



1



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3

Split Billing Required

- This process will require split billing for anything that goes over the 6 hours/units per day, and/or the 30 hours/units per week.
- As providers you will need to submit one claim for services provided that are up to six hours/units a day or 30 hours/units a week using your normal process.
- A second claim will have to be submitted using the authorization number that you receive from Acentra to bill for services over 6 hours/units per day and/or 30 hours/units per week.
- A week is defined as a rolling 7-day period.
- The authorization is given for a maximum of 28 days.

4

PART TWO

Requesting an Authorization

5

3 Ways to Submit an Authorization

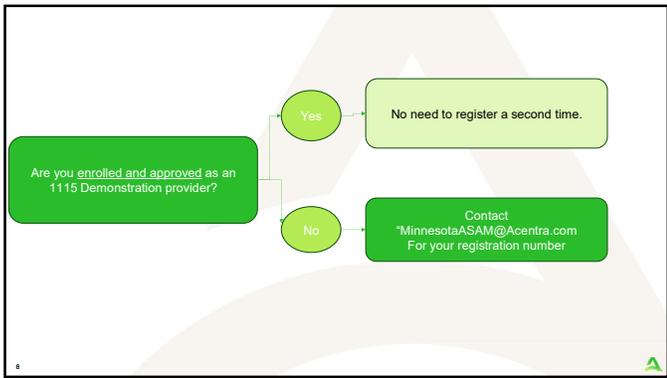
Via Atrezzo Provider Portal	Fax	Mail
<ul style="list-style-type: none"> • Preferred method • Fewer errors • Case ID is confirmation that we received the request • Allows for direct communication with review staff 	<ul style="list-style-type: none"> • Fax DHS-4695 to 866-889-6512 • Include all required documentation • Will not receive case ID as confirmation 	<ul style="list-style-type: none"> • Address: Acentra Attention: MN Medicaid 6802 Paragon Place, Ste 440 Richmond, VA 23230 • Delayed submission • Include all required documentation • Will not receive case ID as confirmation

MHCP Provider Manual Authorization page to be updated in March 2024 when authorization requirements begin.

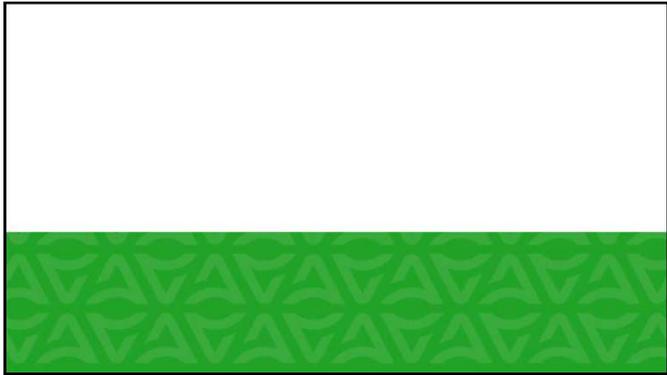
6

PART THREE
**Registering for the
Provider Portal**

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9

PART FOUR

Documentation Requirements and Standards

10

Documentation Requirements for the Initial Request

Current Comprehensive Assessment

- (or Initial Services Plan if request is prior to completion of comprehensive assessment)

Questionnaire

- Questionnaire or DHS Form (see [here](#) for more details)

Initial Treatment Plan (signed by client and clinician)

- Must be signed by clinician and client

Documentation of Treatment Services

- A sampling of group treatment service notes from services received in the last week (4-6 notes)
- The last two (2) individual session notes
- Most recent Treatment Plan Review, if available
- **Treatment plan reviews with integrated notes are not sufficient**

** DHS-4895-ENG MHCP Authorization Form is required on all requests if not using the portal.

11

Documentation Requirements for Continued Authorization past initial 28-day Request

Treatment Plan Review

Documentation must demonstrate the impact of the additional hours.

Documentation of Treatment Services

A sampling of group treatment service notes (4-6) from services received in the last week

The last two (2) individual sessions

Updated Questionnaire

12

Comprehensive Assessment

Understanding "medical necessity"	What it is	What it is not
<ul style="list-style-type: none"> General medicine ASAM's definition 	<ul style="list-style-type: none"> a screening of all biopsychosocial elements Includes collateral information if possible A historical document, updated as more information is learned or the client's situation changes Informs the risk ratings, but does not solely identify them Completed by licensed/credentialed providers in his/her own scope of practice Sets the foundation for medical necessity of services 	<ul style="list-style-type: none"> To be used or completed if the patient is intoxicated or in withdrawal. Consider immediate referral for medical evaluation or withdrawal management services. It is not a diagnostic assessment It is not a 6-dimension assessment

13 <https://www.revisor.mn.gov/statutes/cite/245G.05>

13

Risk Ratings



14

Dimension 1, Severity Rating: 0 1 2 3 4

Reasons severity was assigned:
Client reported using crack/cocaine. She reported using an 8 ball since she was released from jail and her last date of use was 1/16/2023. Client reported being in jail for 7 months. Before being incarcerated, her use was daily and she was using as much as possible. Client denied any withdrawal symptoms.

This is a good example

- Current/past MAT services
- How many times have gone through withdrawal
- How long have symptoms been occurring
- How severe are symptoms
- Any history of medical concerns that could impact withdrawal
 - Treatment history

01 Client demonstrates adequate ability to tolerate and cope with withdrawal discomfort. Mild to moderate intoxication or signs and symptoms associated with daily functioning, but do not pose an imminent danger to self or others. There is a minimal risk of severe withdrawal.

02 Client has some difficulty tolerating and coping with withdrawal discomfort. Intoxication may be severe, but responds to support and treatment rationally that the patient does not pose an imminent danger to self or others. Moderate signs and symptoms, with moderate risk of severe withdrawal.

03 Client demonstrates poor ability to tolerate and cope with withdrawal discomfort. Severe signs and symptoms of intoxication indicate that the client may pose an imminent danger to self or others, and intoxication has not abated at low-intensity levels of service. There are severe signs and symptoms of withdrawal, or risk of severe but manageable withdrawal, or withdrawal is worsening despite withdrawal management at a low-intensity level of care.

04 Client is incapacitated with severe signs and symptoms. Severe withdrawal presents danger, such as seizures. Continued use poses an imminent threat to life.

Reasons Risk Severity Was Assigned
(What about the content of the provider's use and date of most recent use and history of withdrawal problems suggests the presence of withdrawal symptoms requiring professional assistance?)

Client reported his last date of use as 12/31/2022 with methylphenidate (14 gram daily) and Fentanyl (4-5 pills daily). Client reported withdrawal symptoms related to sweating, fatigue, depression, muscle aches, irritability, nausea and anxiety.

15

Individual Treatment Plan

What it is	What it is not	Should not include:
<ul style="list-style-type: none"> Involves problems, needs, strengths, skills, and prioritizing the problem areas that the client wants to work on Short-term, measurable treatment goals and preferences are articulated along with activities designed to achieve those goals. Developed with client and reflects the patient's personal goals Shows the importance of treatment and how client is going to return to baseline 	<ul style="list-style-type: none"> Programmatic or prescriptive Driven by the therapist 	<ul style="list-style-type: none"> Relapse prevention if client is in pre-contemplation or contemplation stages of change

16 <https://www.revisor.mn.gov/statutes/cite/245G.06>

16

What the Patient Wants

The risks and needs, or strengths, skills, and resources identified in a multidimensional assessment do not determine service planning alone.

Practitioners must cultivate an awareness of how these unique risks and needs, as well as the strengths, skills, and resources, function with regard to the patient's personal goals.

The patient who participates in a professionally conducted assessment is showing motivation and readiness to change something. (i.e. staying out of jail to getting a family member, school official, employer, or judge to leave them alone.) Other participants may want to keep a child, job, or they may want to change their probation officer, teacher, supervisor, or life partner.

Personal motivations may not match the needs identified by the clinician. However, the more that priority dimensions can be matched to through the patient's personal goals, the more patient-centered and participatory the service plan and placement can be.



17

17

Examples of Treatment Plans – not individualized

Effective Date: 3/10/2023 Ineffective Date: 3/10/2024

Dimension 1: Acute Intoxication / Withdrawal Potential

Initial Risk Rating: 0 1 2 3 4 Current Risk Rating: 0 1 2 3 4

Problem: The client presents as fully functioning with good ability to tolerate and cope with withdrawal discomfort.

Goal: Goal to avoid further intoxication and potentially resulting withdrawal symptoms for the duration of treatment. (Must be reached to have services terminated) Yes No

Methods: I will give random supervised urine drug screens while in treatment
Amount: 1-2x Frequency: Weekly Target Date: 5/10/2023 Completion Date:

Dimension 2: Biomedical Complications and Conditions

Initial Risk Rating: 0 1 2 3 4 Current Risk Rating: 0 1 2 3 4

Problem: Client reports previous diagnosis of BPD Chronic disease. Client reports managing these concerns with her diet. Client reports these concerns are exacerbated by her stress levels. Client denies any current medications. Client denies any other physical issues or concerns.

Goal: Maintain or improve physical health. (Must be reached to have services terminated) Yes No

Methods: Check in regarding biomedical appointments, changes in medications/diagnosis, biomedical concerns and complications
Amount: as needed Frequency: ongoing Target Date: 4/30/2023 Completion Date:

Methods: Continue to take medications as prescribed
Amount: as needed Frequency: ongoing Target Date: 4/30/2023 Completion Date:

Methods: Patient will discuss in group how they plan to minimize health care issues on recovery efforts.
Amount: 1x Frequency: Daily Target Date: 4/30/2023 Completion Date:

18

18

Importance of the Questionnaire

- Identify how the services which are being offered are specifically helping the individual
- There should be a difference between numbers of hours offered by the program versus what is being recommended for the client (these are not the same nor individualized)
- The questionnaire tells the Clinical Reviewer how the individual is going to benefit from the significance of this amount of treatment
- Individual Outpatient (IOP) with lodging is not justification for the number of treatment hours being received.

22



22

Questionnaire

- Narrative of what has been seen in the recipient's behavior/treatment that indicates need for additional treatment hours.
- Breakdown of how the hours (individual and/or group) will be used in a day and/or week.
- How the clinician expects the extra services to benefit/assist the client in reaching their treatment goals.
- Name and credentials of the licensed professional providing clinical justification.

23



23

Questionnaire, Question 1

1. Provide a narrative of what has been seen in the recipient's behavior/treatment that indicates need for treatment services beyond 6 hours a day or 30 hours a week.

For example:

- What are the currently identified behaviors and/or symptoms to support the benefit of increased services?
- What is the rationale for medical necessity (as defined by ASAM) that indicates the requirement of more than 6 hours a day or 30 hours in a week for this patient at this time?

24



24

Questionnaire, Question 2

2. Provide a breakdown of how the hours (individual and/or group) will be used in a day and/or week.

Be specific:

- What is the patient's baseline (treatment hours determined at the time of assessment) treatment hours?
- How many hours above and beyond 6/day or 30/week will the patient receive?
- How will the additional time be spent? Be specific and include a breakdown of how many group and/or individual hours are being requested and what types of groups will be utilized. (A range of hours for example 0-12, or 0-2 is not individualized nor is it specific enough)

25

25

Questionnaire, Question 3

3. Describe how treatment services (individual/group) beyond 6 hours/day or 30 hours/week assist the client in reaching their treatment goals?

Be specific:

- What goals/objectives is this patient currently not meeting?
- How will you measure/know that the increased hours have helped the patient meet their goals?
- How will you know when the goals are achieved?
- What is the anticipated outcome from the additional group or individual sessions?

26

26

PART FIVE

Submitting the First Request (Case)

27



28

Atrezzo (ANG) Provider Portal

- ❖ Providers can access cases to determine authorization status
- ❖ Receipt of a Case ID# to confirm Acentra has successfully received your submission.



Training Website:
For in-depth training on the Provider Portal, please visit:
mhcp.kepro.com/training

Training Video Link:
[MHCP ANG Provider Portal Create Case Wizard Training Video](#)

29

Portal Case Creation



After logging in, click "Create Case"



The Create a Case Wizard shows each section as a Step. The required information will be indicated by a red asterisk (*).

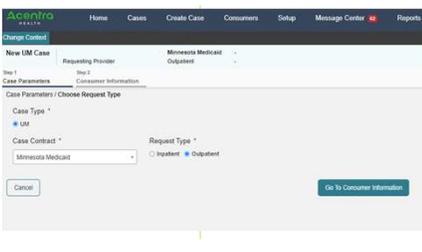
30

Portal Case Creation - Case Parameters



Case Contract:
Minnesota Medicaid
(not Minnesota SUD)

Request Type:
Outpatient



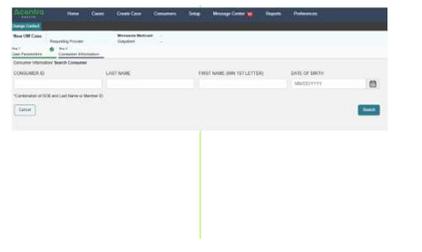
31

Portal Case Creation – Consumer Information



Search for members by:
MN Member ID, or
Last Name & Date of Birth

Click "Search" to continue

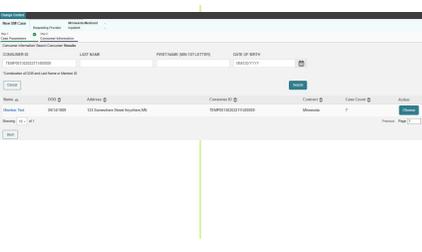


32

Portal Case Creation – Verify Consumer Information



1. Verify member information.
2. Click "Choose" to continue.



33

Portal Case Creation – Check for Duplicates



- Previous cases submitted for this member will be displayed.
- Verify that this is not a duplicate case request by checking the service dates requested.

• Click on "Create Case" to continue.

34

34

Portal Case Creation – Additional Providers



- Attending Physician not needed
- Verify Requesting and Servicing Provider are the same
- Click "Go to Service Details" to continue

35

35

Portal Case Creation – Service Details



- Intake Method: Web
- Place of Service: not needed
- Service Type: 062 – Substance Abuse
- Click "Go to Diagnoses" to continue

36

36

Portal Case Creation – Diagnosis



- Search for all applicable diagnoses
- To add diagnoses simply search for the new code and click on it to add to the list
- Click "Go to Requests" to continue

37

Portal Case Creation – Requests



To make sure that your request gets routed to the right department, only use reconsideration on previously denied cases.

Prior Auth = services which are currently being received which include today's date or are in the future
Retro = services or dates which have been completed

- Click "Go to Procedures" to continue

38

Portal Case Creation – Request 01 Procedure



Only CPT Codes allowed:

- H2035 – Individual Treatment
- H2035 HQ – Group Treatment

Add all service lines for an individual on one case rather than creating separate cases.

If you need assistance with this, please reach out to MNProviderIssues@kepro.com for assistance. Additional training is also training available at <https://mhcp.kepro.com/training>.

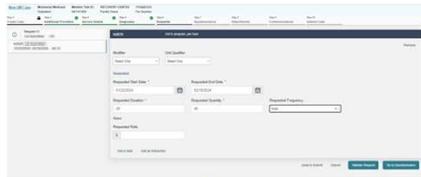
39

Portal Case Creation – Request 01 Procedure



Only CPT Codes allowed:

- H2035 – Individual Treatment
- H2035 HQ – Group Treatment



- **Duration cannot exceed 28 days**
- **Quantity = how many extra units (above 6 per day or 30 per week do you need?)**
- Click on "Validate Request" to continue

40

40

Portal Case Creation – Request 02 Procedure (if needed)



Only CPT Codes allowed:

- H2035 – Individual Treatment
- H2035 HQ – Group Treatment



- **Add all service lines for an individual on one case rather than creating separate cases.**
- Search for "H2035" again to create a second line

41

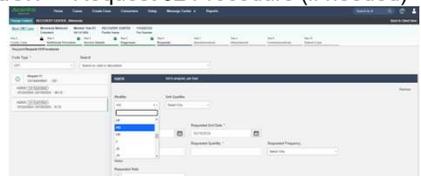
41

Portal Case Creation – Request 02 Procedure (if needed)



Only CPT Codes allowed:

- H2035 – Individual Treatment
- H2035 HQ – Group Treatment



- **Add all requests for an individual on one case.**
- **Dates will copy from the first line**
- **Quantity = how many extra units do you need?**
- Are you asking for extra units per day (over 6 hrs?) or per week (over 30 hrs?)
- Click on "Validate Request" to continue

42

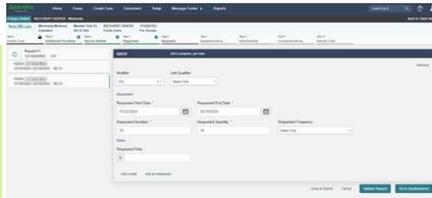
42

Portal Case Creation – Requests



Only CPT Codes allowed:

- H2035 – Individual Treatment
- H2035 HQ – Group Treatment



Both requests will populate on the left-hand side.

Review and verify the date span and quantity are correct.

- Click on "Go to Questionnaires" to continue

43

43

Portal Case Creation – Questionnaires



Complete the Questionnaire

- Click on the title of the Questionnaire, or "Open" to complete the questionnaire.

44

44

Portal Case Creation – Questionnaire Data Needed



• Click "Mark as Complete"



This questionnaire must be completed to provide clinical justification for need of more than 6 hours of services/day or more than 30 hours of services/week.

45

45

Portal Case Creation – Questionnaire Data Needed



Click "Mark as Complete" to continue the case submission.

3. Describe how the clinician expects the extra services to benefit or assist the client in reaching their treatment goals. *

test

4. Name and credentials of the licensed professional providing clinical justification. *

test

MARK AS COMPLETE

This questionnaire must be completed to provide clinical justification for need of more than 6 hours of services/day or more than 30 hours of services/week.

46

Portal Case Creation – Attachments



Click on "Upload a Document"

Upload a document

Max File Size: 10 MB

Allowed File Types: doc, docx, jpeg, png, mdf, pdf, ppt, pptx, xls, xlsx, zip

Request *

RD1

Document Type *

Select One

Internal External

All files uploaded will be encrypted and stored in a secure location in accordance to HIPAA standards, please do not password protect or personally encrypt any files you wish to upload.

Cancel Upload

47

Portal Case Creation – Attachments



- Drag and Drop or Browse for the Required Documents
- Choose the correct "Document Type"
 - Click "Upload"

Upload a document

Max File Size: 10 MB

Allowed File Types: doc, docx, jpeg, png, mdf, pdf, ppt, pptx, xls, xlsx, zip

Request *

RD1

Document Type *

Select One

Current Comprehensive Assessment

Individual Treatment Plan

Progress notes, treatment plan reviews or integrated treatment plan reviews

Current Comprehensive Assessment

Individual Treatment Plan

Progress notes, treatment plan reviews or integrated treatment plan reviews

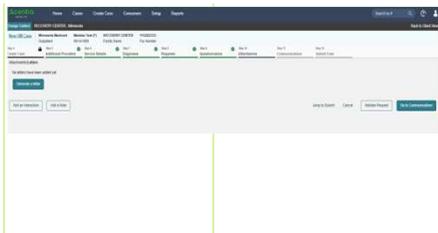
- Required Documents**
- Current Comprehensive Assessment
 - Individual Treatment Plan
 - Progress notes, treatment plan reviews or integrated treatment plan reviews

48

Portal Case Creation – Attachments/Letters



No Attachments or Letters needed
Click "Go to Communications"

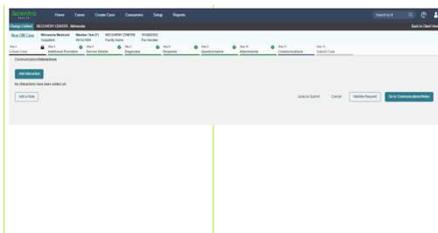


49

Portal Case Creation – Communications



No Communications needed
Click "Go to Communications/Notes"

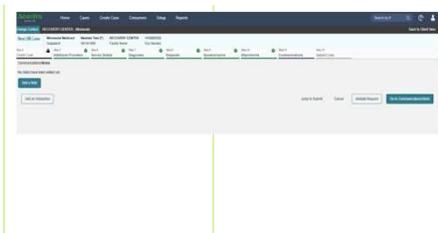


50

Portal Case Creation – Communications/Notes



No Communications/Notes needed
Click "Go to Communications/Alerts"

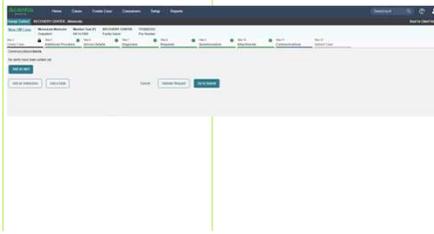


51

Portal Case Creation – Communications/Alerts



No Communications/Alerts needed
Click "Go to Submit"



52

52

Submit Case/Review



This is a summary page of the case you are requesting.
Click "Submit" to submit the request.



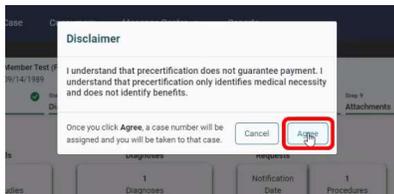
53

53

Submit Case/Attestation



Attest to the information that it being submitted.
Click "Agree"



54

54

Submit Case



Suggestion to Provider: If you print or record this new Case ID number at this point, it will save you time tracking case status, monitoring for pending information or to enter questions/concerns to the Message system. You are able to search for submitted cases using this Case ID number via the Provider portal when required to EXTEND service lines to existing reviews.

55

55

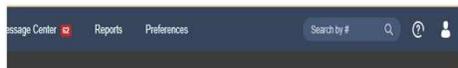
PART SIX

Determining the Authorization status



56

Determining if an Authorization has been Approved



- Once logged in, in the upper right-hand corner you will see a "Search by #" field
- Use the **Case ID** from when you submitted the case to quickly search for it.

57

57

Determining if an Authorization has been Approved

CONSUMER NAME: F, GENDER: 99241984 (D YRS), MEMBER ID: Minnesota Medicaid, CONTRACT: Minnesota Medicaid

CASE ID: 22059002, CATEGORY/CASE: Outpatient, MINNESOTA MEDICAID, CASE SUBMIT DATE: SRV AUTH: 09/26/2022, 123456789

UM-OUTPATIENT

Consumer Details

CASE SUMMARY

- Notice that this case shows "Completed" in orange.
- Under "SRV AUTH" you will see your prior authorization number for claims.
- You may click on the "Case Summary" button to see the approval information.
- You can also scroll down to "Service Details" to see the approval information.

58

Determining if an Authorization has been Approved

- Approval information under the service details tab

H2035 Add to program, per hour **Approved** Clinical Reviewer: Approved Units: 5.21 09/19/2022 - 09/30/2022

Request

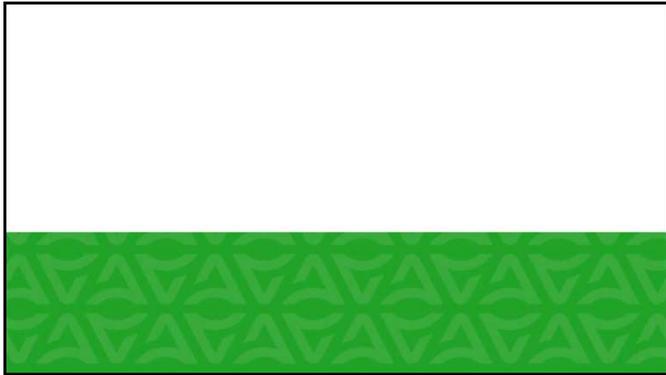
Req	Request Type	Modification Date	Procedure Code Description	Certification Status Unit Quantity	Requested Start Date Requested End Date	Requested Duration Requested Quantity Requested Frequency	Certified Start Date Certified End Date	Certified Duration Certified Quantity Certified Frequency
R01	Rate	09/26/2022 09:23:29	H2035 Add to program, per hour	Approved	09/19/2022 09/30/2022	5	09/19/2022 09/30/2022	5
R01	Rate	09/26/2022 09:23:29	H2035 Add to program, per hour	Approved	09/19/2022 09/30/2022	5	09/19/2022 09/30/2022	5
R02	Rate	09/26/2022 09:43:11	H2035 Add to program, per hour	Approved	09/19/2022 09/30/2022	21	09/19/2022 09/30/2022	21
R02	Rate	09/26/2022 09:43:11	H2035 Add to program, per hour	Approved	09/19/2022 09/30/2022	21	09/19/2022 09/30/2022	21

59

PART SEVEN

How to Extend a Case
(ask for additional units for authorization)

60



61

Authorization Resources



Acentra SUD Team (ASAM and SUD PA):
MinnesotaASAM@Acentra.com
(for portal registration numbers, program questions, assistance)

Acentra Customer Service: 866-433-3658
MNProviderIssues@kepro.com
(password resets, adding new users, system look out issues)

- [MHCP Substance Use Disorder \(SUD\) Services Provider Manual](#)
- [Provider Manual Authorization Page](#)
- [Authorization Forms](#)
- [MN Statute 245G](#)
- [MN Statute 254B.05](#)

62



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HEALTH

☎ Acentra Provider Services: (866) 433-3658
✉ MNProviderIssues@kepro.com (technical assistance)

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63
