ACENTRA HEALTH AND DMAS NEWSLETTER

Winter 2026

Acentra HEALTH

CardinalCare
Virginia's Medicaid Program

In this edition...

Announcements……..……..……...3-7

Reminders……..……..……..…..8-9

Acentra Health's How To Guide……....10

Clinical Tips ……..……..11

Reconsideration Request & Appeals ……....12

Acentra Health Q1 Provider Training Calendar……...13

Contact Us……..……....14

Visit https://vamedicaid.dmas.virginia.gov/sa for Provider training materials, FAQs, forms, and other useful content.

- Service Authorization-Related Forms
- DMAS Provider Manual Library
- Acentra Health Portal Trainings and Service Authorization Presentations
- Acentra Health Portal and Service Specific FAQs
- Member Resources

ANNOUNCEMENTS

CMS Interoperability

Effective January 1, 2026, the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) has initiated a shift in how healthcare payers and providers approve prior authorizations.

These changes are to include faster decision times and the requirement to provide specific denial reasons. For additional information, please see **CMS Interoperability and Prior Authorization Final Rule.**

ANNOUNCEMENTS

New Provider Pend Response Timeframes

New Prior Authorization Timeframes **Effective January 1, 2026**
To align with CMS Interoperability requirements, Acentra Health is updating prior authorization and provider pend timeframes:

Authorization Decisions: NEW

- **Urgent & IP Concurrent:** within **72 hours**
- **Standard:** within **7 calendar days** *(may extend 14 days if additional info is requested by Acentra Health)*

Authorization Decisions: NO CHANGE

- **Retrospective and Reconsideration Reviews: Acentra Health will process within 30 Calendar Days.**

New Provider Pend Response Timeframes **Effective January 1, 2026**
Provider pend allowances will be reduced for many services. Please review your processes to ensure timely responses.

Provider Pend Response time:

- **Urgent / IP Concurrent*:** Providers will have **24 hours** (including on weekends or holidays) to respond to requests for additional information.

***Inpatient Concurrent includes services:** 0200 Intensive Rehab, 0051 Substance Use (ARTs) (Procedure Code 2036 and H0011), 0401 Inpatient Psych, 0093 EPSDT Inpatient Psych, 1020 Specialized Care and Long Stay Hospital*

- **Inpatient:** 1 business day to respond to requests for additional information.
- **Outpatient:** 3 business days to respond to requests for additional information.
- **Retrospective Reviews:** 3 business days to respond to requests for additional information.

ANNOUNCEMENTS

New IVR Enhancement at Acentra Health

As part of our ongoing commitment to modernizing systems and enhance service delivery, we're excited to introduce new Interactive Voice Response (IVR) capabilities designed to make interactions faster, easier, and more efficient. These enhancements include:

- **Caller Authentication & Case Status Inquiries** – Callers can quickly verify their identity and access real-time case updates without waiting on hold.
- **Expanded Provider Access** – Providers can check real-time status of submitted requests: approved, denied, pending, or void, directly through the IVR, regardless of submission method.
- **Streamlined Support** – After receiving case details, providers can choose to speak with a representative for additional assistance.

All case status inquiries will be automatically documented with date, time, and case details for accurate and transparency. These improvements reduce average handle time and deliver a more convenient, responsive experience for every caller.

ANNOUNCEMENTS

New Email Mailbox within Acentra Health

Acentra Health has created a new support mailbox to assist providers with issues specific to the **Atrezzo Provider Portal**: **ANGissues@acentra.com**. Providers can use this mailbox for help with account creation, registration codes, sign-in issues, reactivating dormant accounts, merging accounts, and password resets.

For **higher-level concerns**, providers should continue using the **VA Provider Issues Mailbox** at **vaproviderissues@acentra.com**.

ANNOUNCEMENTS

Join the Acentra Health Community Stakeholder Advisory Council

Acentra Health invites dedicated healthcare providers to become members of our newly established Community Stakeholder Advisory Council (C-SAC) in Virginia.

As a Quality Improvement Organization (QIO) contracted by the Department of Medical Assistance Services (DMAS), Acentra Health is committed to enhancing healthcare access and outcomes for Medicaid/ FAMIS Fee-for-Service beneficiaries. The C-SAC will serve as a collaborative forum where providers, patients, advocates, and community leaders come together to advise on policy, training, and community engagement initiatives.

Members will help shape service delivery, promote transparency, and ensure alignment across stakeholder groups. If you are passionate about improving healthcare in Virginia and want to make a meaningful impact, we encourage you to apply and lend your voice to this important work.

If you are interested in joining this council, please complete the questionnaire below:

Advisory Board Interest Form

Important Reminders

Provider Reminder: Contunity of Care Request

Once a members eligibility changes from one managed care organization to Medicaid FFS (Fee for Service), **a Service Authorization request can be sent** to Acentra Health to ensure Continuity of Care.

During this time, services **should not stop** when a member transitions.

When submitting the request, **providers should ensure** that they include the following information:

- ✅ When submitting the request, The Provider should select “Continuity of Care” as the Request Type.
- ✅ The Provider should notate continuity of care within the “Notes” or “Communication Section” of the submission.
- ✅ The Provider should attached the previously approved authorization to the new service auth submission.
- ✅ The Provider should attach a copy of the member’s MCO approval letter. The approval letter MUST include the Member’s name, Provider’s Name, Dates Approved and Services Approved.
- ✅ Continuity of Care Request may not apply to all service types.

Reminders

BH Service Authorization and Registration Grid

Providers should refer to the Registration Grid to verify that all required qualifying criteria are met before submitting service requests.

BH Service Authorization Registration Grid

Eligibility Checks

Providers should continue to verify Member eligibility on a consistent basis. This is to ensure that authorizations can be reviewed and processed in a timely manner. Failing to do so may delay claims being processed.

Providers can also verify a Member's eligibility without the Virginia Medicaid identification card using two other identification keys, such as full name, Social Security Number, and date of birth.

Click Here to Visit MES' Provider Resources

Click Here to Learn More About Member Eligibility Checks

How to Obtain Registration Codes

✅ **First Step:** Call our **Customer Services Department** at **1-888-827-2884** if you are:

- A newly enrolled provider or needing to complete a new registration in the MES system.
- If you experience issues after, email the ANG Issues Provider Inbox ANGissues@acentra.com.

Trouble Finding New Servicing Locations in MES?

Important Reminder:

Even if your new service location is active in the MES system and can be found manually in Atrezzo, it **must still be officially registered in Atrezzo**. This is necessary so that **Provider Group Administrators can add users** to the location.

To register for the location in Atrezzo, follow the same steps as registering for a new location. You will need:

- The **NPI number**
- The **correct registration code**

Atrezzo Login Issues?

Contact **Customer Services first** (1-888-827-2884), if you experience issues after, email the ANG Issues Provider Inbox ANGissues@acentra.com.

Clinical Tips

Psychiatric Residential Treatment Facilities & Therapeutic Group Homes

Medicaid Coverage for Youth not Medicaid – Eligible at Admission

1. When Youth Become Medicaid-Eligible During Admission
If a youth applies for Medicaid after entering a PRTF or TGH, the Certification of Need (CON) must be:

- Completed within 14 calendar days of admission
- Completed by the CIPOC team
- Medicaid may cover services retroactively only if the CON is completed within the 14-day window

2. Required CON Signatures:

- TGH: LMHP, LMHP-R, LMHP-RP, LMHP-S
- PRTF: Psychiatrist responsible for the plan of care

3. Notification Requirements After Medicaid Eligibility

- Once Medicaid eligibility is visible in VAMMIS:
- Provider must notify the FFS Service Authorization Contractor within 5 calendar days of the Medicaid eligibility decision date
- If notification is late → No reimbursement for days before the notification date

4. IACCT & Authorization Steps

- Provider notifies FFS Contractor
- FFS Contractor notifies the IACCT
- After IACCT completion, provider has 5 business days to submit the service authorization

5. Retroactive Coverage Requirements
To receive coverage back to admission or Medicaid eligibility start, all deadlines must be met:
✓ Youth meets medical necessity
✓ FFS Contractor notified within 5 calendar days
✓ CON completed within 14 days of admission
✓ Service authorization submitted within 5 business days after IACCT completion

Reconsideration Request and Appeals

To ensure the security and confidentiality of our members' information, please follow these guidelines:

- **Individual Member Request:** To maintain HIPAA compliance and confidentiality, requests should be submitted individually for each member rather than in bulk or grouped formats
- **Secure Information Storage:** Our system securely stores member information in compliance with HIPAA regulations, similar to electronic health records (EHR).
- **HIPPA Compliance:** This ensures that protected health information (PHI) is handled securely and appropriately.

Steps for Reconsideration and Appeal Submission:

1. Reconsideration Request Submission:

- **Timeline:** The provider has 30 calendar days from the initial denial to submit a reconsideration request through the Atrezzo Portal.
- **Action:** The reconsideration is reviewed by the medical team, who will assess the information available at the time of reconsideration.
- **Outcome:** A decision is made based on the reconsideration request, which may result in either an approval or a continued denial.

2. If Reconsideration is Denied:

- **Next Step:** If the reconsideration is denied, the provider can then submit an appeal to DMAS.
- **Action:** DMAS will review the appeal and render a final decision.
- **Outcome:** DMAS will inform the provider of the outcome of the appeal, including whether the request is approved or denied.

Acentra HEALTH

January – March 2026
VA DMAS Provider Training and Office Hours Schedule

Acentra Health has established a monthly schedule of Provider Open Calls dedicated to Providers who have technical issues that require escalation or questions about processes that have not been resolved within one week. Please note: no PHI will be shared during these calls.

January 2026

SUN	MON	TUE	WED	THURS	FRI	SAT
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Feburary 2026

SUN	MON	TUE	WED	THURS	FRI	SAT
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
23	24	25	26	27	28	29

March 2026

SUN	MON	TUE	WED	THURS	FRI	SAT
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Select the Date and Time to Register

Provider Trainings

Training for IACCT Providers	Training TGH & PRTF Providers
02/10/2026 @ 10am	03/18/2025 @ 11am

Stay in the Know and Sign Up for the Acentra Health Newsletter!
Just scan the QR code

For more information about Acentra Health, Provider Manuals, training materials, and reference guides,, please visit ***https://vamedicaid.dmas.virginia.gov/sa.***

Contact Us

First Point of Contact:
Acentra Health Customer Service

804-622-8900 or **888-827-2884**

- Atrezzo technical assistance
- Authorization submission/status
- Troubleshooting error codes
- Service authorization questions

Atrezzo Account Issues:
ANGissues@acentra.com

- Questions related to registration codes, password resets, account lockouts, merging accounts, or escalated issues associated with Atrezzo User Accounts

Escalated Issues:
vaproviderissues@acentra.com

- Questions about processes that have not been resolved within one week
- Technical issues requiring escalation

CONTACT US

For initial outreach, please always contact Acentra Health Customer Service at 888-827-2884.

Acentra Health Customer Service

888-827-2884

Initial outreach.

Minor Atrezzo Portal issues.

Inability to log into Atrezzo.

Registration challenges.

Account lockouts.

Passwords combining user profiles.

General questions associated with the Atrezzo Provider Portal.

Acentra Health Provider Email

vaproviderissues@acentra.com

Escalated concerns associated with submission issues.

Authorization statuses/ challenges.

Provider Type and Specialty Type issues.

Complex technical issues that inhibit a Provider from submitting an authorization.

Troubleshooting error codes generated by potential user or system errors

angissues@acentra.com

Account Issues related to creations, password resets, registration codes, and merging accounts

DMAS

enhancedBH@dmas.virginia.gov

General BH Service Auth-related questions

PAUR06@dmas.virginia.gov

General Medical Service Auth-related questions.

Conduent

Virginia.edisupport@conduent.com

800-552-8627

All Claims issues.

Gainwell

VAMedicaidProviderEnrollment@gainwelltechnologies.com

804-270-5105 or 888-829-5373

All Provider enrollment issues.

Sign up to receive this newsletter quarterly straight to your email inbox using the QR code.