID number** and select the **Clinical screen dropdown.**

2. In the Clinical screen options, select the **Discharge dropdown.** Select the **Discharge Disposition dropdown** and choose the discharge location or reason based on the case. Select the **Living Arrangement dropdown** and choose the discharge destination based on the case.

3. Change the **requested end date** and add a **discharge date** based on when your client is leaving your care. Then select **Submit.**

If you have issues using the discharge function in ANG, please email **vaproviderissues@acentra.com** or call **804-622-8900** or **1-888-827-2884 (toll free)** for assistance.

Clinical and Submission TIPS from ACENTRA HEALTH

Continuity of Care

When a member's eligibility transitions from a Managed Care Organization (MCO) to Medicaid FFS, the provider shall submit a request to Acentra Health to advise that the request is for a managed care transfer. This will ensure honoring of the approval for the continuity of care period and waiving of timeliness requirements. Please upload and attach proof of the authorization in Atrezzo. Acentra Health will honor the approval up to the last approved date under the continuity of care provisions. For continuation of services beyond the continuity of care period, Acentra Health will apply the medical necessity/service criteria.

Treatment Foster Care - Case Management Provider

- When submitting authorizations, please ensure that the submissions are filled out completely, to include the questionnaire that is associated with the authorization being filled out. The questionnaire cannot be uploaded or submitted in another part of the authorization.

- Please be sure that the CONS, Updated/ Current FAPT Notes, as well as the Correct FIPS Codes are added for the locale that you are submitting for.

- **Please Note that the FIPS Codes are:**
  - A 3-digit CSA Locality Code
  - Is not a 2- digit code, 4- digit code, or the CPT code of the service submitted for which would be T1016.
- **Timely Submissions:**
  - No sooner than 30 days prior to the initial date of service and 10 days after the initial date of services.
- **Authorizations**
  - Should only be submitted for a 12-month duration.
    - Example: 04/01/2024 through 03/31/2025
    - The authorization generated and uploaded into Atrezzo will only reflect 1 unit/ month for 12 months.

Residential Providers (Psychiatric Residential Treatment Facilities, Therapeutic Group Homes, and Independent Assessment, Certification and Coordination Team (IACCT) Providers)

IAACT Inquiry (Enhancing Communication between The Provider and The Legal Guardian)

- Referral Sources and Providers should alert the Legal Guardians that they will be receiving a call from Acentra Health regarding the IACCT Process and what's the purpose is.
- Referring Providers should ensure they are entering the correct identifiable information for the member on the IAACT Inquiry.
    - Reviewers received incorrect names, Medicaid numbers, etc.

- Acentra Health has noticed an increase in IACCT Referral in which the youth's needs can be addressed through alternatives levels of care/ IN some instances, moving forward with an IACCT Assessment is not appropriate. Please consider the following prior to making a referral:

    - **Lack of documented need:**
        - Residential services are often reserved for youth with a history of significant behavioral health challenges that require intensive treatment and support. Without a documented history of such challenges, the need for residential services may not be evident.
    - **Availability of alternative interventions**
        - If a youth has not undergone previous behavioral health treatment (e.g. within the past 3 months any of the following: IIH, TDT, MHSS, Crisis Services, Outpatient, Case Management) it may be assumed that less intensive interventions, such as outpatient therapy or community-based programs (described above), could be more appropriate and effective in addressing their needs.
    - **Clinical Providers submitting Service Authorization requests should ensure that necessary attachments are being submitted with the request.**
    - Once requests are submitted, Acentra Health reviewers cannot adjust the request.
    - Ensure that the Legal Guardians and youth signatures are on the plans of care and submitted with the service authorization request.

Applied Behavioral Analysis (ABA) Providers

- For all requests exceeding 20 hours (80 units) or more per week, submit the schedule of activities used to structure the service sessions and describe how the activity will facilitate the implementation of the behavioral modification plan.
- Please be aware that Acentra Health requires the submission of the 97155 Procedure Code with all ABA Requests. When submitting claims for ABA, Providers should bill using the specific CPT code for the service that was provided. Authorization will only be provided for Procedure Code 97155, and providers should enter the total number of authorized units needed which may include other procedure codes (e.g. 97153, 97154,97156,97157,97158, 0373T)

Assertive Community Treatment (ACT) Providers

- When submitting authorizations, providers submitting for OP Psych ACT H0040 Request, need to ensure that the appropriate modifier is attached to this request.

ARTS Providers

- When completing the clinical questionnaire for consumers please send in or include the following, all of which will assess the reviewer in deeming them medically necessary for services:
  - Include or identify if the member is on/ receiving MAT Services
  - A list of medications that the member is on
  - Identify a list of medical issues that are associated with the member.

Outpatient Rehabilitation Process Updates

When requesting an Evaluation to be completed:
Submit a hard copy of the order requesting an Evaluation signed by Medical Doctor, NP, or PA for Physical Therapy. Order/Referral must clearly state:

1. The member's name
2. Which therapy type is being requested
3. The date order was written
4. Must include "Evaluate & Treat"
5. Signature from Medical Doctor, NP, or PA must be clearly visible on order/referral or Plan of care.

When requesting Initial treatment visits, this can be after the 5 visits or before:
Submit the Evaluation and/or Plan of Care for Physical Therapy signed by a Licensed therapist or Medical Doctor. Evaluation or Plan of Care should be dated prior to or on request start date of 07/23/2024. Evaluation and/or Plan of Care must include SHORT term and LONG-term goals with dates they will be accomplished (TIMEFRAMES) in a date format, why you are requesting therapy (FUNCTIONAL DEFICITS), and how many times per week and how long (weeks, months, days) you are requesting therapy (frequency and duration) in order to meet criteria.

When requesting continuation/recertification/extension of services:
Submit clinical notes and current Plan of Care (within the last 30 days from requested start of care) for progress in treatment. Please do not submit only the Plan of Care. Please do not submit the original Evaluation when requesting continuation of therapy. Submit documentation that shows progress or regression in therapy. Clinical note MUST include the following specific functional deficits, frequency, and duration of treatment, and updated short- and long-term goals with active timeframes. Goal dates must be active within or after the requested dates of service and timeframes must be in full date or months/weeks/days format.

CONTACT US

Acentra Health

For initial outreach, please access our dedicated Customer Service Call Center. For any ongoing or unresolved issues, we kindly request that you contact Acentra Health via the Provider email address with your concerns. Thank you for your continued support and collaboration.

General questions related to Acentra Health Services:

- **Toll-Free Telephone:** **804.622.8900** or **888.827.2884**
  - The Call Center Help Line should be accessed when you are experiencing minor portal issues, inability to log into ANG, registration challenges, account lockouts, passwords combining user profiles, and general questions associated with the portal.

- **Email:** **VAproviderissues@kepro.com**
  - The Provider email should be accessed when the Provider is experiencing escalated concerns associated with submission issues, authorization statuses/ challenges, provider type and specialty issues, complex technical issues that inhibit a provider from submitting an authorization and troubleshooting error codes generated by potential user or system error.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS)

General BH Service Authorization related questions:
enhancedBH@dmas.virginia.gov

General Medical Service Authorization related requests:
PAUR06@dmas.virginia.gov

Claims
Conduent
General Email: **virginia.EDISupport@conduent.com**
Conduent Claims Support Helpline: **800.552.8627**

Provider Enrollment Issues
Gainwell Technologies
804.270.5105 or **888.829.5373**
VAMedicaidProviderEnrollment@gainwelltechnologies.com

Find Information Regarding **Upcoming Meetings** at the Department of Medical Assistance Services (DMAS) website.

Acentra HEALTH