



State of Maine
Department of Health and
Human Services

Administrative Services
Organization

PROVIDER MANUAL

OCTOBER 2023

Accelerating
Better Outcomes



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Accelerating
Better Outcomes



SECTION ONE

**Acentra Health
Introduction**

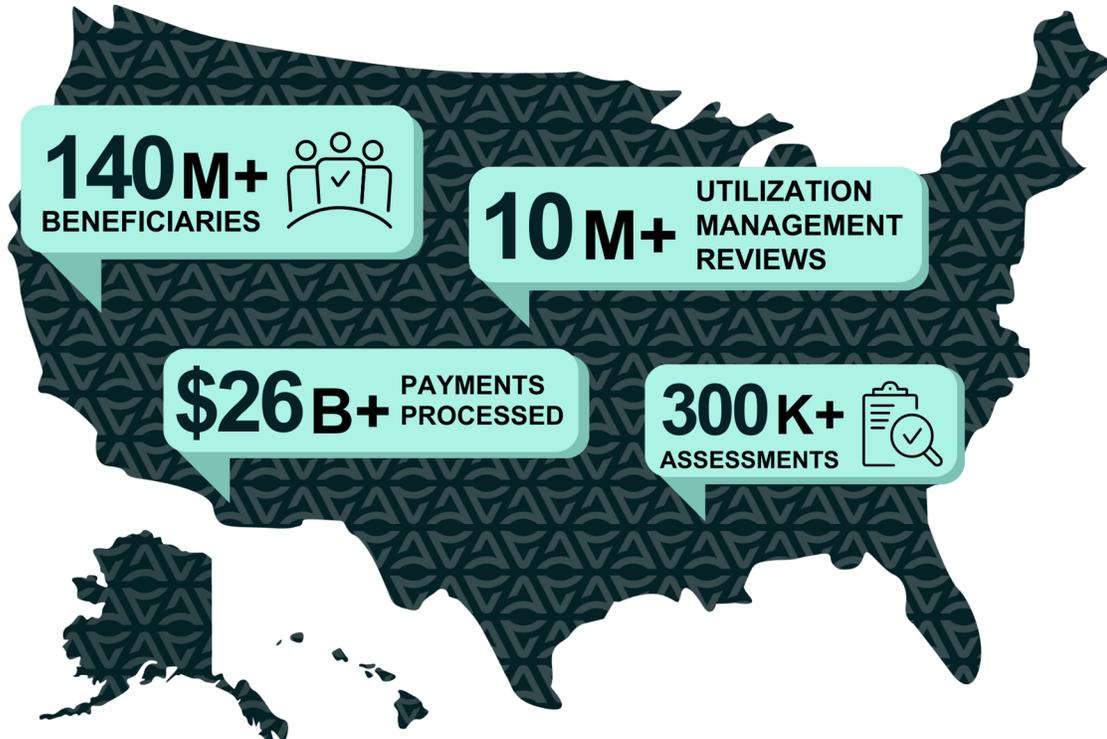


An Introduction to Acentra Health

Acentra Health, formed in 2023 by the merger of industry leaders CNSI and Acentra Health, combines public sector knowledge, clinical expertise, and technological ingenuity to modernize the healthcare experience for state and federal partners and their priority populations. We are headquartered in McLean, Virginia with 32 office locations nationwide and a location in Chennai, India.

Acentra Health brings together a deep collective of expertise across all facets with 30+ years of public sector health knowledge and experience. We deliver continued excellence through our services and solutions to produce maximum value and impact. Our power derives from our ability to integrate innovative technology with high-quality care management, quality oversight, and clinical assessment capabilities. This, combined with access to claims, encounter, provider, and clinical data, helps us create a critical longitudinal view of beneficiary and member health and social services interactions. Our goal is to help our clients unify and analyze these data sets to inform better real-time decisions to improve care and accelerate better health outcomes.

With an expansive network, Acentra Health requires the hard work and dedication of our 3,000 employees, 4,500+ credentialed clinicians, and 450 physicians serving on the company's Advisory and Review panel. Together, our team of technology and business experts, skilled clinicians, and highly talented healthcare professionals work as one to help state and federal partners lead the way in achieving better health outcomes for priority populations we serve.



In 2007, APS Healthcare (acquired by Acentra Health in 2015 and now Acentra Health) was awarded the contract with the State of Maine’s Department of Health and Human Services (DHHS) to provide the State with a Behavioral Health Utilization Management System for MaineCare members. Under this Administrative Services Organization (“ASO”) agreement, Acentra Health is responsible for providing prior authorization, continued stay, and discharge reviews for many behavioral health services, as well as conducting assessments for children’s residential placement. The contract also includes an array of other provider and member services including quality management initiatives, an appeal and reconsideration process, and DHHS grievance process.

Acentra Health’s extensive experience developing innovative, collaborative models of utilization management, care management, provider relations and quality improvement emphasizes community partnerships, training, and technical assistance. Acentra Health has been highly successful in improving collaboration and coordination among providers, increasing access, and improving clinical outcomes while controlling costs. Acentra Health is continuing this approach in Maine. Acentra Health’s team is located at 82 Running Hill Road in South Portland, Maine.

Acentra Health utilizes its proprietary, internet-based authorization system, Atrezzo®, which providers use to participate in the Maine Behavioral Health Utilization Review program. Acentra Health’s Provider Manual is designed to inform providers about, and guide providers through, the processes and programs Acentra Health utilizes to achieve these goals.

WHAT OUR CLIENTS SAY

“

I like to use [Atrezzo] because it is fast, and the response time is also fast. The people are courteous and willing to help you solve problems.

— Comment from a recent provider satisfaction survey

Confidentiality

Acentra Health, its subsidiaries, and affiliates are committed to ensuring that our privacy practices comply with industry best practices, and as applicable, all federal and state laws and regulations including but not limited to the Health Insurance Portability and Accountability Act (HIPAA). Acentra Health’s Chief Privacy officer, Melissa Leigh is responsible for the development and implementation of Acentra Health privacy policies and procedures.



MELISSA LEIGH
Chief Legal & Compliance Officer

Office Location

The Maine office is located at the following address:

- 82 Running Hill Road, Suite 202
South Portland, ME 04106

Call Center and Contact Information

Telephonic Information

- The Acentra Health Toll-Free **Telephone Number** is: 1-866-521-0027
- The following options are available from this number:

| | |
|---|---|
| Option 1: Member Services | For member questions, appeals, member resources, and other member concerns |
| Option 2: Katie Beckett | For calls regarding Katie Beckett referrals |
| Option 3: Provider Relations/IT Helpdesk | For Atrezzo® access, training, technical support, and general questions |
| Option 4: Clinical Team | For provider access to the clinical staff to discuss clinical review of provider requests, and to address provider holds. |
| Option 5: Appeals | For questions regarding adverse decisions |
| Option 6: Critical Incident Level I | To report a level I critical incident to the Office of Behavioral Health |
| Option 7: OHH Care Coordination | For OHH Providers to confirm behavioral health services for their members. |

- **Communication/Language Assistance:** The Maine Call Center utilizes CTS Language Link to assist callers needing an interpreter and 711 TTY-based Telecommunications Relay Service to support persons with hearing or speech disabilities.

Fax Information

- The Acentra Health toll-free E-fax number is 1-866-325-4752. All faxes are responded to within 48 business hours.

E-mail Information

| | |
|---|--|
| Provider Relations Direct E-mail | ProviderRelationsME@Acentra Health.com |
| Maine Appeals Direct E-mail | AppealsME@Acentra Health.com |
| Maine Intake Direct E-mail | IntakeME@Acentra Health.com |

Office Hours and Observed Holidays

- Acentra Health is open Monday through Friday 8:00am to 6:00pm.

Our offices will be closed in observance of the following holidays:

- ✓ New Year's Day
- ✓ Martin Luther King, Jr. Day
- ✓ Memorial Day
- ✓ Juneteenth
- ✓ Independence Day
- ✓ Labor Day
- ✓ Veteran's Day
- ✓ Thanksgiving Day and Friday after
- ✓ Christmas Da

Leadership Team



Senior Executive Director

Robert Noble, MBA
rnoble@kepro.com



Clinical Director

Kelly Parnell, LCSW
kparnell@kepro.com



Medical Director

Vanessa Katon, D.O.
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Operations Manager

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Clinical Manager

Allison Parker, LCPC
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Customer Service Supervisor

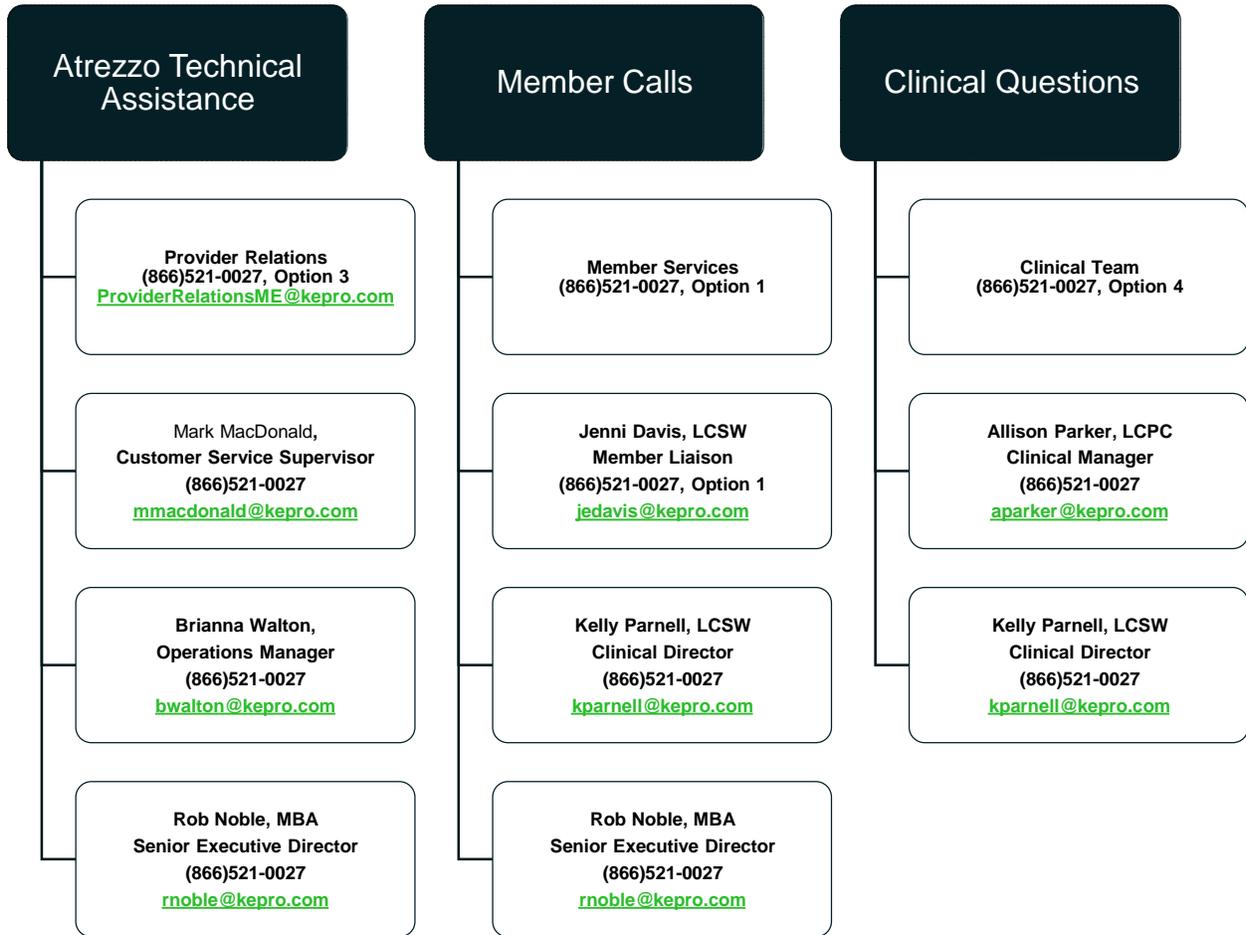
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mmacdonald@kepro.com

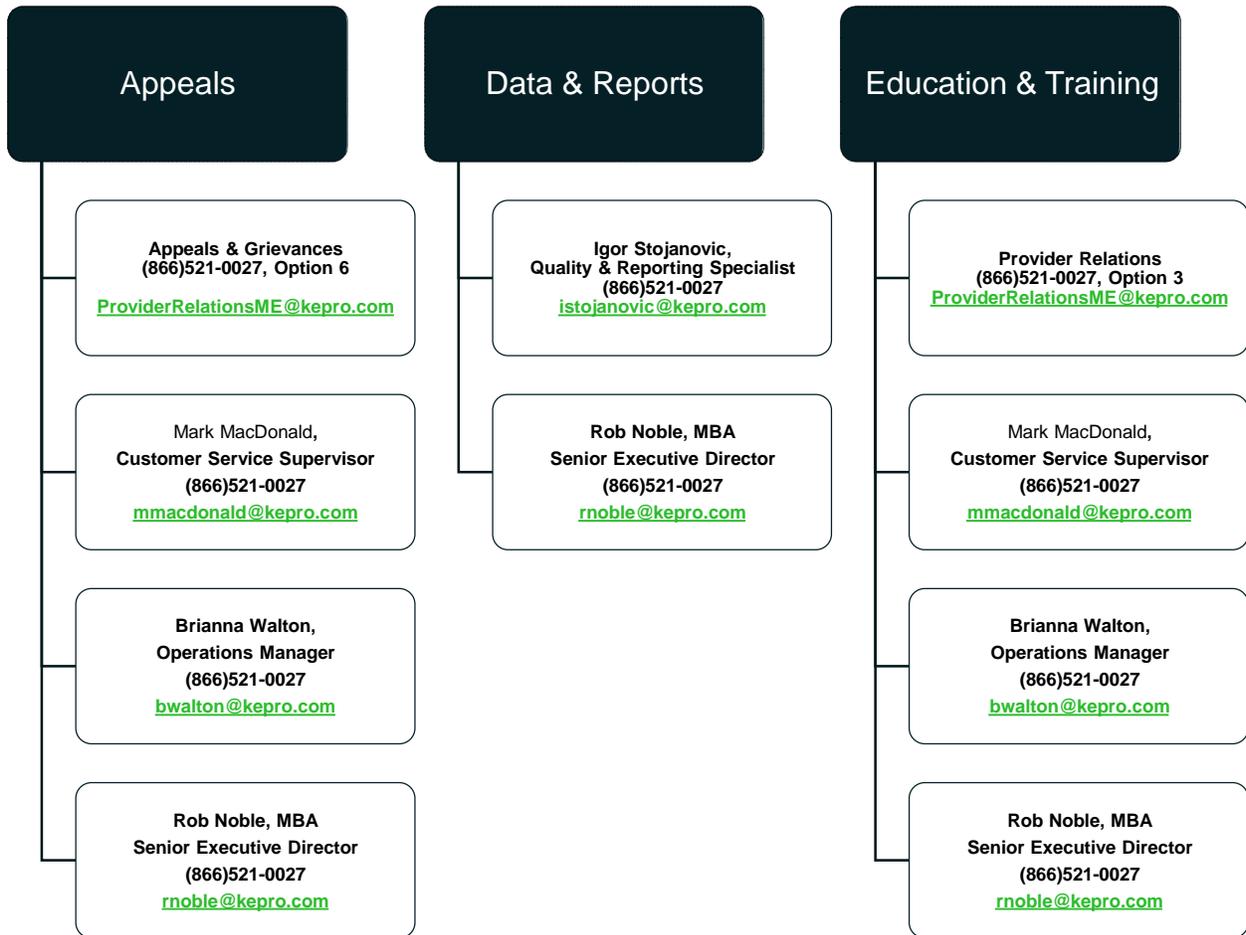


Quality & Reporting Spec

Igor Stojanovic
lstojanovic@kepro.com

Escalation Tree





QualityCareforME Website

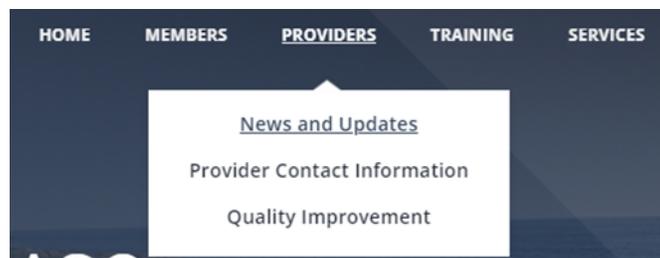
Acentra Health’s Maine website is a repository for news and updates, member training information, and provider information including training materials, and services we review.

Our website also includes a chat with us feature. Through the chat, providers can access additional resources pertaining to Atrezzo and the submission process, or they can chat with a live representative of our Provider Relations team.

To visit our website, go to <https://me.Acentra Health.com>

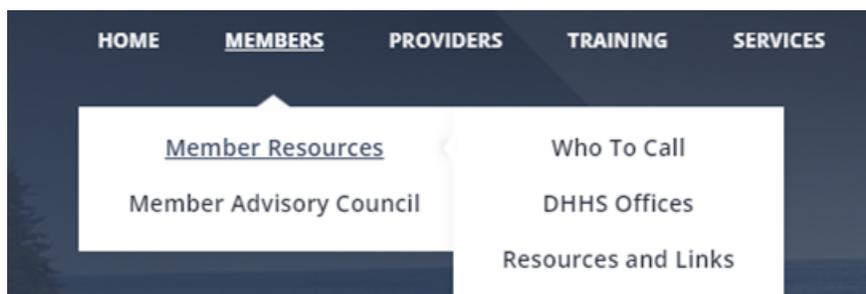
Home Page

Acentra Health Maine’s most recent announcements regarding the ASO will be displayed on the home page of the website. Archived announcements and updates are stored under the News and Updates tab and can be found under Providers > News & Updates



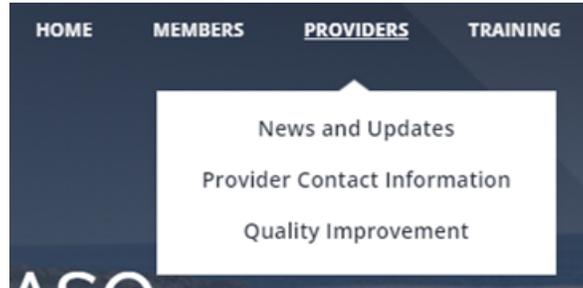
Members

The Members tab contains helpful member resources as well as information about our Member Advisory Council.



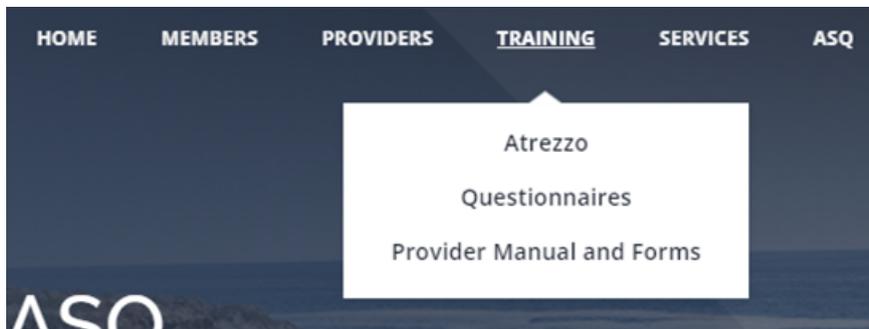
Providers

The Providers tab contains News and Updates, Provider Contact Information, and information pertaining to Quality Improvement.



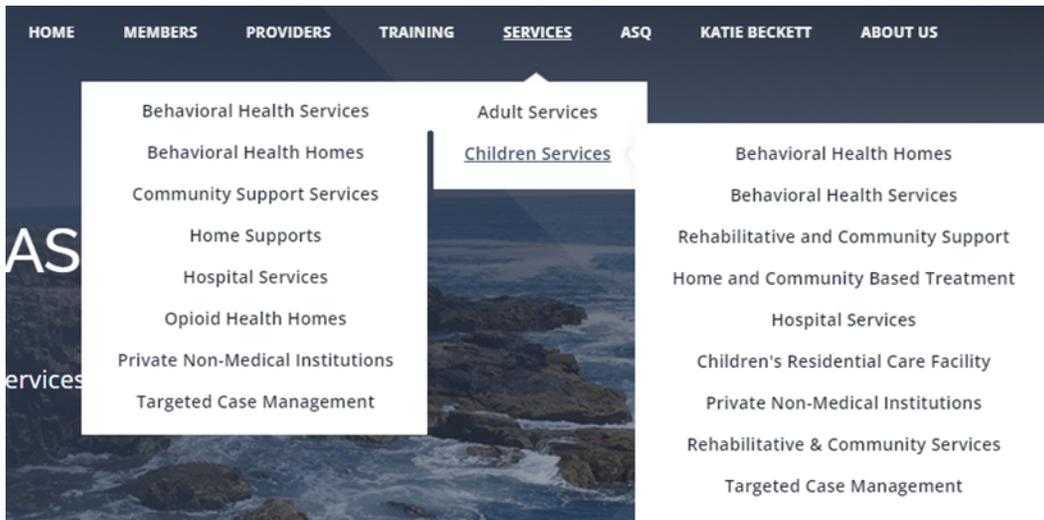
Training

The Training tab contains training resources and videos under the Atrezzo section, a copy of all Questionnaires, and Provider Manual and Forms.



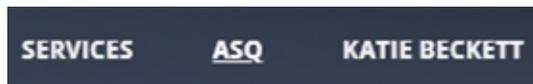
Services

The Services tab contains information regarding Adult and Children Services that are submitted into the Acentra Health portal, Atrezzo. Within this tab, information can be found regarding requirements, submission guidelines, and forms pertaining to the service if applicable.



ASQ

The ASQ tab contains information about the Ages & Stages program for Primary Care Plus providers.



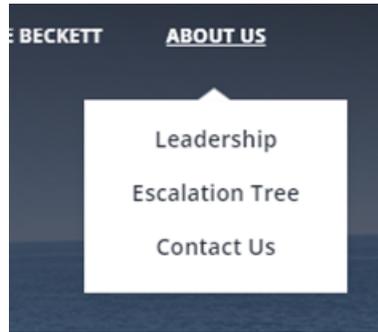
Katie Beckett

The Katie Beckett Benefit tab includes information regarding the Katie Beckett medical eligibility process as well as a documentation checklist.



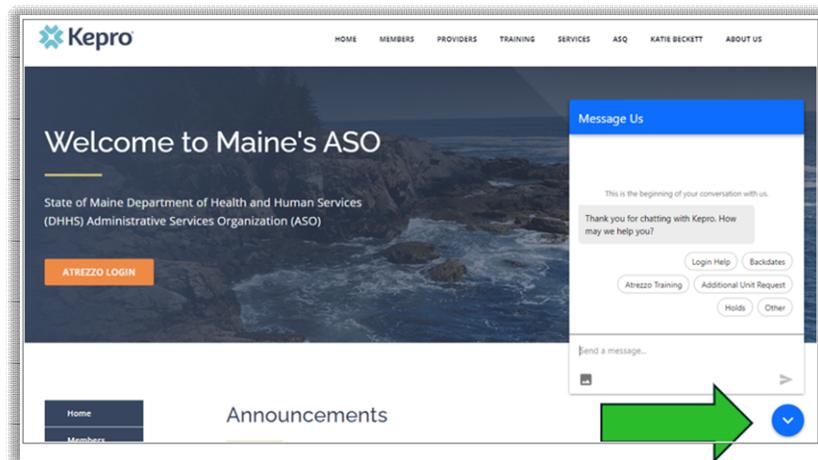
About Us

The About Us tab includes the Acentra Health Maine Leadership team, an Escalation Tree which identifies who to contact when concerns arise, and our Contact Us page.



Chat with Us

The Chat with Us feature allows providers to access resources pertaining to Atrezzo and the submission process. Providers can also choose to speak with a live representative of our Provider Relations Team.

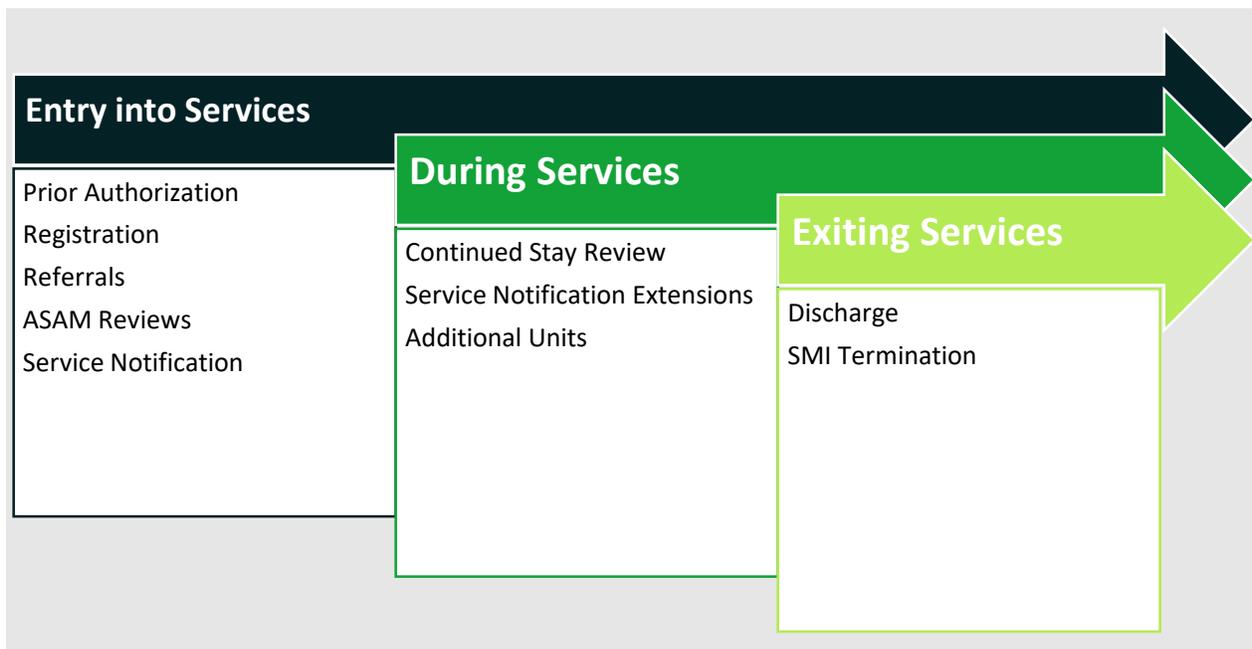


SECTION TWO

**ASO Process
Overview**



An Overview of the ASO Process



Maine ASO Service Grid

The Maine ASO Service Grid contains the behavioral health services Acentra Health is contracted to review. There are two service grids: one for MaineCare Funded Services and one for OBH Funded Services.

The service grids are divided into the Sections of MaineCare policy that Acentra Health reviews. Each section includes the following information:

- Billing procedure codes and applicable modifiers
- Maximum length of billable unit per service
- Types of authorizations required for service(s)
- Default number of units available per initial authorization
- Maximum length of time available per initial authorization
- Maximum length of time available for subsequent authorizations

Acentra Health’s Service Grid shows which processes are required for what service. The Service Grid is regularly updated, and the most recent version of the grid can be found at: <https://me.Acentra Health.com/resources/manuals-forms/> For service descriptions of each program, please visit the [MaineCare Benefits Manual](#).

How to Read the Service Grid

The yellow highlighted rows show the Sections of MaineCare policy that flow through Kepro.

Indicates the type of service grid (MaineCare Funded or OBH Funded) and date the grid was last updated

The procedure code descriptions are displayed under the corresponding section of MaineCare policy

| Service Name | Procedure/Service Code | Code Modifier | Code Modifier |
|--|------------------------|---------------|---------------|
| Section 13 Targeted Case Management - Children | | | |
| Targeted Case Management - Chronic Medical Care Needs | T1017 | UB | |
| Targeted Case Management - Behavioral Health | T1017 | UC | |
| Targeted Case Management - Developmental Disabilities | T1017 | UD | |
| Targeted Case Management - Child Members Experiencing Homelessness | T1017 | US | |

Procedure codes and modifiers are what providers use in Atrezzo to indicate the service they are providing.

Kepro Maine
ASO MaineCare Funded Service Grid
April 24, 2022

Indicates what type of reviews are required for each service.

Indicates the length of each service (measured in days) for continuing requests.

| Code Modifier | Billing Unit | Service Notification | Service Notification Extension | Referral | Critical Incident | Prior Auth Review | Initial Registration | Continued Stay Review | SMI Termination | Discharge Review | Initial Auth Period Days | Auth Unit Default | Maximum Continued Stay Period Days |
|---------------|--------------|----------------------|--------------------------------|----------|-------------------|-------------------|----------------------|-----------------------|-----------------|------------------|--------------------------|-------------------|------------------------------------|
| | 15 Min | | | | | X | | X | | X | 30 | 1 | 90 |
| | 15 Min | | | X | | | X | X | | X | 30 | 1 | 180 |
| | 15 Min | | | X | | | X | X | | X | 30 | 1 | 180 |
| | 15 Min | | | | | | X | X | | X | 30 | 1 | 90 |

The billing unit column indicates how much time one unit of service equates to. Example 1 unit = 15 minutes of service.

Indicates the length of each service (measured in days) for the initial request.

Indicates what the default units are for the initial request. Units should be tailored to each individuals needs, however some services have a max amount of units that can be requested initially.

Clinical Process

Utilization Review is the process by which clinical information is reviewed and evaluated using MaineCare Rules and Policies. Requests are assessed for:

- Eligibility
- Medical necessity
- Quality and outcome focused
- Delivered in the least restrictive setting possible
- For a clinically appropriate amount of time and level of intensity

Acentra Health's Utilization Review (UR) processes include:

- a. Referral
- b. Prior Authorization Review
- c. Registration
- d. Continued Stay Review
- e. OBH Funded Review
- f. Service Notifications
- g. Retroactive MaineCare Review
- h. SMI Termination
- i. Referral Refusal
- j. Critical Incident
- k. Discharge Review
- l. ASAM Reviews

The following is a *general* description of each of Acentra Health's UR processes. Some services have unique or specific requirements per DHHS. As a reminder, authorization of services from Acentra Health is not a guarantee of payment by MaineCare. Registration requests are authorized by Acentra Health solely in an administrative capacity based on MaineCare and provider eligibility. Clinical authorizations are based on provider report and documentation submitted. Providers are responsible to ensure they provide services consistent with all MaineCare policy, DHHS licensing, and DHHS contracts in order to be eligible for claims reimbursement by MaineCare.

Referral

The Referral is an administrative submission which allows Acentra Health to collect data and eligibility information required by DHHS. Referral submissions initiate waitlist monitoring and tracking.

Prior Authorization

Acentra Health uses the Prior Authorization (PA) review process to review clinical data submitted by providers to ensure requested services meet the clinical need of the member and the member is clinically eligible for the service prior to the start of services.

Registration

Registrations are an administrative submission of data and are reviewed for duplication and non-concurrent services only.

Continued Stay Review

Continued Stay Reviews are submitted when the authorization expires.

OBH Funded Reviews

OBH Funded Reviews are utilized for certain adult services for members who do not have MaineCare eligibility to cover services. Providers must be contracted with OBH and have funds available to utilize this review process.

Service Notifications

Service Notifications are utilized for Long-Term Supported Employment, Baxter Fund, Adult Hospitalizations for Riverview Psychiatric Center & Dorothea Dix Psychiatric Center, Section 21, and SUD PNMI Appendix B providers.

Retroactive MaineCare Review

Retroactive MaineCare Reviews are utilized when a member regains retroactive MaineCare, and services were provided during the time a member's eligibility wasn't active. Acentra Health reviews clinical data and treatment plans submitted by the Provider to ensure medical necessity and eligibility. The Retroactive MaineCare Review is not intended to be used as a backdate method and requests of that nature will be voided. Approved Retroactive MaineCare requests does not guarantee payment, but rather establishes if a member was eligible for the service.

SMI Termination

SMI Terminations are required to be submitted prior to discharge for adult members who have a Serious and Persistent Mental Illness (SPMI).

Referral Refusal

Referral Refusals are required to be submitted when a provider is seeking permission from the Office of Behavioral Health to reject a referral.

Critical Incident

Critical Incidents are required to be submitted to report a serious event that creates a significant risk of harm to client, and/or jeopardizes public safety or program integrity.

Discharge Review

Discharge Reviews are required to be submitted within five (5) days of the member discharging from services. Please Note: If your service requires you to complete an SMI Termination, the discharge will be submitted by Acentra Health once the SMI Termination has been approved.

ASAM Review

ASAM Reviews are required to be submitted for all residential substance use disorder (SUD) admissions within ten (10) days of admission and then every 30 days after.

Physician Review, Adverse Decisions, and Notifications

The following section discusses physician reviews, adverse decisions (including denials), how providers and members are notified of decisions, reconsiderations, and the appeal process.

Physician Review Process

When a Acentra Health Clinical Reviewer is unable to determine if a provider's service request is medically necessary, the request is referred to a Acentra Health Physician Advisor for review.

- The physician has three (3) days to decide.

Based on the clinical information available, the Acentra Health physician advisor may:

- Authorize the service as requested (Approved – Physician Approved).
- Authorize part of the requested service (dates and/or units) and deny parts of the requested service (Approved – Partial Approval).
- Renegotiate with the provider. The doctor and provider will agree on a change to the service (Approved – Recon Partially Overturned).
- Deny the requested service entirely (Denied – Physician Denied)

Notifications

- For all Physician Advisor decisions, the provider will be notified immediately via Acentra Health's Atrezzo system.

- For adverse decisions (denials and partial authorizations/partial denials) the member or guardian will be sent written notice of the decision via U.S. mail within one business day of the Physician Advisor's decision.
- For adverse decisions only (denials and partial authorizations/partial denials), notifications will also be made available to providers in the Acentra Health Atrezzo system.

The *denial* letter to the member contains:

1. Demographic information regarding the member
2. Service Type
3. Dates and units of denied service
4. The requesting provider organization's name
5. A statement of clinical rationale used in denying the requested service
6. Information on how to request a reconsideration and/or file an appeal with Acentra Health
7. Free legal help

The *partial authorization/partial denial* letter to the member contains:

1. Demographic information regarding the member
2. Service Type
3. Dates and units of service approved
4. Dates and units of service denied
5. The requesting provider organization's name
6. A statement of clinical rationale used in denying requested service
7. Information on how to request a reconsideration and/or file an appeal with Acentra Health
8. Free legal help

The *confirmation of appeal* letter to the member contains:

1. Demographic information regarding the member
2. Service Type
3. Date of appeal request
4. Information regarding the hearing process
5. Free legal help

Reconsiderations and Appeals

This section will review the process for requesting a reconsideration or appeal after an adverse incident.

Provider Options Following an Adverse Decision

When a provider receives notification of a denial or partial authorization/partial denial, the provider has the following options: ***(Please Note: the member or the member's representative can ask for an appeal at any point in this process).***

1. Request a Reconsideration: For all adverse decisions (denials or partial authorizations/partial denials), a provider may ask Acentra Health to “reconsider” the denial or partial authorization/partial denial. A provider may submit additional information to an Appeals Specialist at the time of reconsideration request, which will then be reviewed by a second physician advisor.
2. For partial authorizations/partial denials that are not under appeal, provider may submit a Continued Stay Review near the end of the authorized time and/or units. If that request is also denied, the provider can still ask for a reconsideration on the denied request.

Member Options Following an Adverse Decision

When a member is notified of a denial or partial authorization/partial denial, the member has the following options:

1. Request a Reconsideration: For all adverse decisions (denials or partial authorizations/partial denials), the member or member's representative may ask Acentra Health to “reconsider” the denial or partial authorization/partial denial as long as the provider has not already requested a reconsideration.
2. For partial authorizations/partial denials that are not under appeal, the member or the member's representative may speak to their provider about submitting a Continued Stay Review near the end of the authorized time/units. If that request is also denied, the member or provider can still ask for a reconsideration of the denied request.

The member or member's legal guardian can request an appeal at any point in this process by contacting Acentra Health Appeals department. or MaineCare Member Services. Requests for appeal must come from the member or member's legal guardian.

Reconsideration Request Process

Providers may request a reconsideration of a denial or a partial authorization/partial denial. Requests for reconsideration of a decision **must be made by a provider within 60 calendar days of the date of the denial or partial authorization/partial denial.**

1. Reconsiderations may be requested by contacting Acentra Health's Appeals and Grievance Specialist by email at AppealsME@AcentraHealth.com or by calling 1-866-521-0027, Option 5; or by mailing the request to:

Acentra Health
Attn: Appeals and Grievance Department
82 Running Hill Rd. Suite, 202
South Portland, ME 04106

2. The Appeals and Grievance Specialist will collect all the available information and refer the reconsideration to a Acentra Health Physician Advisor for review. This Physician Advisor will be a licensed, board-certified psychiatrist, and/or board-certified in addiction psychiatry or certified by the American Society of Addiction Medicine (ASAM). Acentra Health will ensure the physician involved in the determination and review of the reconsideration request will not have been previously involved in the case.
3. Depending upon the service, the physician will make a decision regarding the reconsideration request up to three (3) business days.

Acentra Health provides a report on reconsideration requests to DHHS on a monthly basis, or more frequently as requested. Reports to DHHS may include summaries of the number of reconsiderations by provider type, setting of care, age, and documentation as to the outcomes of reconsiderations.

Member Appeal Process

MaineCare members, in compliance with all rules and regulations, retain the right to file appeals with the Department of Health and Human Services (DHHS), Office of MaineCare Services, for up to sixty (60) days from date of receipt of the notice of denial or potential authorization/partial denial.

For the Acentra Health previously authorized services to remain in place, the request must be a Continued Stay Review, and the member must appeal the decision within ten (10) calendar days of receiving notification. See the Acentra Health Member Handbook for more detailed information. The Handbook can be found online at www.qualitycareforme.com

Appealing an Adverse Decision

As noted above, a member or provider can ask Acentra Health for reconsideration of a denial or partial authorization/partial denial within sixty (60) calendar days. If two reviews by Acentra Health physicians result in two denials, the member may choose to appeal.

- Most appeals start with Acentra Health Appeals team. A member or guardian calls Acentra Health Member Services and requests an appeal. *Appeals must be requested by the member or guardian; a provider cannot ask for an appeal.*
- The member or guardian can contact Acentra Health's Appeals department by calling 1-866-521-0027 option 5; or by mailing a letter signed by the member to:

Appeal Request

Attn: Appeals and Grievance Department

Acentra Health

82 Running Hill Road, Suite 202

South Portland, ME 04106

- After talking with Member Services, if the member or guardian decides to appeal the Acentra Health decision (also called "requesting a fair hearing"), The Acentra Health Appeals and Grievance department will start the appeal process on behalf of the member.
- If for any reason the member does not want to file, the appeal through Acentra Health a request can be made for an appeal through *MaineCare* Member Services.
 - The member or guardian can call MaineCare Member Service's toll-free number (1-800-977-6740, TTY/TDD 1-800-977-6741, or use Sorenson) and ask to appeal Acentra Health's decision ("request a fair hearing")

- The member or guardian can also write to them. The address is:

DHHS Office of MaineCare Member Services

11 State House Station

Augusta, ME 04333-0011

SECTION THREE

**Atrezzo Provider
Portal**



The Use of Acentra Health's Atrezzo System

Acentra Health's proprietary system, Atrezzo is a web-based system that works across numerous internet browsers; however, Chrome is preferred, and system functionality is enhanced with this platform. Its modular design is easily configurable to meet each client's unique short and long-term requirements for data information, and intelligence today and in the future. Atrezzo is HIPAA and ICD-10CM/PCS compliant.

New Provider/Organization Registration

All providers/organizations that work with Acentra Health must register for a Acentra Health Atrezzo account.

To Register a New Provider/Organization:

1. Contact MaineCare Provider Enrollment at 1-866-690-5585.
2. Verify that authorization is needed from Acentra Health for the billing procedure codes that will be utilized. Verify that you or your agency is contracted with MaineCare for the service(s) you will be providing.
3. Once confirmation is received from MaineCare Provider Enrollment, contact Acentra Health Provider Relations at 1-866-521-0027, Option 3.
 - a. Provider Relations sets up your organization based upon your NPI number(s) and provides your primary contact with a Group Administrator username and password.
4. The Group Admin username and password provides you with the ability to set up your employees with a username and password so they can submit requests in Atrezzo. Each employee who will be submitting requests in Atrezzo will need to have their own username and password.

Multi-Factor Authentication (MFA) Summary

Single-Factor authentication (username/password) is not sufficiently secure when handling sensitive Personal Health Information (PHI) or Personally Identifiable Information (PII). Multi-Factor authentication is required to properly secure access to sensitive information.

What is MFA?

Multi-Factor authentication (MFA) is an authentication method that requires users to verify identity using multiple independent methods. Instead of just asking for a username and password, MFA implements additional credentials like a pin sent via email or text, or a verification call made to a pre-registered phone number.

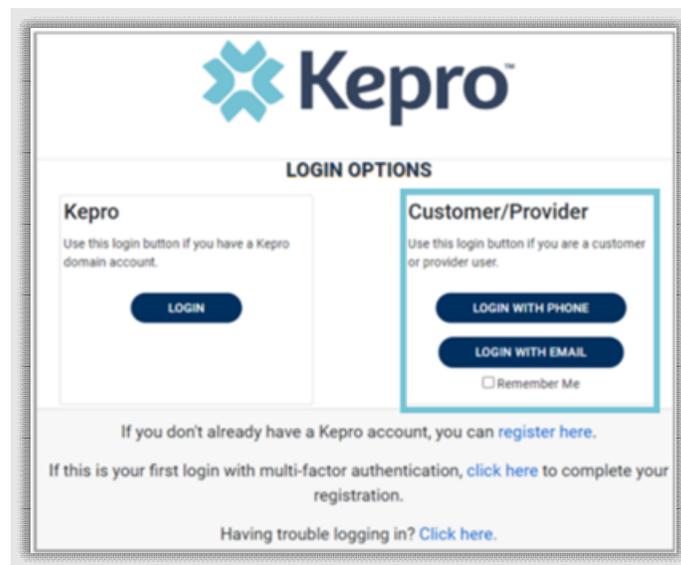
How MFA Works

The goal of MFA is to provide a multi-layered defense system. This helps to ensure that the users who access our system are who they say they are. Even if one factor is compromised, there are still more barriers to breach. For example, to log in to a secure program, a user would need to type a password and enter another number from a text, phone call, or email. Only the correct password combined with the correct password from the additional authentication factor would give a user access. It is important to never share your username/password of MFA factors with anyone.

MFA Registration

Customer and provider users are any users who do not have a Acentra Health.com email address. These users should use the login button under the Customer/Provider heading on the right-hand side of the login page.

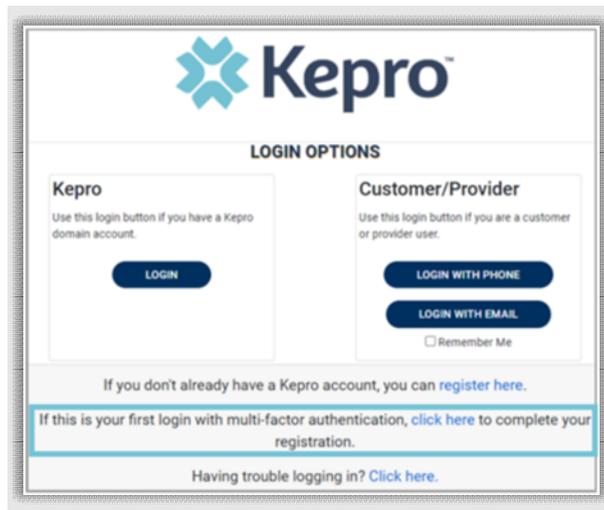
After entering the Atrrezzo Provider Portal URL (<https://portal.Acentra Health.com/>), the login page will display.



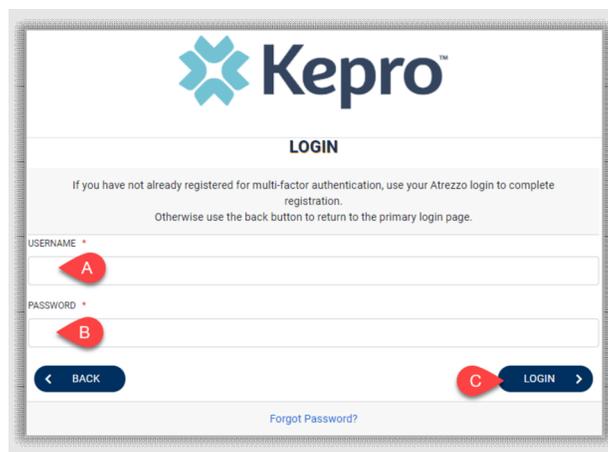
MFA Registration – Customer Portal User; MFA Registration Only

Use these instructions if you are a customer or provider user and you already have an Atrezzo username and password. The instructions below will guide you through completing the Multi-Factor Authentication (MFA) Registration.

From the login screen, click the link to complete the multi-factor authentication registration at your first login. This will be a one-time registration process.



To begin the registration process, enter your Atrezzo username and password and click Login.

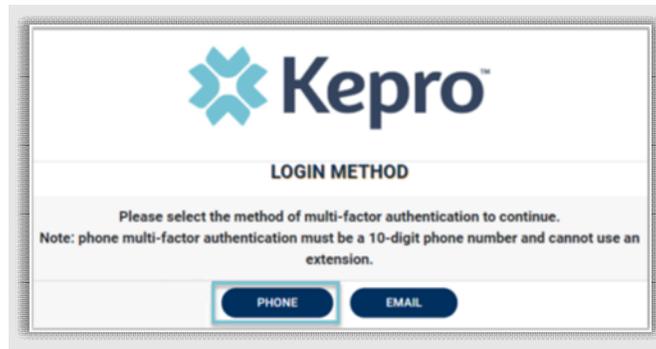


Select the best multi-factor authentication method for you. A phone registration will require a direct line with 10-digits; extensions are not supported.

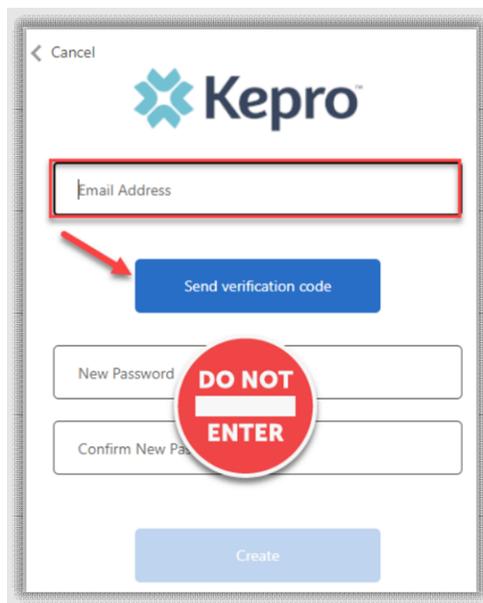
NOTE: When choosing an authentication method, you will be required to enter an email address for both options. Only choose the Email option if you do not have access to a direct phone line (landline or mobile).

Phone Verification

Click the PHONE button



Enter your work email address, then click Send Verification Code. A code will be sent to your email.



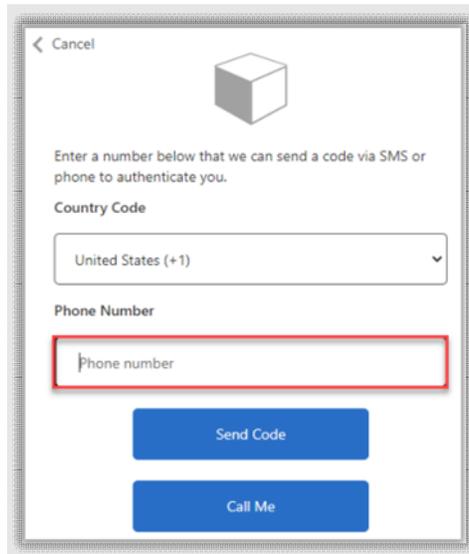
IMPORTANT: Do NOT enter anything in the Password section (this is not needed at this step).

Enter the verification code sent to the email address entered; then click Verify Code.

IMPORTANT: Do NOT enter anything in the Password section (this is not needed at this step).

After email verification is complete, enter a new password, confirm the password, and click Create. This is creating a password for the Multi-Factor Authentication Registration.

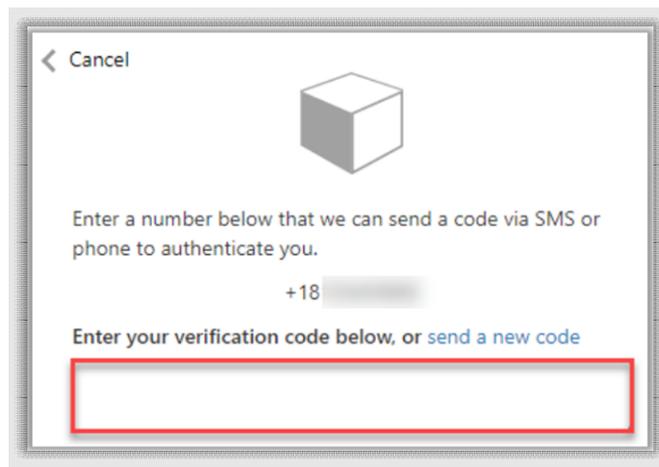
Enter your phone number and select Send Code or Call Me.



A screenshot of a mobile application interface for phone authentication. At the top left is a back arrow and the word "Cancel". In the center is a 3D cube icon. Below the icon is the text: "Enter a number below that we can send a code via SMS or phone to authenticate you." Underneath is a "Country Code" dropdown menu currently showing "United States (+1)". Below that is a "Phone Number" input field with a red border and the placeholder text "Phone number". At the bottom are two blue buttons: "Send Code" and "Call Me".

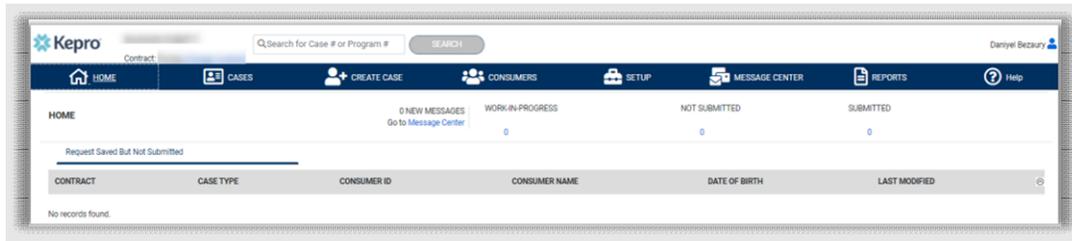
When phone call is selected, the user will receive a phone call on the registered phone number and will be prompted to press the # key to complete authentication.

For SMS text authentication, enter the verification code received.



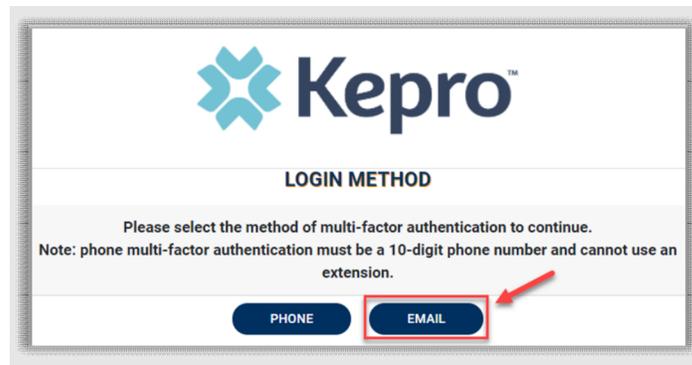
A screenshot of a mobile application interface for SMS verification. At the top left is a back arrow and the word "Cancel". In the center is a 3D cube icon. Below the icon is the text: "Enter a number below that we can send a code via SMS or phone to authenticate you." Underneath is a partially visible phone number starting with "+18" followed by a greyed-out area. Below that is the text: "Enter your verification code below, or send a new code" in blue. At the bottom is a large empty input field with a red border.

The system will automatically authenticate and display the home page.

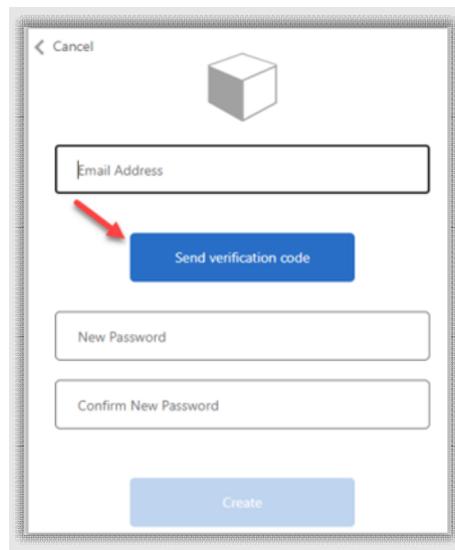


E-mail Verification

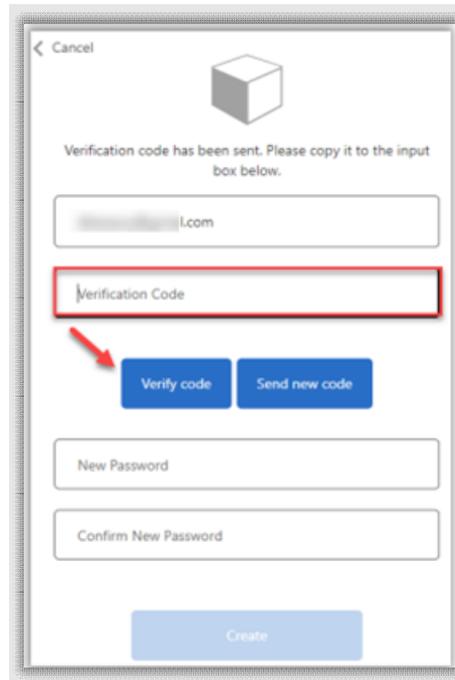
Click the EMAIL button



Enter your work email address, then click Send Verification Code. A code will be sent to your email.

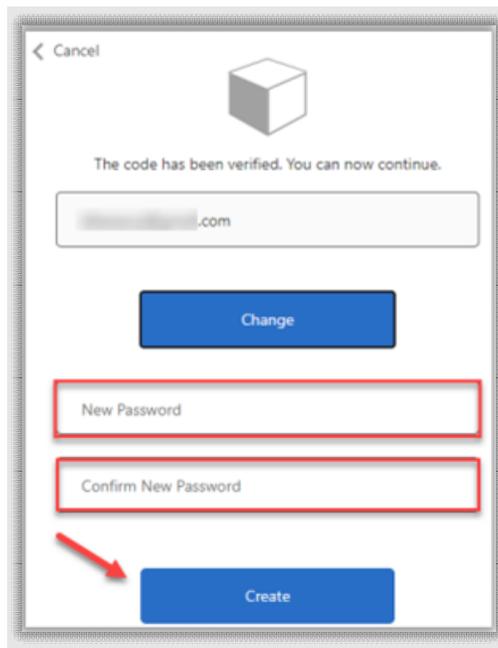


Enter the verification code sent to the email address entered; then click Verify Code.



A screenshot of a mobile application interface for account verification. At the top left is a back arrow and the word "Cancel". In the center is a 3D cube icon. Below the icon, the text reads "Verification code has been sent. Please copy it to the input box below." There are three input fields: the first contains a masked email address followed by ".com"; the second is labeled "Verification Code" and is highlighted with a red border; the third is labeled "New Password". Below the "Verification Code" field are two blue buttons: "Verify code" (with a red arrow pointing to it) and "Send new code". Below the "New Password" field is another input field labeled "Confirm New Password". At the bottom center is a light blue button labeled "Create".

Enter a new password, confirm the password, and click Create.



A screenshot of a mobile application interface for password creation. At the top left is a back arrow and the word "Cancel". In the center is a 3D cube icon. Below the icon, the text reads "The code has been verified. You can now continue." There are three input fields: the first contains a masked email address followed by ".com"; the second is labeled "New Password" and is highlighted with a red border; the third is labeled "Confirm New Password" and is also highlighted with a red border. Below the "Confirm New Password" field is a blue button labeled "Create" (with a red arrow pointing to it). Above the "New Password" field is a blue button labeled "Change".

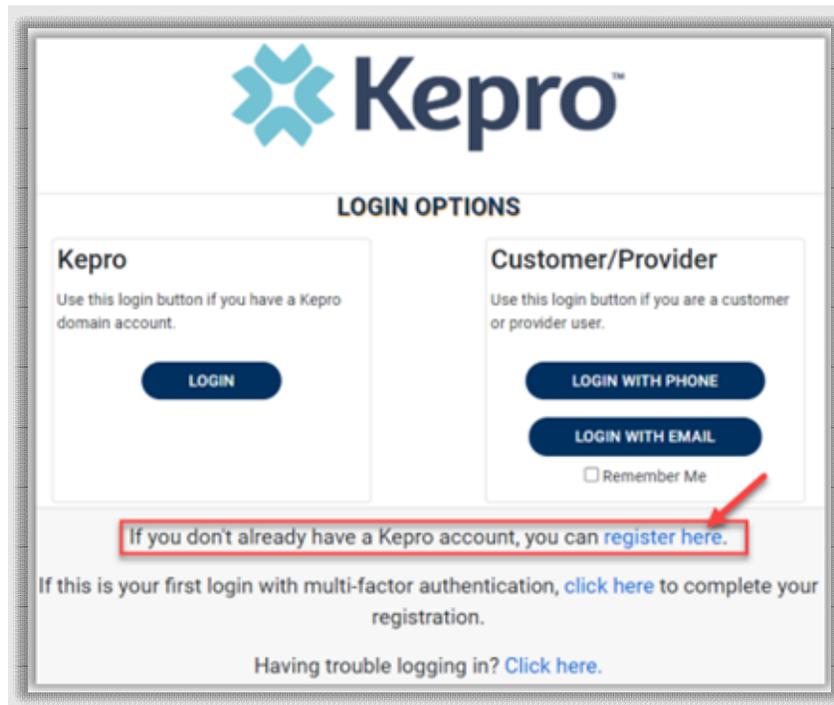
The system will automatically authenticate and display the home page.



New Provider Registration & MFA Registration

Use these instructions if you are a new provider and need to register for a Acentra Health account. The instructions below will guide you through registering for the Atrezzo Provider Portal and completing the Multi-Factor Authentication (MFA) Registration. Both registration and MFA registration are a one-time process.

From the login screen, click the link to register for a Acentra Health Account



Enter the NPI and Registration Code, then click Next. **Please Note:** If you are billing through an agency, the NPI number will be the agency's NPI number. The Registration Code can be obtained by calling Acentra Health Provider Relations at 1-866-521-0027, Option 3.

Kepro™

Create a New Account - Specify Your Organization

NPI *

PROVIDER REGISTRATION CODE *

LOGIN NEXT

Please refer to the registration section of the Atrezzo Connect Provider Portal End User Guide for more information on how to register. You can find this document on your payer-specific Kepro website.

Create a Username, and enter all required fields under Contact Information, then click next.

Create a New Account - Enter User Information

Organizational Information

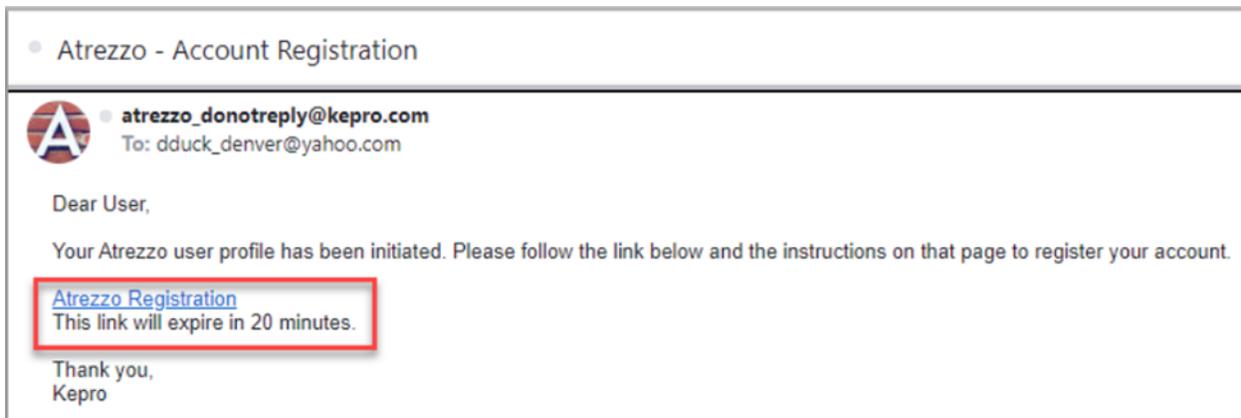
Please enter the required (*) fields

Account Information

USERNAME *

The image shows a registration form titled "Contact Information". It contains several input fields: "FIRST NAME", "LAST NAME", "ADDRESS 1", "ADDRESS 2", "CITY", "STATE" (a dropdown menu with "Select State" selected), "ZIP CODE", "EMAIL", "CONFIRM EMAIL", "PHONE", and "FAX". Red callout bubbles labeled B through G point to the following fields: B (FIRST NAME), C (LAST NAME), D (EMAIL), E (CONFIRM EMAIL), and F (FAX). At the bottom of the form are two buttons: "LOGIN" with a left arrow and "NEXT" with a right arrow. A red callout bubble labeled G points to the "NEXT" button.

A message will display confirming the Registration is complete. To complete the Multi-Factor Authentication registration, you must click the link in your within **20 minutes**.

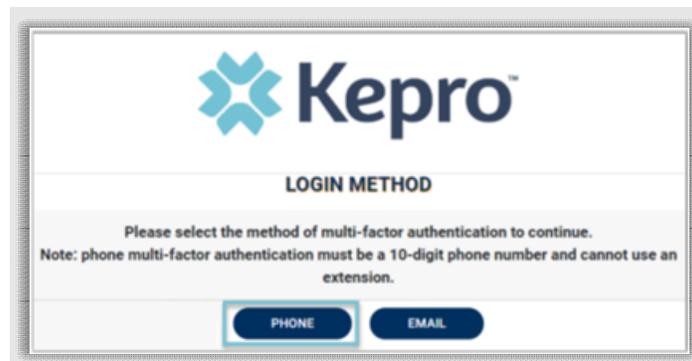


Select the best multi-factor authentication method for you. A phone registration will require a direct line with 10-digits; extensions are not supported.

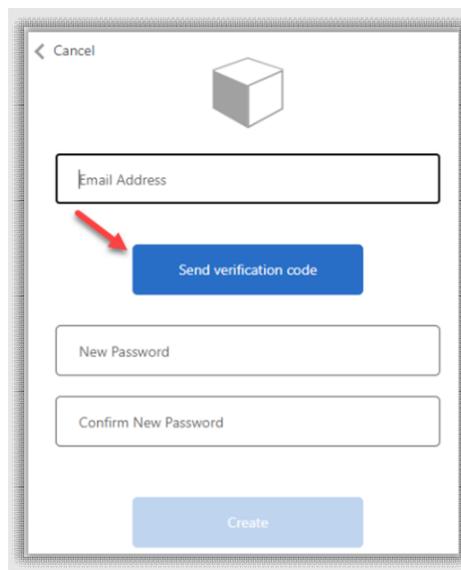
NOTE: When choosing an authentication method, you will be required to enter an email address for both options. Only choose the Email option if you do not have access to a direct phone line (landline or mobile).

Phone Verification

Click the PHONE button



Enter your work email address, then click Send Verification Code. A code will be sent to your email.



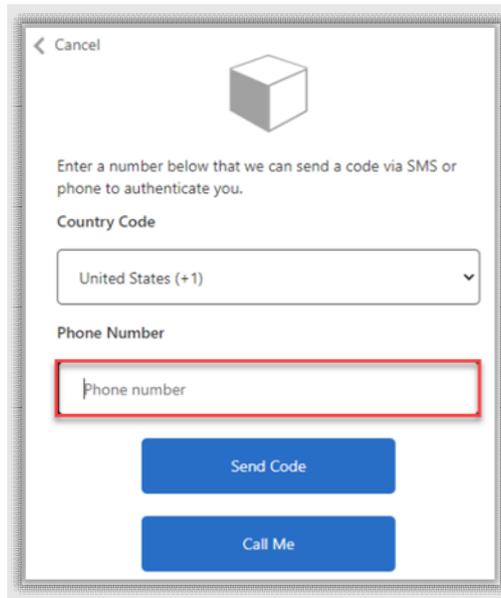
Enter the verification code sent to the email address entered; then click Verify Code.

A screenshot of a mobile application interface for account verification. At the top left is a back arrow and the word "Cancel". In the center is a 3D cube icon. Below the icon, the text reads: "Verification code has been sent. Please copy it to the input box below." There are three input fields: the first contains a partially obscured email address ending in ".com"; the second is labeled "Verification Code" and is highlighted with a red border; the third is labeled "New Password". Below the "Verification Code" field are two blue buttons: "Verify code" (with a red arrow pointing to it) and "Send new code". Below the "New Password" field is a "Confirm New Password" field. At the bottom is a light blue "Create" button.

Enter a new password, confirm the password, and click Create.

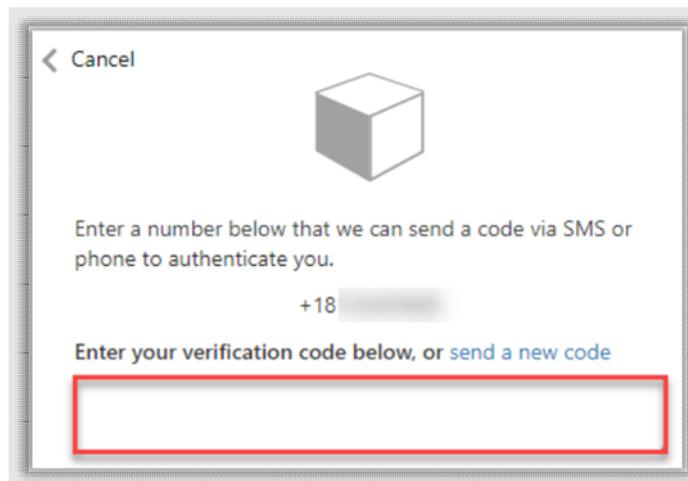
A screenshot of a mobile application interface for password creation. At the top left is a back arrow and the word "Cancel". In the center is a 3D cube icon. Below the icon, the text reads: "The code has been verified. You can now continue." There are three input fields: the first contains a partially obscured email address ending in ".com"; the second is labeled "New Password" and is highlighted with a red border; the third is labeled "Confirm New Password" and is also highlighted with a red border. Below the "Confirm New Password" field is a blue "Create" button, which is pointed to by a red arrow.

Enter your phone number and select Send Code or Call Me.

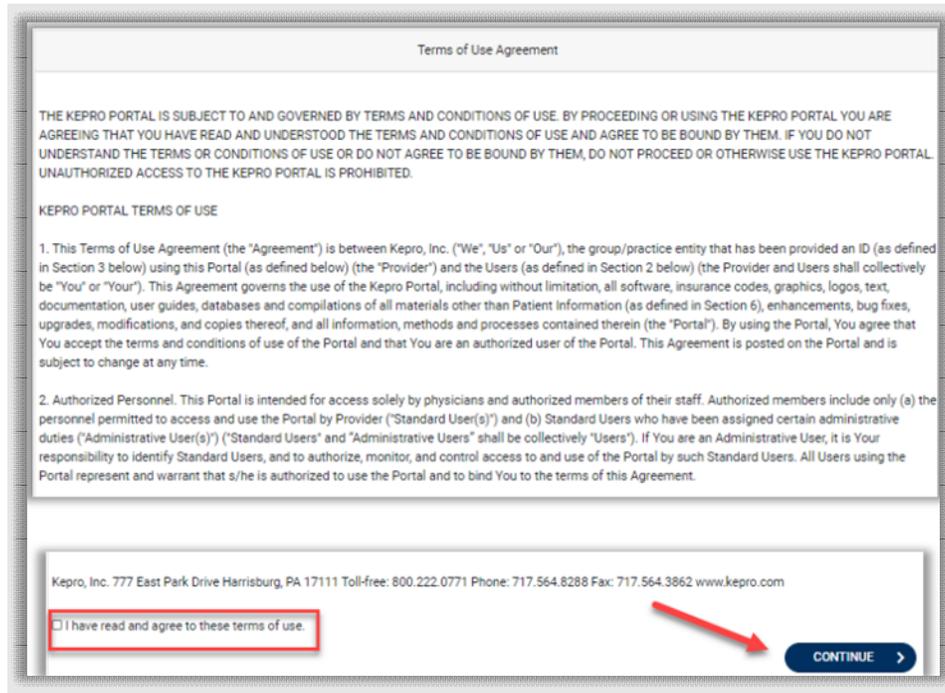


When phone call is selected, the user will receive a phone call on the registered phone number and will be prompted to press the # key to complete authentication.

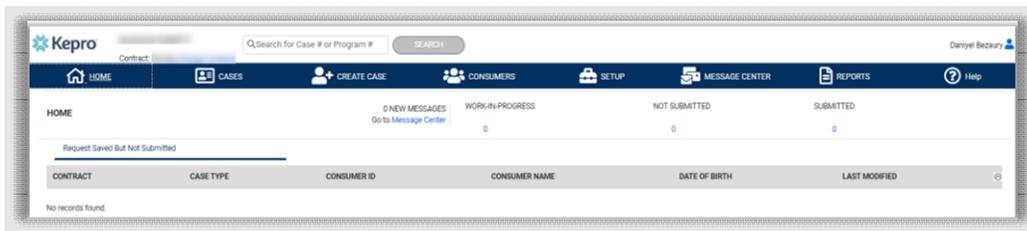
For SMS text authentication, enter the verification code received.



As a new user, you will need to read and agree to the Terms of Use.

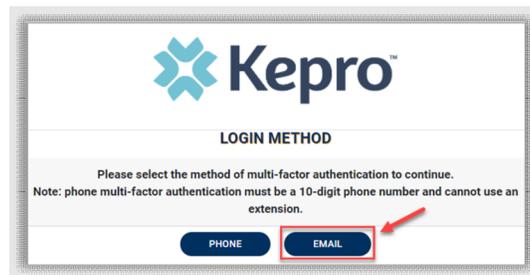


The system will automatically authenticate and display the home page.

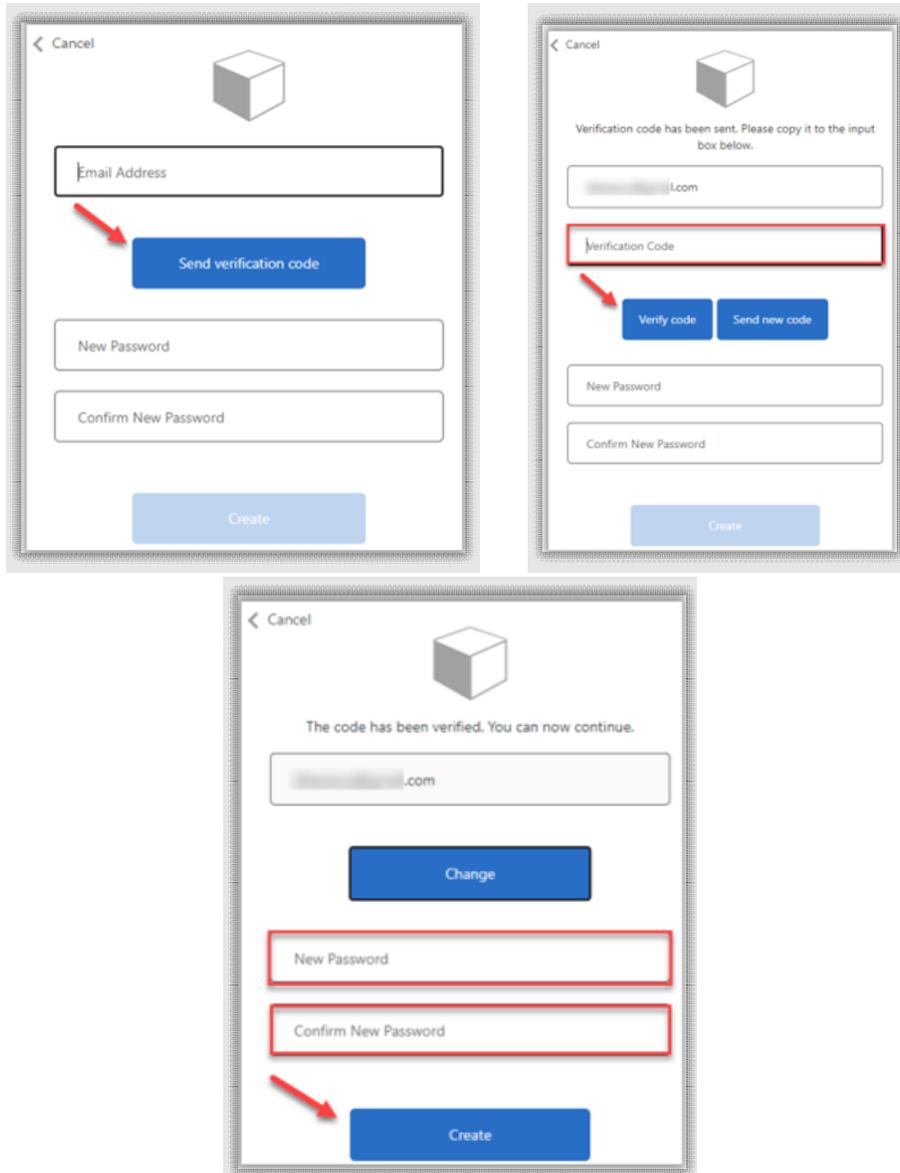


E-mail Verification

Click the EMAIL button



Enter your work email address, then click Send Verification Code. A code will be sent to your email. Enter the verification code sent to the email address entered; then click Verify Code.



Enter a new password, confirm the password, and click Create.

As a new user, you will need to read and agree to the Terms of Use.

Terms of Use Agreement

THE KEPRO PORTAL IS SUBJECT TO AND GOVERNED BY TERMS AND CONDITIONS OF USE. BY PROCEEDING OR USING THE KEPRO PORTAL YOU ARE AGREEING THAT YOU HAVE READ AND UNDERSTOOD THE TERMS AND CONDITIONS OF USE AND AGREE TO BE BOUND BY THEM. IF YOU DO NOT UNDERSTAND THE TERMS OR CONDITIONS OF USE OR DO NOT AGREE TO BE BOUND BY THEM, DO NOT PROCEED OR OTHERWISE USE THE KEPRO PORTAL. UNAUTHORIZED ACCESS TO THE KEPRO PORTAL IS PROHIBITED.

KEPRO PORTAL TERMS OF USE

1. This Terms of Use Agreement (the "Agreement") is between Kepro, Inc. ("We", "Us" or "Our"), the group/practice entity that has been provided an ID (as defined in Section 3 below) using this Portal (as defined below) (the "Provider") and the Users (as defined in Section 2 below) (the Provider and Users shall collectively be "You" or "Your"). This Agreement governs the use of the Kepro Portal, including without limitation, all software, insurance codes, graphics, logos, text, documentation, user guides, databases and compilations of all materials other than Patient Information (as defined in Section 6), enhancements, bug fixes, upgrades, modifications, and copies thereof, and all information, methods and processes contained therein (the "Portal"). By using the Portal, You agree that You accept the terms and conditions of use of the Portal and that You are an authorized user of the Portal. This Agreement is posted on the Portal and is subject to change at any time.

2. Authorized Personnel. This Portal is intended for access solely by physicians and authorized members of their staff. Authorized members include only (a) the personnel permitted to access and use the Portal by Provider ("Standard User(s)") and (b) Standard Users who have been assigned certain administrative duties ("Administrative User(s)") ("Standard Users" and "Administrative Users" shall be collectively "Users"). If You are an Administrative User, it is Your responsibility to identify Standard Users, and to authorize, monitor, and control access to and use of the Portal by such Standard Users. All Users using the Portal represent and warrant that s/he is authorized to use the Portal and to bind You to the terms of this Agreement.

Kepro, Inc. 777 East Park Drive Harrisburg, PA 17111 Toll-free: 800.222.0771 Phone: 717.564.8288 Fax: 717.564.3862 www.kepro.com

I have read and agree to these terms of use.

CONTINUE >

The system will automatically authenticate and display the home page.

Kepto

Contract

Search for Case # or Program #

SEARCH

Daniyel Bezaury

HOME CASES CREATE CASE CONSUMERS SETUP MESSAGE CENTER REPORTS Help

HOME

0 NEW MESSAGES
Go to Message Center

WORK-IN-PROGRESS
0

NOT SUBMITTED
0

SUBMITTED
0

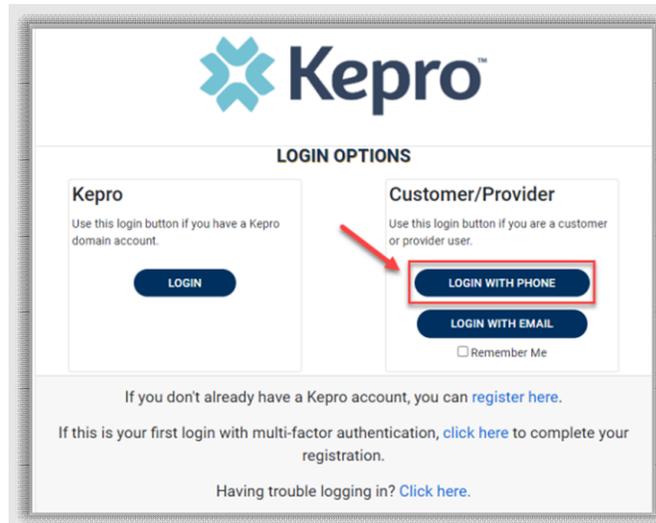
Request Saved But Not Submitted

| CONTRACT | CASE TYPE | CONSUMER ID | CONSUMER NAME | DATE OF BIRTH | LAST MODIFIED |
|-------------------|-----------|-------------|---------------|---------------|---------------|
| No records found. | | | | | |

Phone Login

Use these instructions if you have already registered MFA with a direct phone number and want to login via SMS text or voice call.

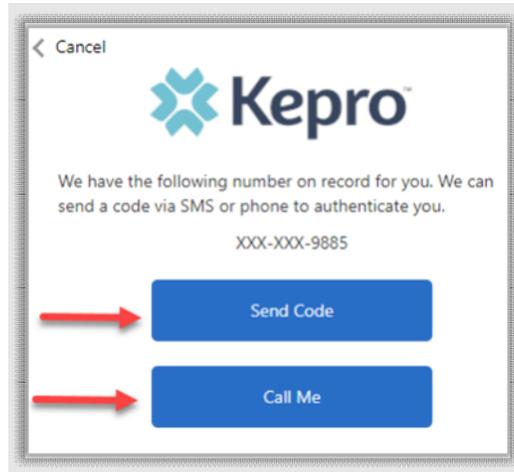
From the login page, click Login With Phone



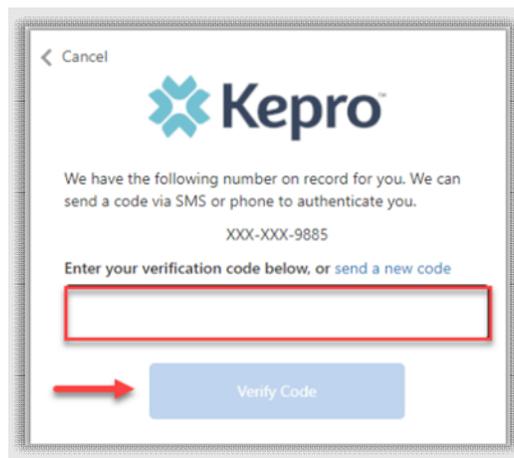
Enter the email address and password created during the registration process. Click Sign in.



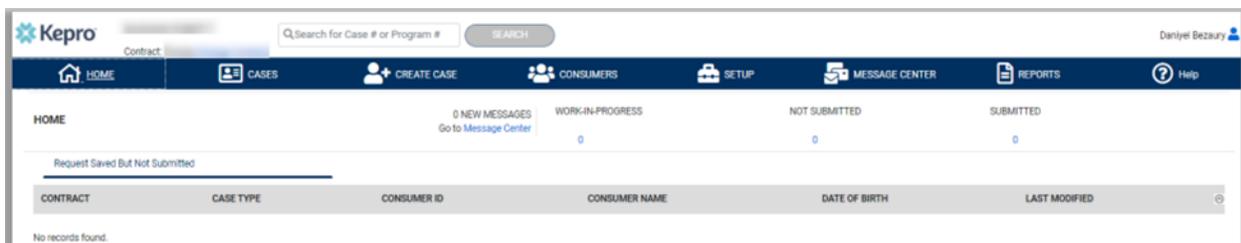
Confirm the phone number on file to receive a verification code. Select Send Code for an SMS text verification code or Call Me for a voice call prompting to press the # to complete verification.



If Send Code option is selected, enter code received via text and click Verify Code.



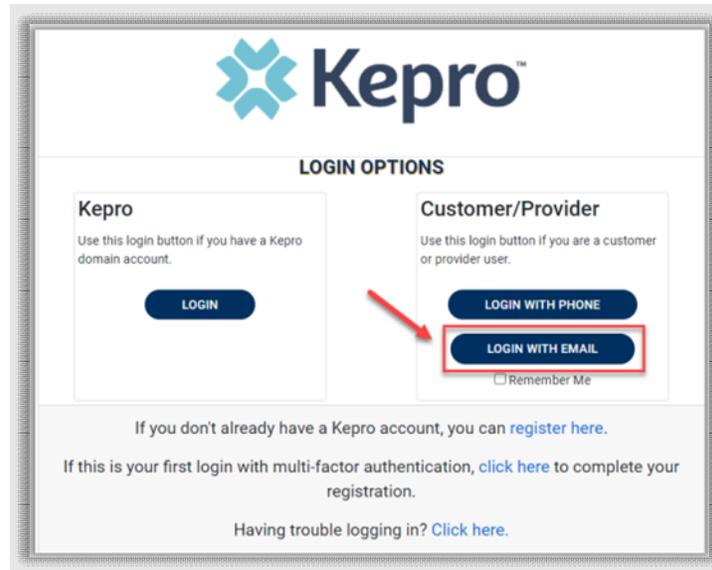
Login will complete and the home screen will display.



E-mail Login

Use these instructions if you have already registered MFA and want to login using your email address. Use this option only if you do not have access to a direct phone line.

From the login page, click Login with Email

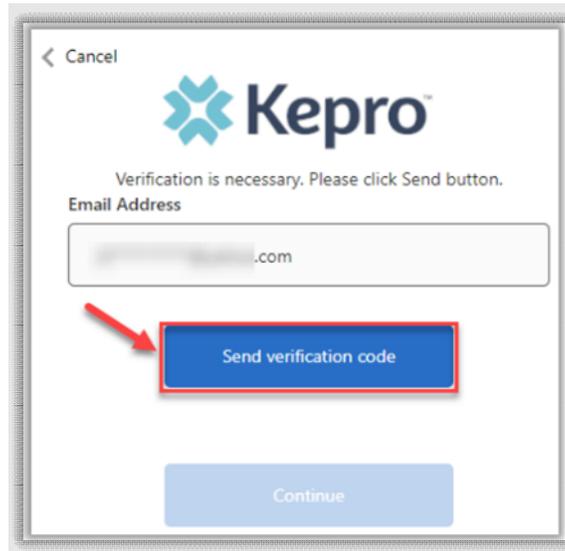


Enter the email address and password created during the registration process. Click Sign In.

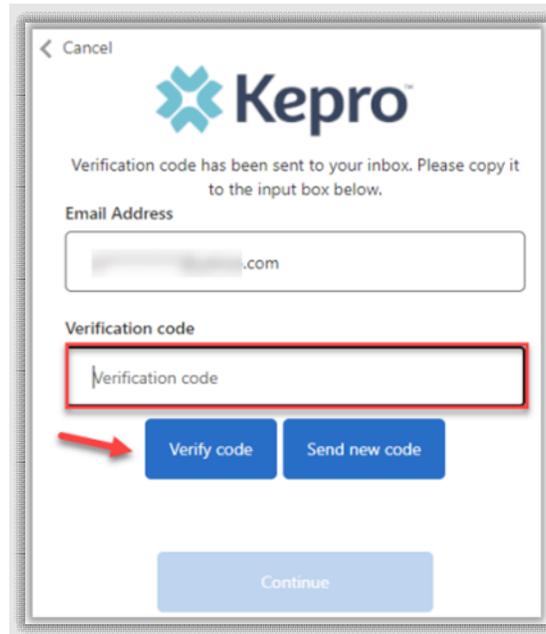


The email address will prepopulate from the sign in, click Send Verification Code.

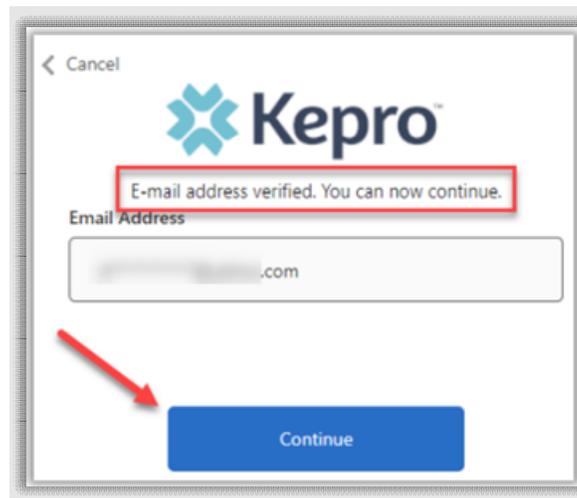
NOTE: The verification code will expire within 30 seconds for proper login. Make sure you have access to the email address at the time you are selecting Send Verification Code to avoid having to repeat the process.



Enter the verification code sent to the email address, then click Verify Code.



A message will appear confirming verification. Click Continue.



Login will complete and the home screen will display.

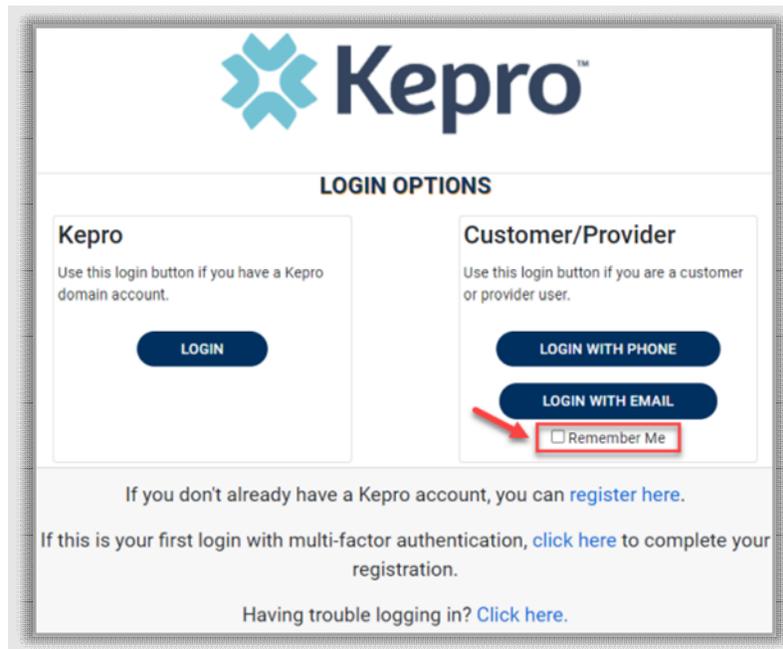


Remember Me Functionality

Use these instructions to enable your computer to remember your login credentials for four (4) hours. You should **NOT** use this option if you use a shared device.

When the Remember Me button is checked on the login screen, external users will be able to login without entering Atrezzo credentials or MFA for four (4) hours.

To use this feature, check Remember Me box then click Login with phone or Login with Email.



For the next four (4) hours, when accessing Atrezzo, you will click Login with Phone or Login with Email and bypass the login credentials and MFA steps. After four (4) hours, you will need to login with your credentials and MFA when prompted. You must use the same login option (Login

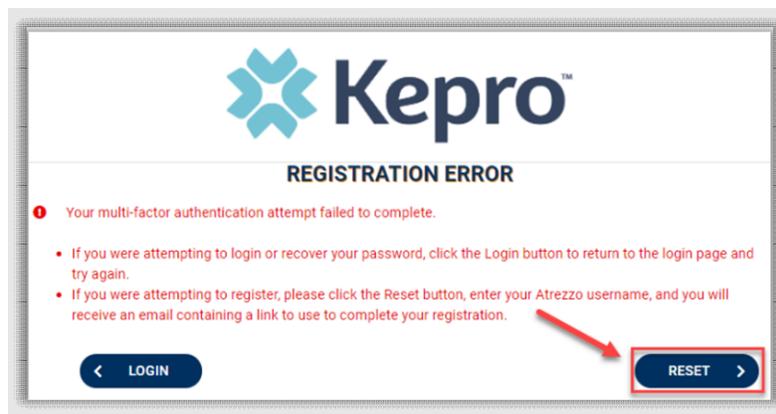
with Phone or Login with Email) for the Remember me functionality to remember the credentials. If you select a different login option, you will be required to enter MFA credentials.

To turn off this feature, uncheck the Remember Me box before clicking Login with Phone or Login with Email, and you will be prompted to enter login credentials and MFA at the next sign-on.

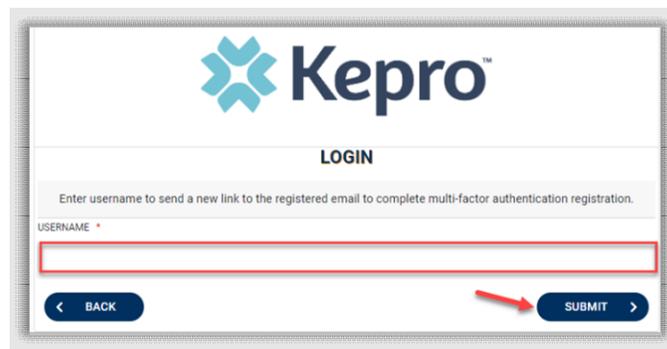
NOTE: This feature will only work if the browser is configured to “continue where you left off” by reopening tabs on startup. The Remember Me functionality will work as long as the browser remains open, but if the browser is closed, the Remember Me functionality will not work without following the below instructions.

Registration Error Message

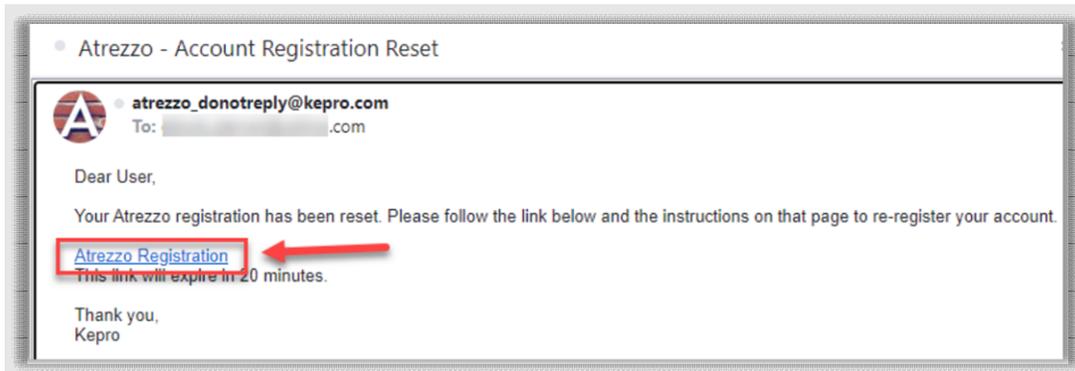
If a Registration Error message is received while attempting to register, click Reset.



Enter your username and click Submit. An email will be sent to the registered email address to complete the registration process.

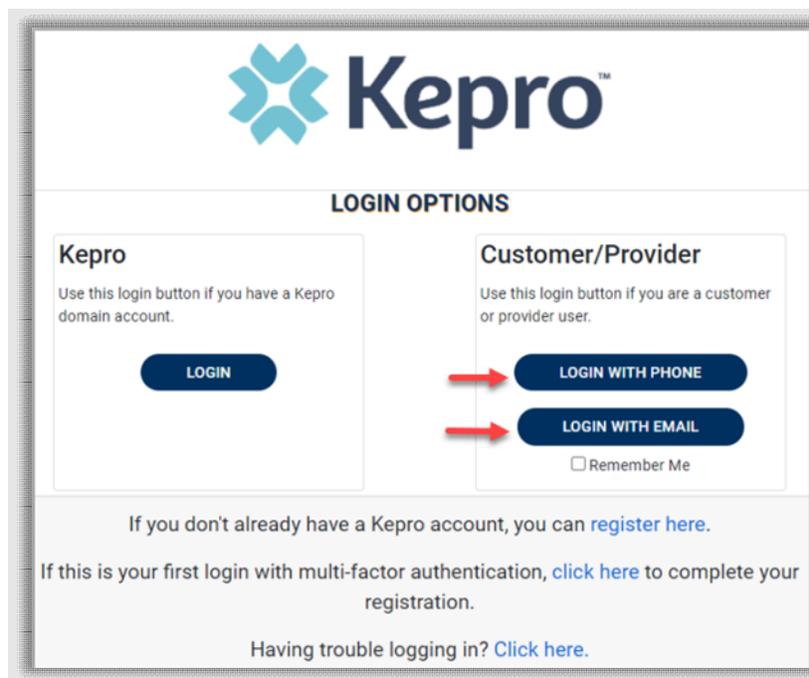


Click the link in the email. This will complete the registration process.

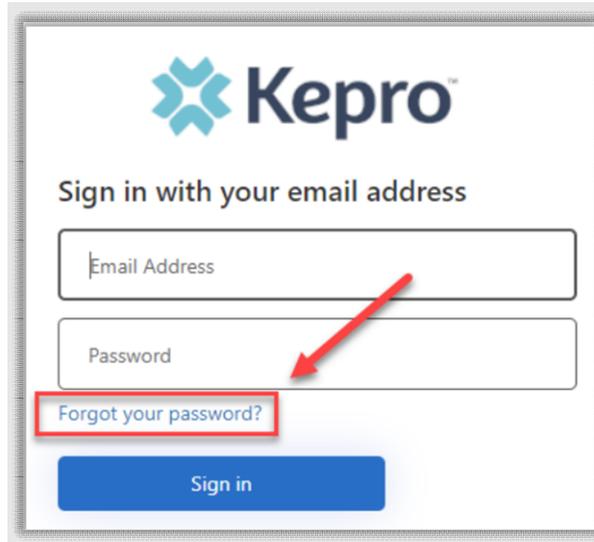


Forgot or Reset Password

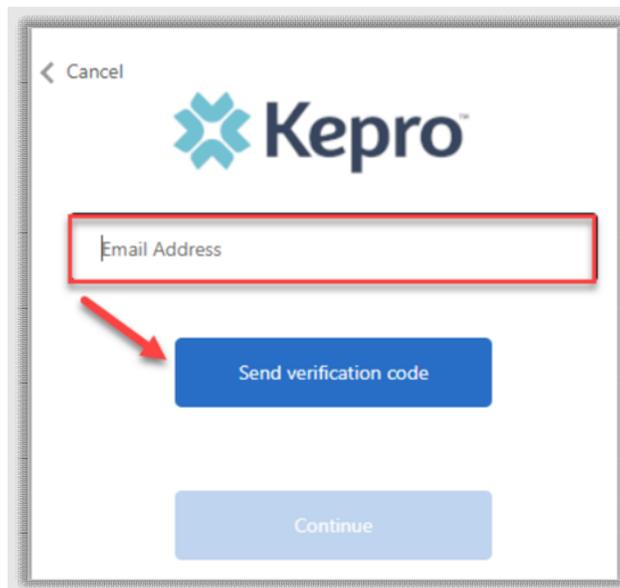
Click your usual login method. Login with Phone or Login with Email under the Customer/Provider heading on the right-hand side of the login page.



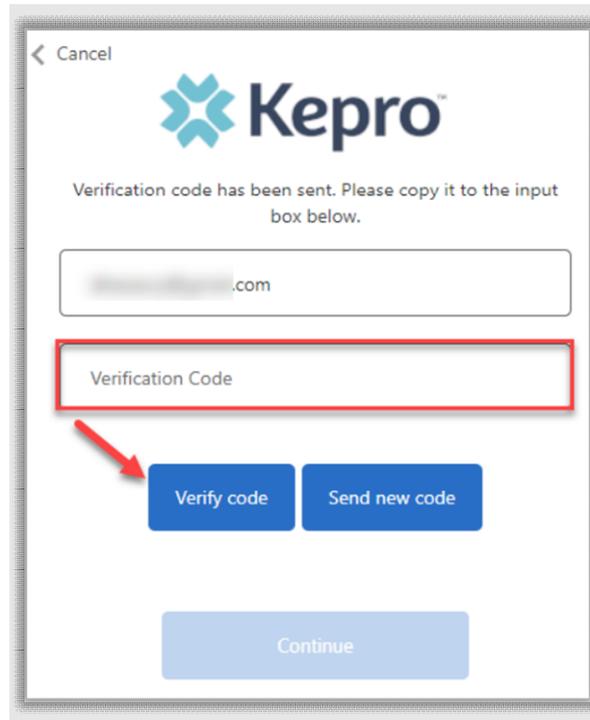
On the next screen, select the "Forgot your password?" link.



Enter in your email address and click the "Send verification code" button.



Enter the 6-digit code received via email and click the “Verify code” button.

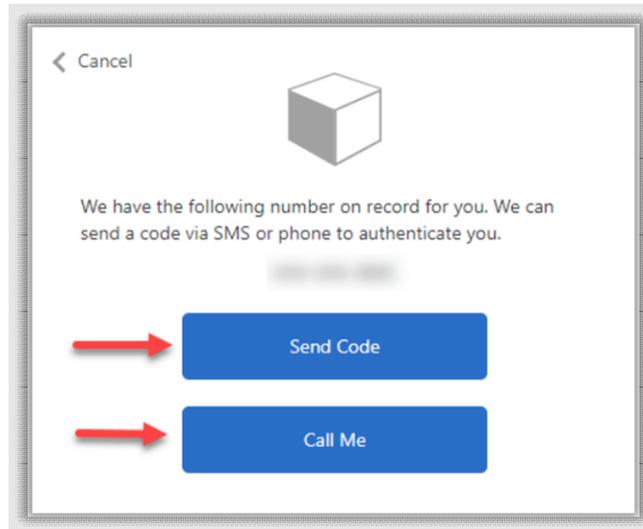


Click the “Continue” button.

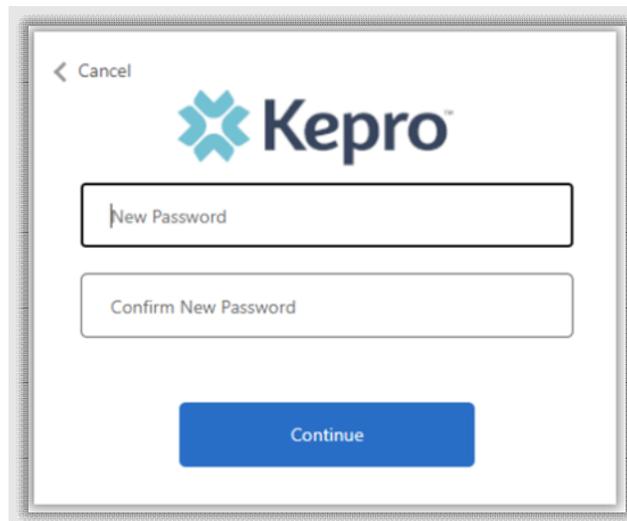


NOTE: This step will only appear for users who registered a phone number during MFA Registration. Email only users will not be prompted for a phone number and will be prompted to change their password after email verification is complete.

Phone users will be prompted to select Send Code for a SMS text or Call Me for voice verification. If Call Me is selected, you will be prompted to press # on the keypad for verification. If Send Code is selected, you will receive a 6-digit code via SMS text.



Once verification is complete, enter a new password and confirm the password. Click the "Continue" button. The home page will display once the reset password process is completed.

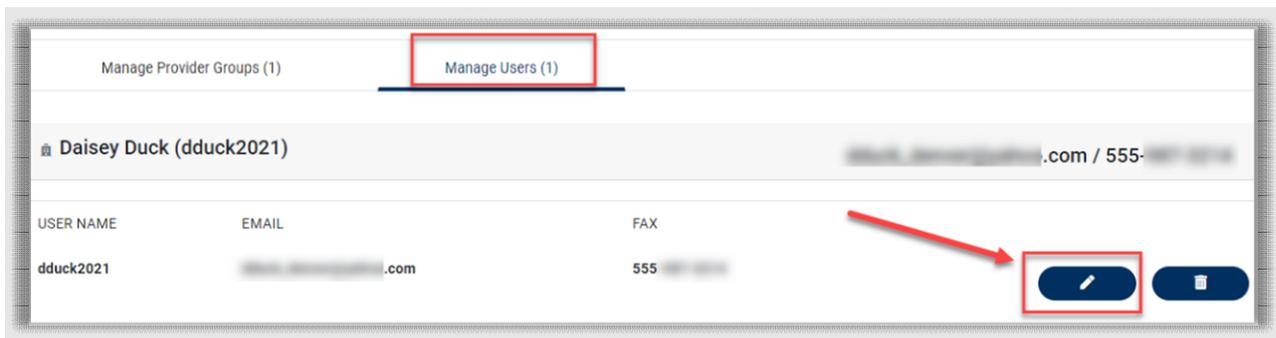


Provider Administrator Reset Registration

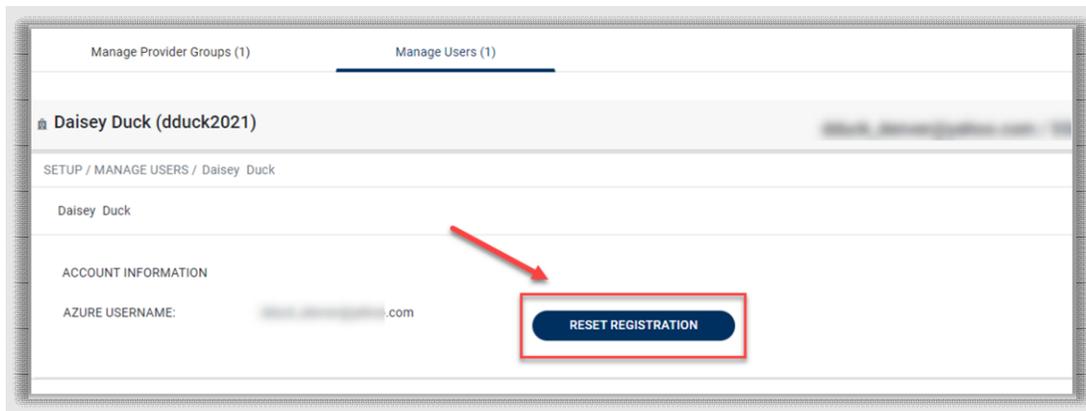
As a provider admin, you will have the ability to reset MFA registration for any users you manage. From the home screen, click Setup, then click Manager Users, and expand section for appropriate user.



Click the pencil icon



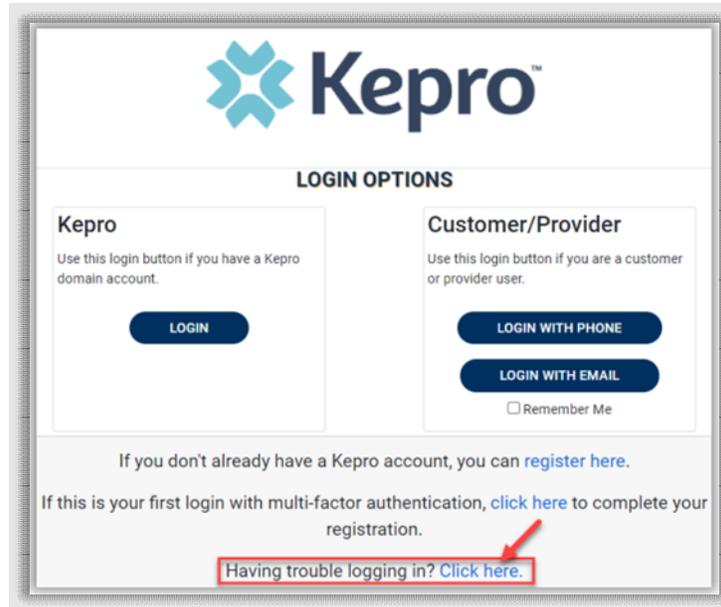
Once open, click Reset Registration. This will reset the users MFA registration. They will need to re-register their MFA login information either by clicking the link on the login page, or following the link sent to their email.



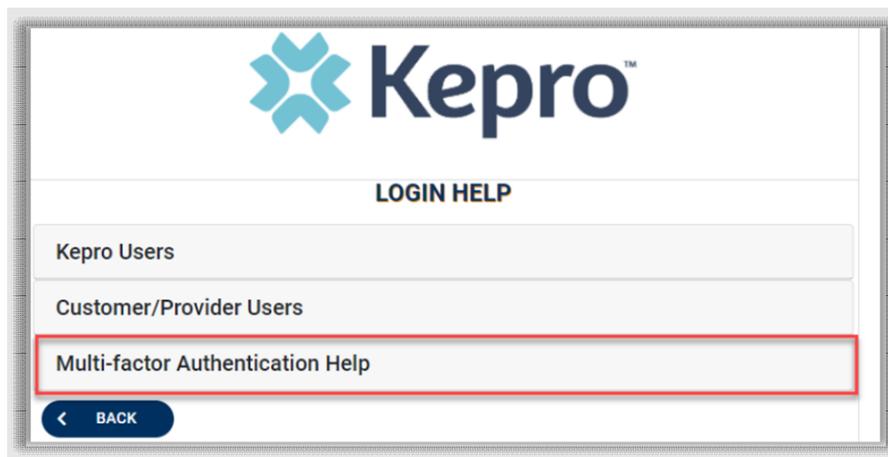
Having Trouble Logging In?

If you began the multi-factor registration process, verified your email, created a password, but did not complete the process, you will need to [Click here](#) to send a link to the registered email to complete the multi-factor authentication registration.

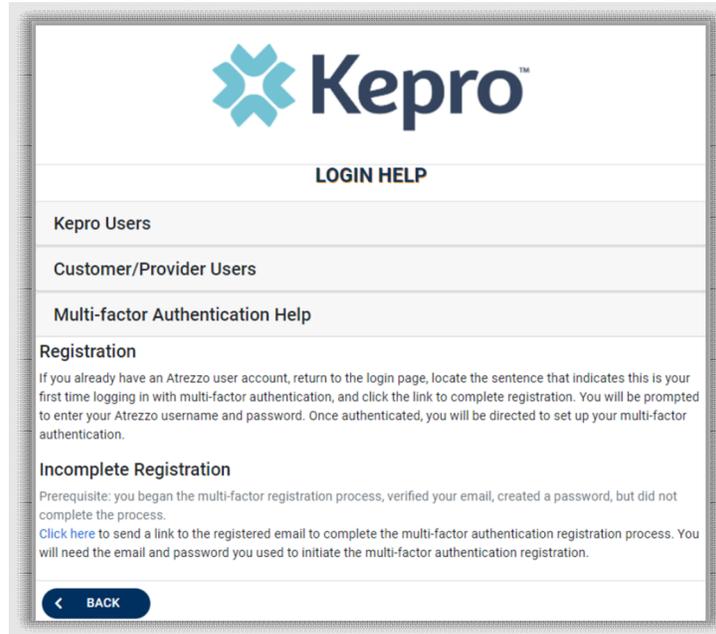
This link is also available in the portal, by clicking the link at the bottom of the page.



Click Multi-Factor Authentication Help



Follow the prompts for the assistance needed.

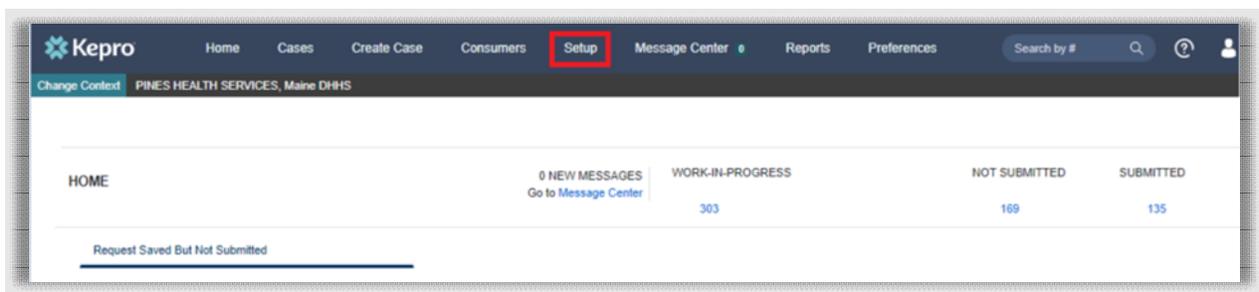


Adding and Deleting Users

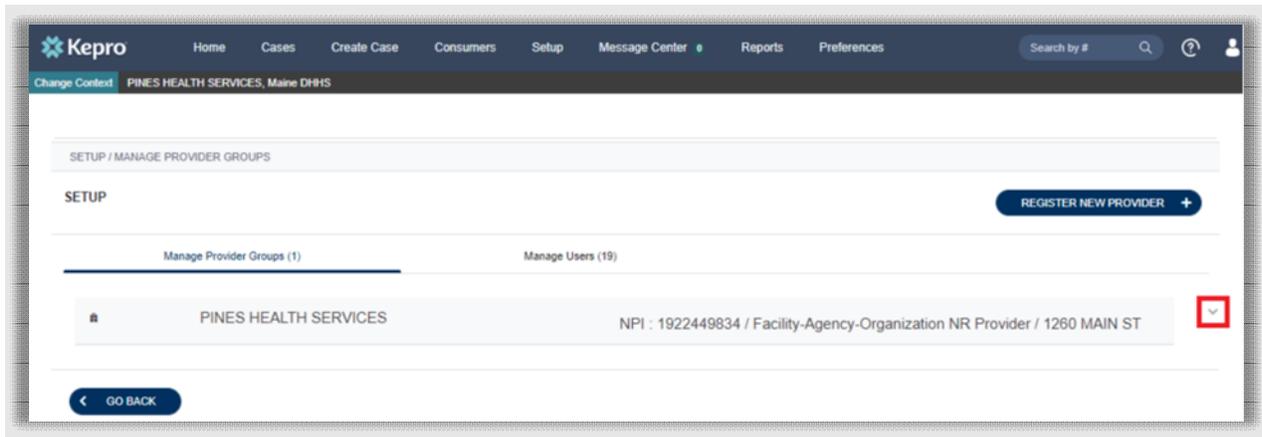
Organization users with a Group Admin or Admin role have the ability to add and remove user accounts and change passwords.

Adding Additional Users

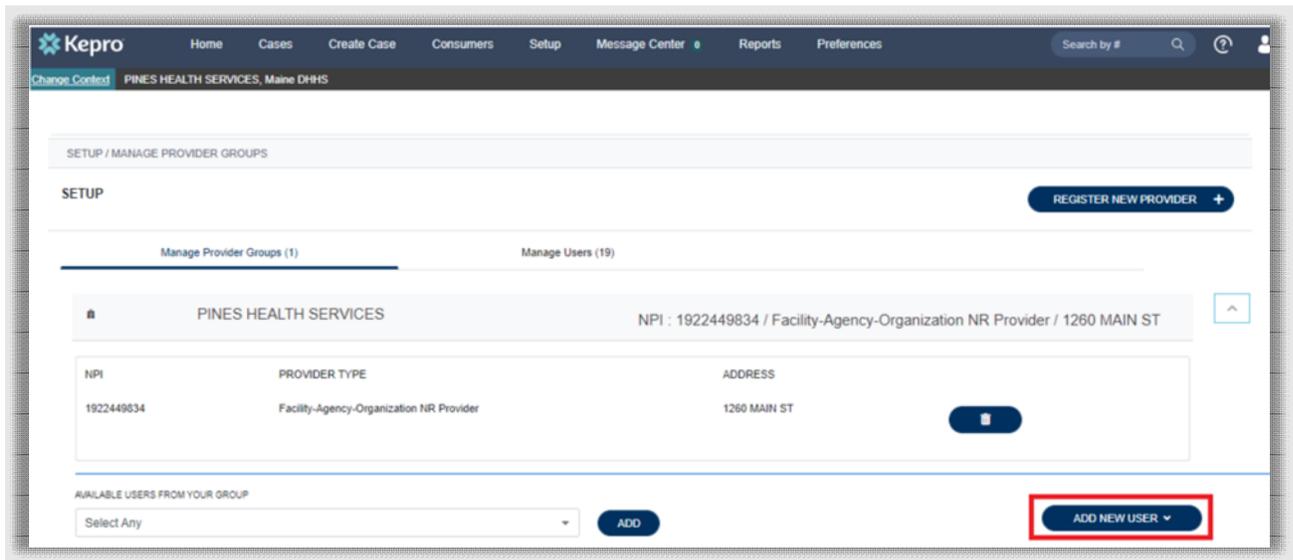
Once you login to Atrezzo, you will be directed to the home screen of the Provider Portal. From the home screen, you will work in the Setup option located at the top of the navigation page. To add and manage users, click Setup. This feature is only available to Provider Group Administrators and Provider Administrators.



You will see that your provider group will display. In this section of Manage Provider Groups, you can add additional users if needed for your location. To add additional users, you will expand the provider group listed by clicking on the arrow.



Next click Add New User.



As the provider group administrator, you will need to create the username. If the username is available, you will be notified right away.

ACCOUNT INFORMATION

USER NAME *

maineaso

✓ This Username is available!

If you select a username that is already in use, you will be notified the username is unavailable.

ACCOUNT INFORMATION

USER NAME *

provttest2

❗ This Username is unavailable!

You will now complete the required fields for the user. Required fields are indicated by a red asterisk and then click create.

ACCOUNT INFORMATION

USER NAME *
maineaso
✓ This Username is available!

CONTACT INFORMATION

FIRST NAME *
Test

LAST NAME *
User

EMAIL *
testuser@testemail.com

CONFIRM EMAIL *
testuser@testemail.com

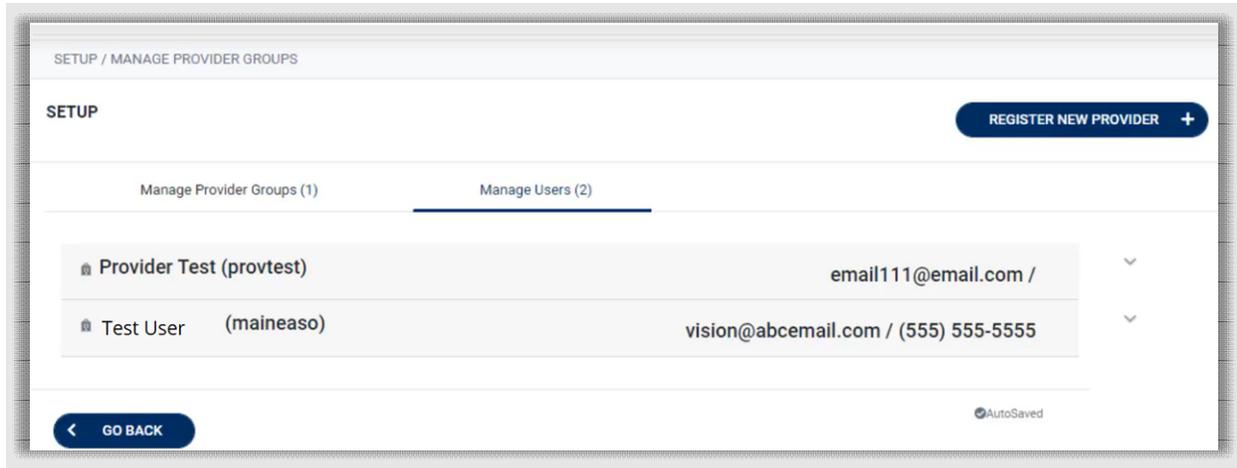
ADDRESS LINE 1
ADDRESS LINE 2
CITY
STATE/PROVINCE
Select One

POSTAL CODE
PHONE
FAX *
(555) 555-5555

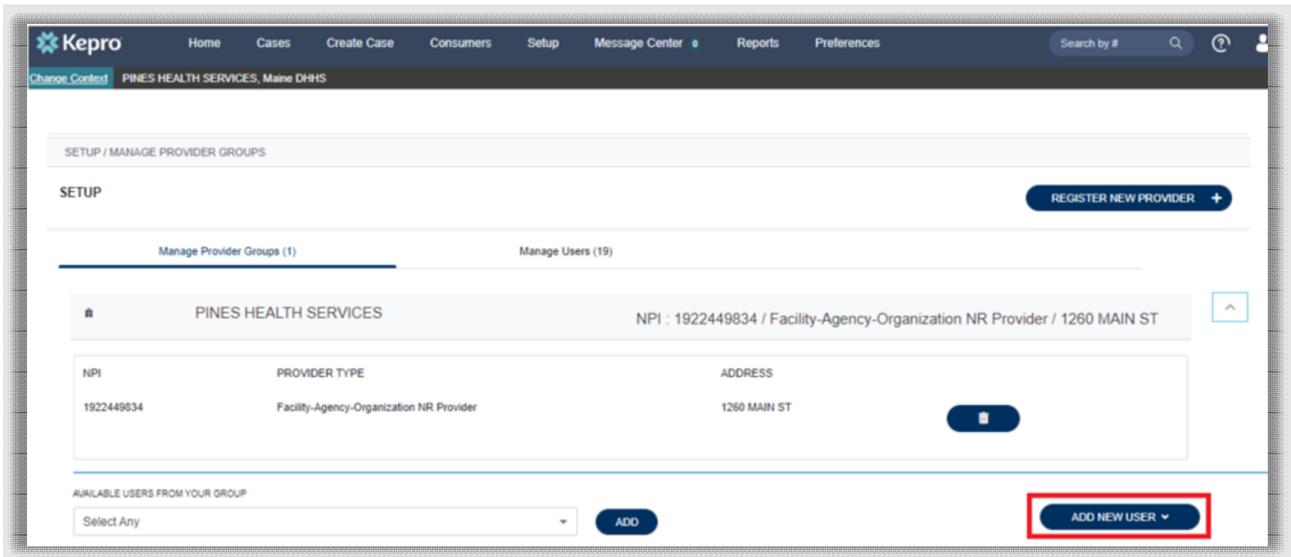
Note: Providers in receipt of Faxed Determination Letters: Official Communication of service authorization will be sent to the fax number entered above.

CREATE >

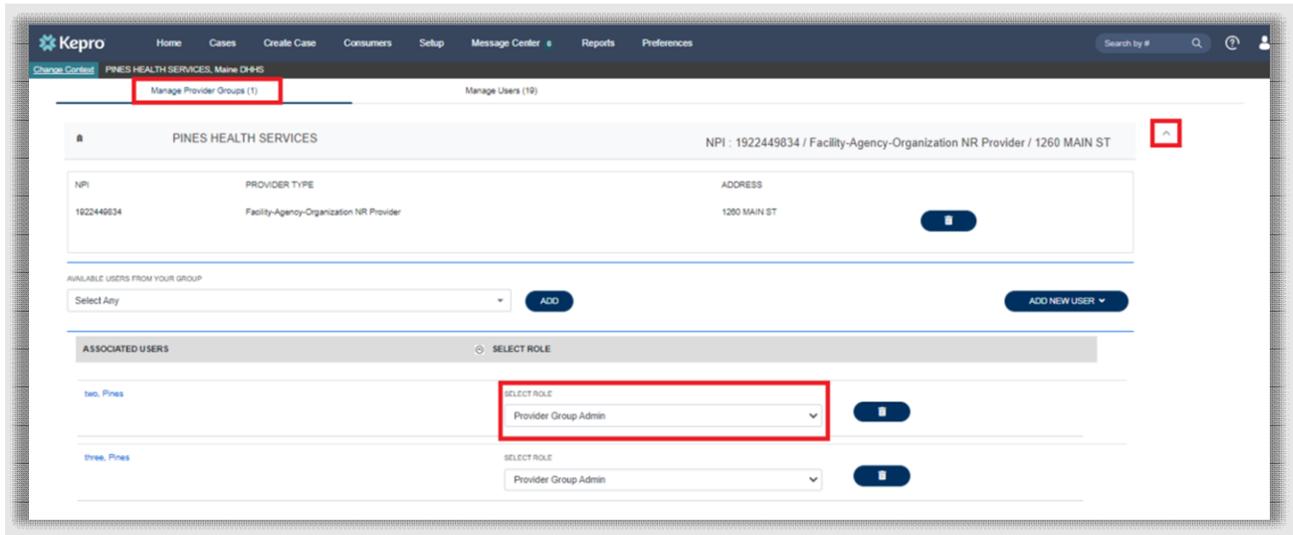
The user will be added and will display under the Manage Users along with all other users that have been setup.



To add additional users, navigate back to the manage provider groups, expand the group by clicking on the arrow and click add new users.



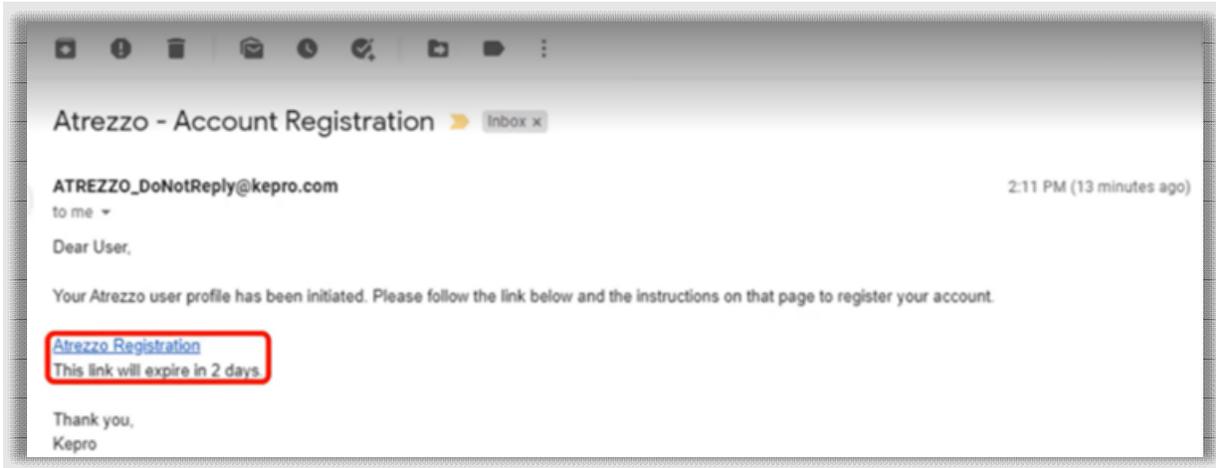
Newly added users will default to the user role of staff account. To change the user role, navigate back to Manage Provider Groups and expand the provider group. Users will be listed at the bottom.



There are five different types of Atrazzo accounts you can choose from.

1. **Provider Staff Account** – users with this type of user role can add authorization requests, view determination letters, obtain status updates and send and receive messages.
2. **Provider Group Admin** – users with this type of user role can perform the same functions as a provider staff account as well as add and manage users and add and manage additional providers for the entire provider group.
3. **Provider Admin** – users with this type of user role can perform all the same functions as the provider group admin but only for the one provider that the user is associated with.
4. **Provider Group Admin +Reports** – users with this type of user role can perform the same functions as a provider group admin. In addition, users will have the Reports tab in Atrazzo where you can view reports such as the Daily Authorization Report.
5. **Provider Admin +Reports** – users with this type of user role can perform the same functions as a provider admin. In addition, users will have the Reports tab in Atrazzo where you can view reports such as the Daily Authorization report.

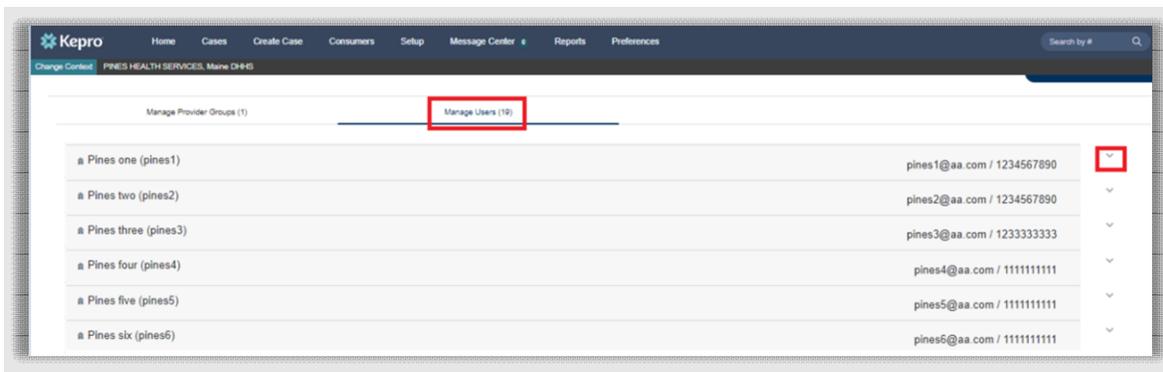
Once all users have been added to the provider portal account, they will receive an email to complete the MFA Registration process.



The process of adding and managing users will only need to be completed for new users that need to be added to the provider account.

Managing User Accounts

To manage a specific user, click on the Manage Users tab and then click on the arrow for the user you wish to manage.

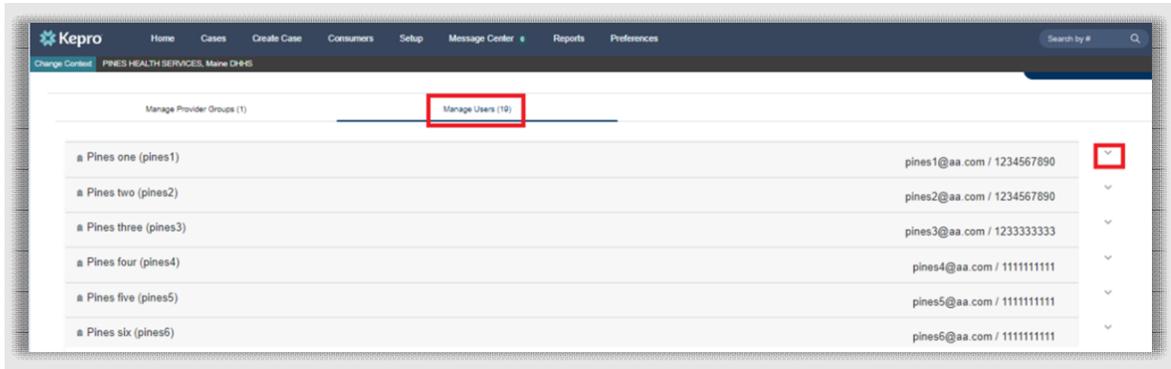


Here you will have the ability to update the email address or fax number if it has changed. Click on the pencil icon to edit the user.

Resetting a User's Multi-Factor Authentication

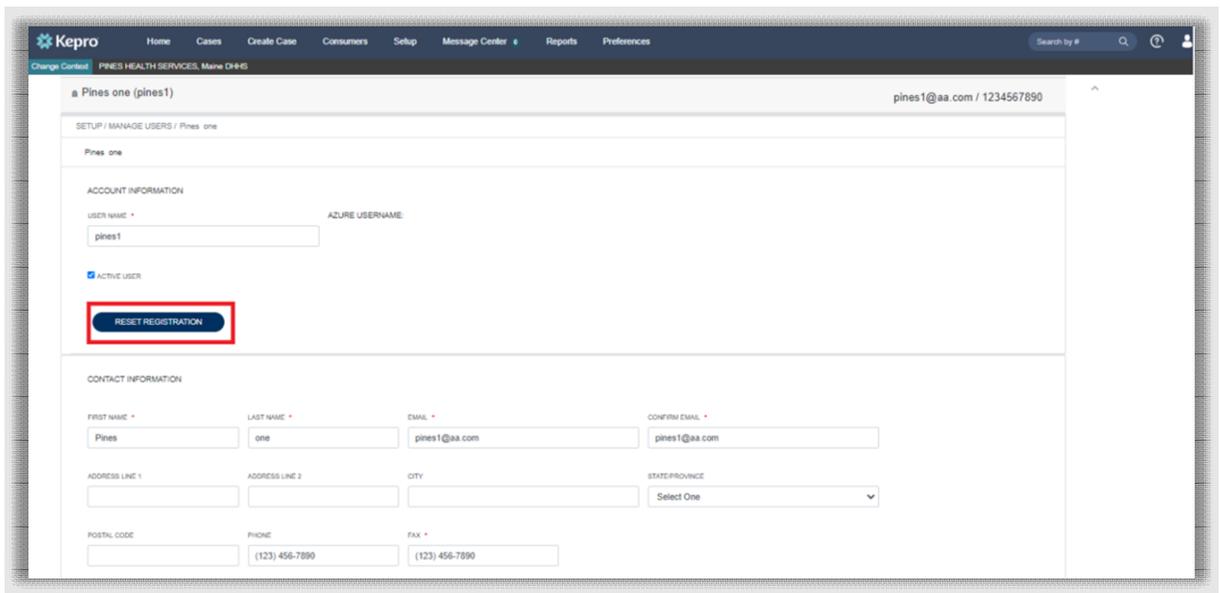
If the user needs assistance with resetting their multi-factor authentication (MFA) this would be done if their email address or phone number has changed, or if the user did not activate their MFA within two (2) days.

Click on the Manage Users tab and then click on the arrow for the user you need to reset the MFA for.

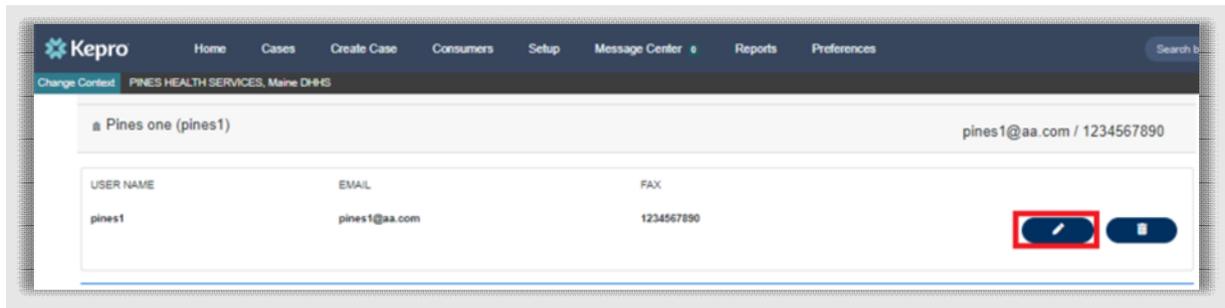
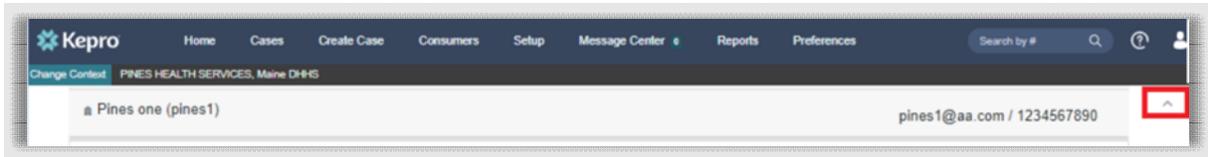


You will click reset registration and it will remove all associations with the MFA account. Click Ok to verify. The user will receive an email that their credentials have been reset and they will be provided with a link to complete the registration process. They must complete the MFA registration within two (2) days.

Under contact information, additional information can be added or updated as needed. You will notice there is not a save button on this page. When you add information to the box and then click out of it, that information will automatically be saved.

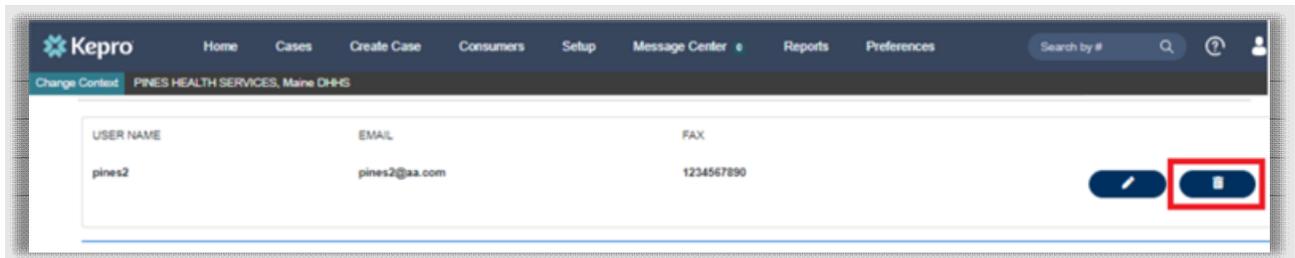


Once you have completed all the changes for that account, you can close the section by clicking on the arrow.

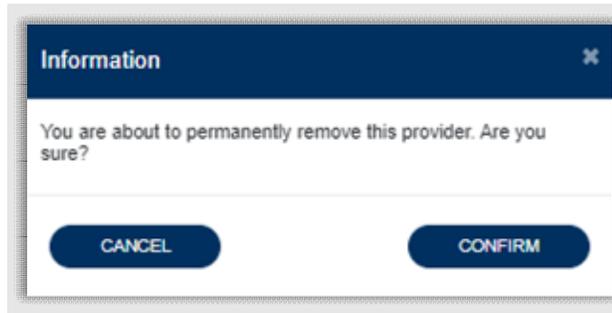


Deactivating a User's Account

When a user is no longer active or no longer needs access to the provider account, the provider group administrator can remove them. From the Manager Users tab, expand the user you wish to deactivate by clicking on the arrow and then click the trash can icon.



You will receive an informational message to confirm you are about to permanently remove the users, are you sure? You would select cancel if no and confirm if yes. If you confirm deactivation, the user will no longer appear under the Manage Users section.

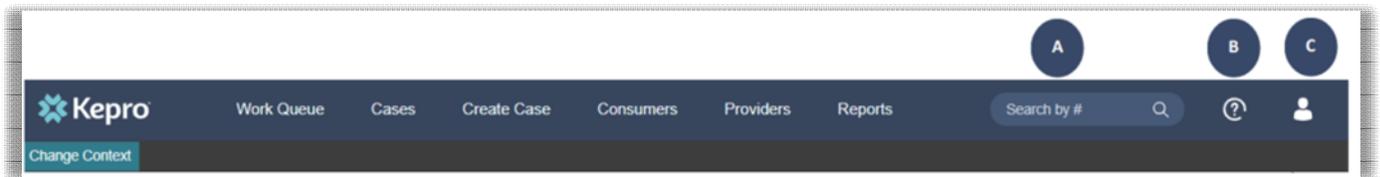


System Navigation

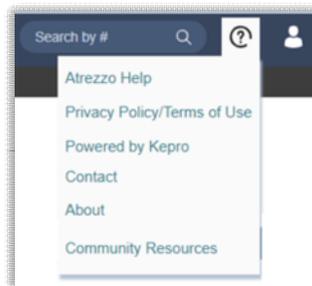
This section will highlight features found on all screens throughout the system and provide information on how to utilize these features for optimal navigation. The ability to search and view profile information will appear on all pages through the system, regardless of navigation.

General System Features

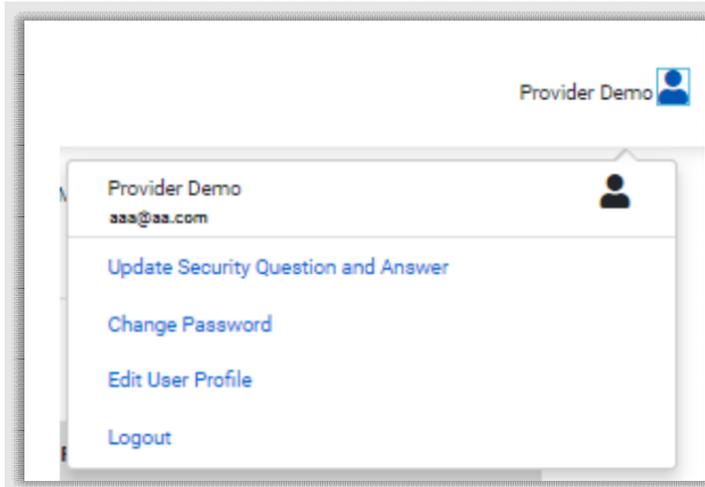
After successful login, the system will default to the Home Screen which will display cases created but not yet submitted for your agency. See below for the features present on all pages throughout the system to assist with navigation.



- A. To search a Case number, enter in the Acentra Health case ID and click enter on your keyboard
- B. This section will allow you to navigate to the Atrezzo Help page. The Atrezzo Help page has training and how to videos and user guides pertaining to the Atrezzo system.

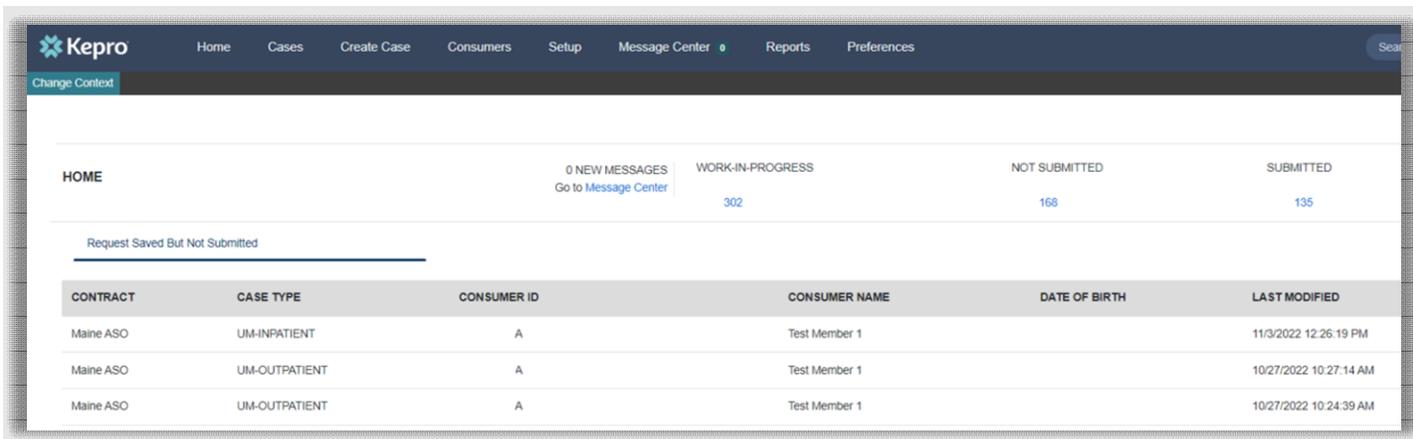


- C. This section will identify the user logged in. Click on the  icon in the upper right corner to open menu options where you can update your security question and answer, change password, edit user, or logout.

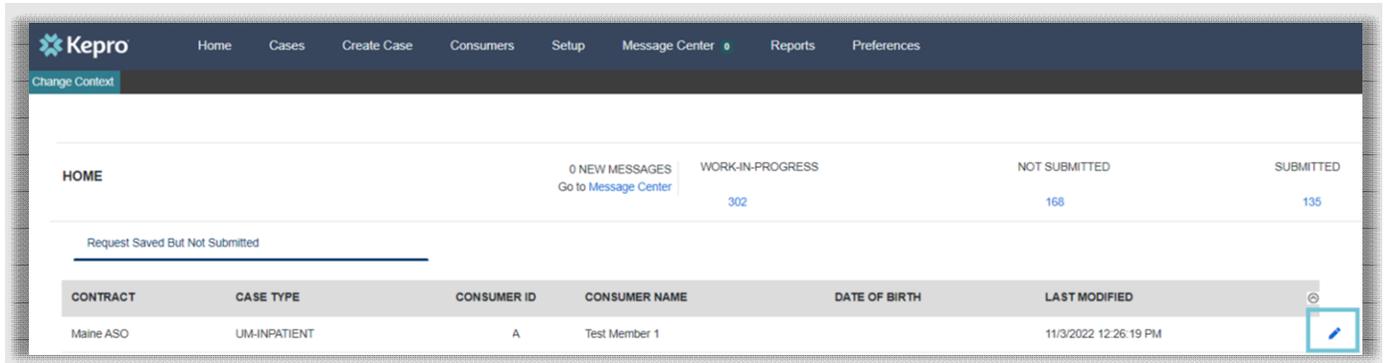


Home Screen View

Once successfully logged in, the user will be taken to the Atrazzo Home Screen which will default to display all “Requests Saved But Not Submitted”. This will provide a list of Members with cases that have been started but are incomplete and have not been submitted to Acentra Health.



To complete an un-submitted case, you can click the pencil edit icon that will appear when hovering over the Consumer line.

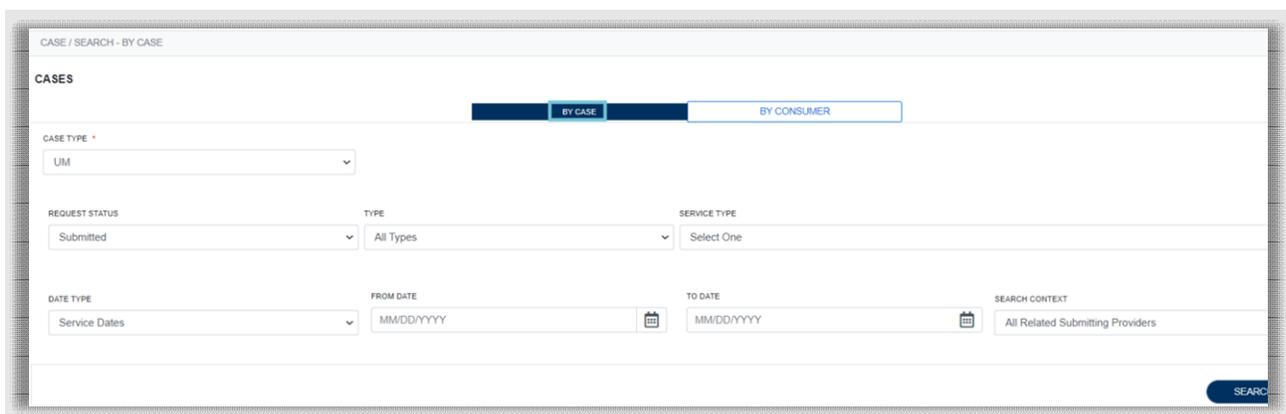


Cases

This section will identify the steps to search for cases based on selected search parameters. This section is searchable by Case or Consumer. Select the specific search on the top.

To search By Case, select UM from the Case Type drop down. Available sections will vary based on user role. Once the Case Type is specified, additional search parameters will appear. To identify specific cases and ensure efficient search results, try selecting specific information in each drop down to narrow search results.

Note: You must enter a submitted date span for search results to render. The date span cannot exceed 30-days.



To search By Consumer, enter in the member's MaineCare ID in the Consumer ID Box. If you do not have the MaineCare ID, you may search by the last name and Date of Birth fields.

CASE / SEARCH - BY CONSUMER

CASES

BY CASE BY CONSUMER

CONSUMER ID LAST NAME DATE OF BIRTH SEARCH CONTEXT

MM/DD/YYYY All Related Submitting Providers

Combination of DOB and Last Name or Consumer ID is required

SEARCH

Search results will render below. The Case ID will be displayed as a header. Below the Case ID, you will see the corresponding request within the case displayed as Request 01, Request 02, etc. Clicking on a Request line will open the specified Case Page.

- Case: 210960004

| | | | | | | | | | |
|------------|-----------|----------|------------|-----|--------------------------|---------------------|-----------------|----------------------|---------|
| Request 01 | Submitted | 4/6/2021 | Outpatient | N/A | 140 - Section 17 Comm... | 4/6/2021 - 4/6/2021 | View Procedures | No letters available | Actions |
|------------|-----------|----------|------------|-----|--------------------------|---------------------|-----------------|----------------------|---------|

Create Case

This section will identify the steps to create a new case request. The Create Case Wizard walks the user through the submission process in a step-by-step manner. You will not be able to move to the next step until you have completed all the information on the current step.

From the home page, click **Create Case**.



Step 1 – Case Parameters

1. Select UM for **Case Type**
2. Select Maine ASO for **Case Contract**

3. Select Outpatient for the **Request Type** (If you are providing a Section 45 or 46 Hospital service, you will choose Inpatient)
4. Click **Go to Consumer Information**. Note: Go to Consumer will remain grayed out until all required fields are completed.

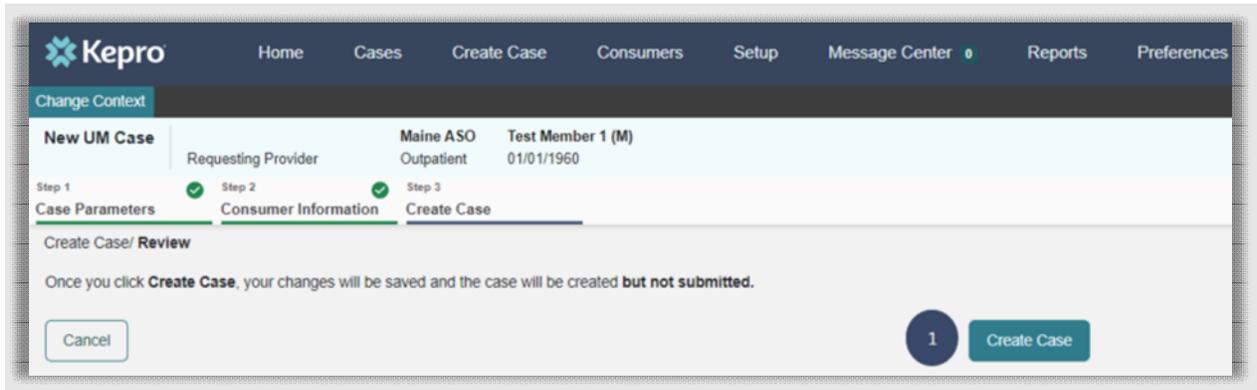
Step 2 – Consumer Information

1. In the **Consumer ID** box enter the Member's MaineCare ID box. You may also search for the Member by using their last name and Date of Birth.
2. Click **Search**.
3. Review the search results. If the correct member match is found, click **Choose**.
4. If a member match is not found, click **Add Temporary Member** to add the member to the system.

- If the member has had a previously submitted or unsubmitted cases, they will display. If this is a new request, click on **Create Case**.

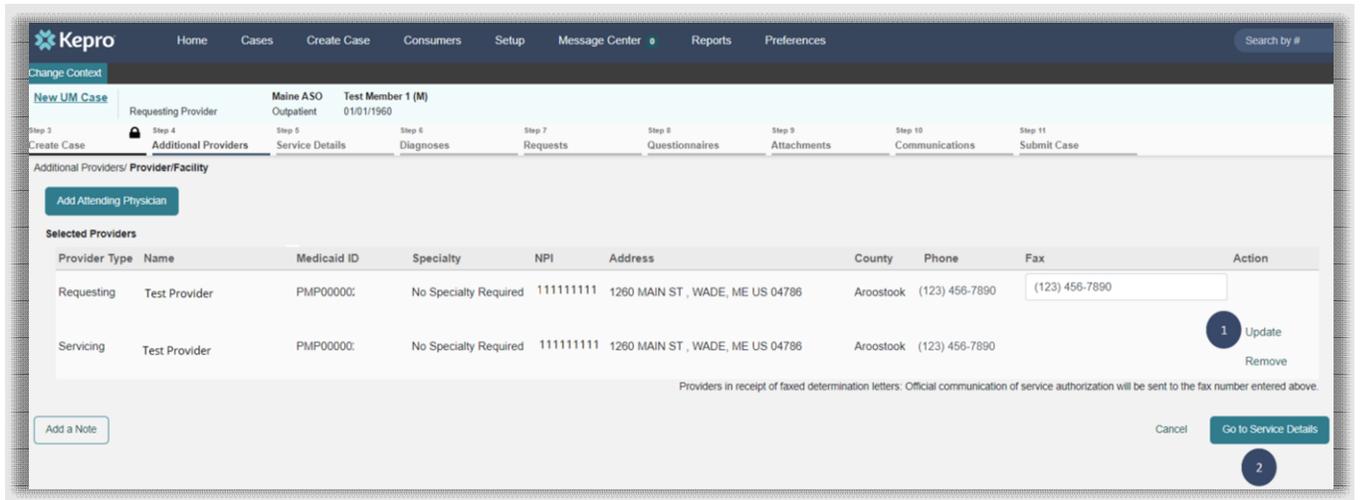
Step 3 – Create Case

- Select **Create Case**. Once you click Create Case, your changes will be saved, and the case will be created but not submitted.



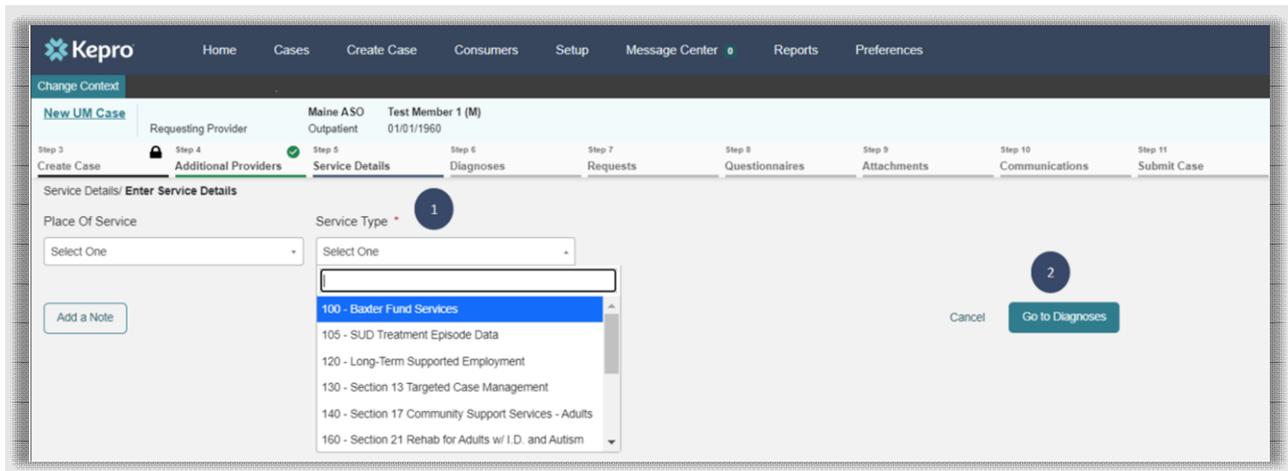
Step 4 – Additional Providers

1. The Requesting and Servicing providers will automatically be indicated based on the NPI number your login is associated with. If you are providing a Residential Service or submitting a Substance Use Disorder (SUD) Treatment Episode Data request, you will want to update the Servicing NPI to your NPI +3.
2. If no changes are needed to the Servicing Provider, click on Go to Service Details



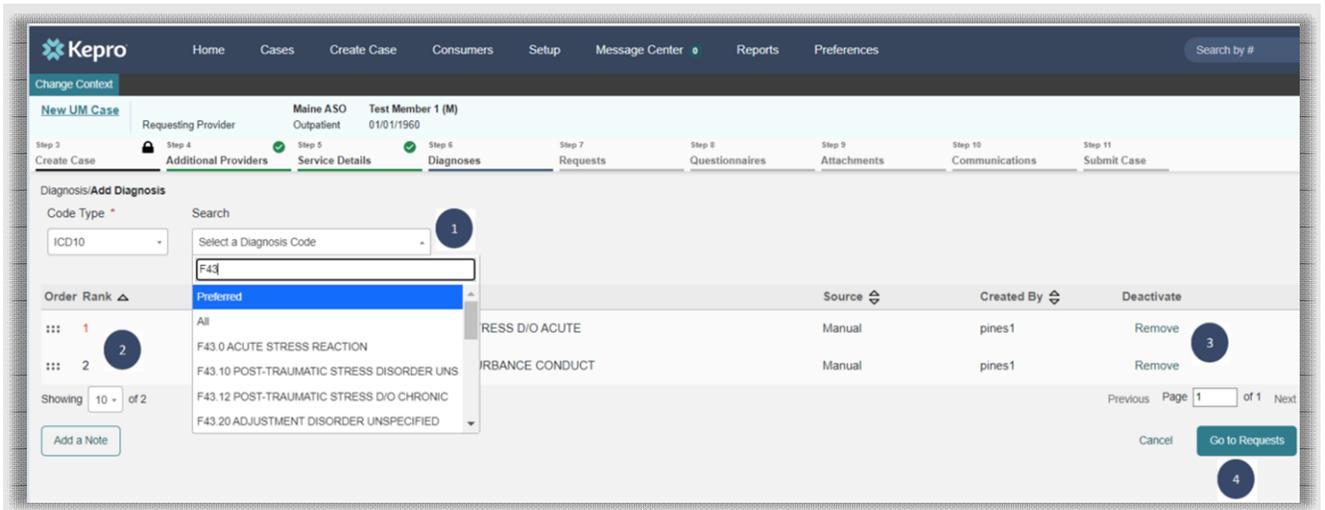
Step 5 – Service Details

1. Select the section of MaineCare Policy for the service you are providing from the **Service Type** drop down. The place of service field is not required; however, you can complete this field if you choose to.
2. Click **Go to Diagnoses**



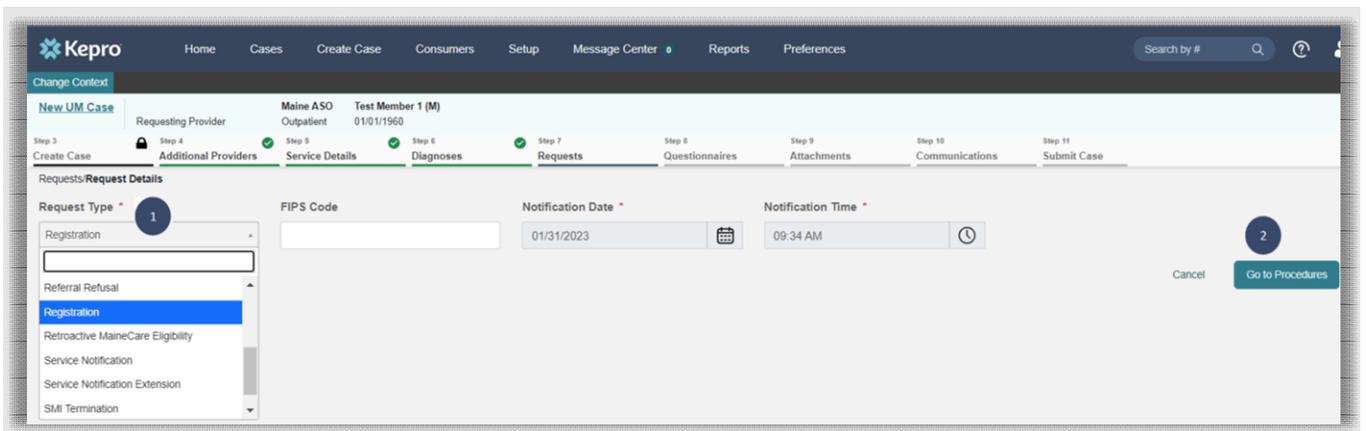
Step 6 – Diagnoses

1. In the Diagnosis **Search** box, start typing in either the diagnosis code or the description of the code. You will need to enter in at least three characters for the search feature to start finding results. Once you have found the diagnosis code, click on it to automatically add it to your request. Repeat the same search process for each additional diagnosis code.
2. If you have added more than one diagnosis code, you can rearrange the order of how the diagnosis codes appear by clicking on the diagnosis line and dragging it up or down in the list.
3. If you have added a diagnosis code in error, you may remove it by clicking on the **Remove** link. Please note: Once your request has been submitted, you will not be able to remove the diagnosis code.
4. When you have finished adding the diagnosis code(s), click on **Go to Requests**

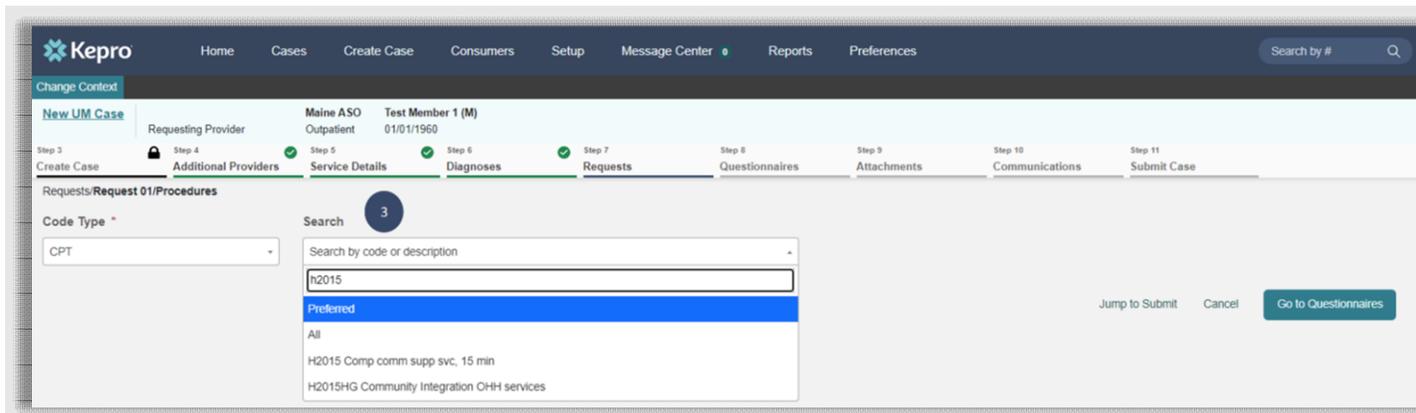


Step 7 – Requests

1. In the **Request Type** box, select the type of request for the service you are submitting. Please refer to the [Maine ASO Service Grid](#) for information on request type.
2. Click **Go to Procedures**

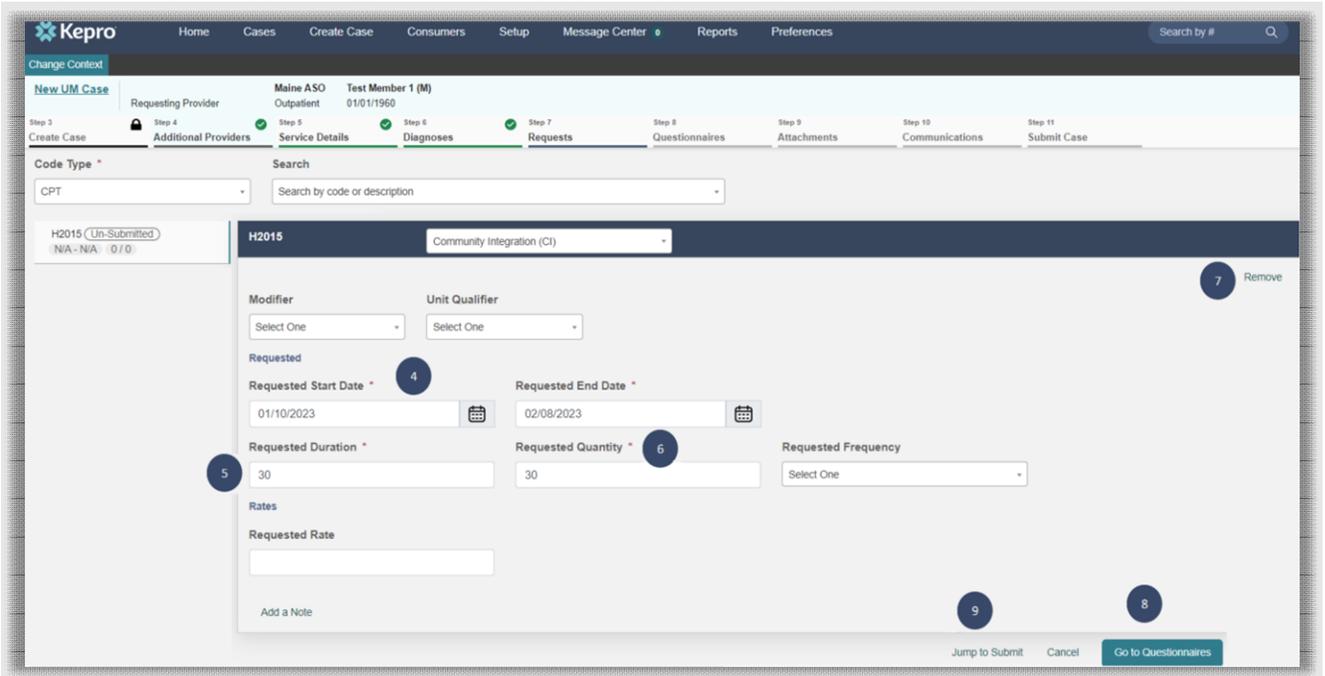


3. In the **Search** box, start typing in either the procedure code or the description of the code. You will need to enter in at least three characters for the search feature to start finding results. Once you have found the procedure code, click on it to automatically add it to your request.



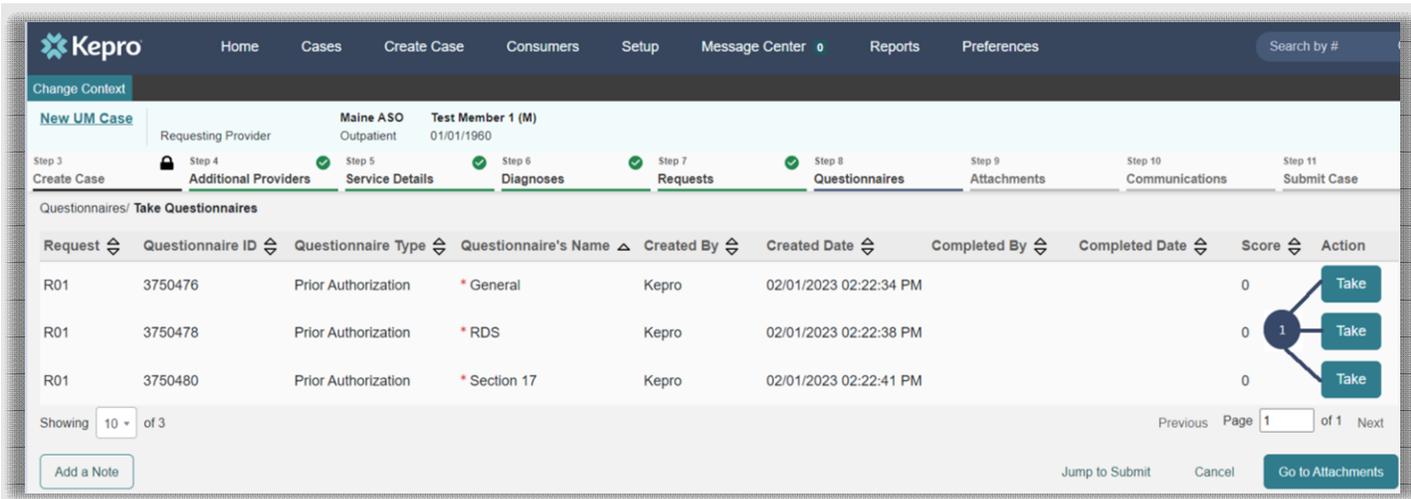
4. In the **Requested Start Date** box, enter the start date of this request.
5. In the **Requested Duration** box, enter in the total duration for this request. This will automatically populate the end date.
6. In the **Requested Quantity** box, enter in the total number of units needed for this request. Please use the Maine ASO Service Grid located at <https://me.AcentraHealth.com/resources/manuals-forms> to calculate the service length and units based on procedure code.
7. If you have added a procedure code in error, you can click on **Remove**.
8. Most requests will require you to complete the questionnaire(s). Click on **Go to Questionnaires** to navigate to the next step.
9. If your request does not require you to complete questionnaires or attach documents, you may click on **Jump to Submit**. Please note: If you click jump to submit and you are required to complete questionnaires, you will receive an error message and will not be able to submit until the questionnaires have been completed.

Please Note: Requests can be submitted up to thirty (30) days in advance of the requested start date during the 1135 Covid Waiver. When the waiver ends, requests will only be able to be submitted ten (10) calendar days in advance of the requested start date. Requests can be backdated a maximum of five (5) calendar days from the submit date.



Step 8 – Questionnaires

1. Any required questionnaires will be displayed on the questionnaire page. Click on **Take** to begin the questionnaire.

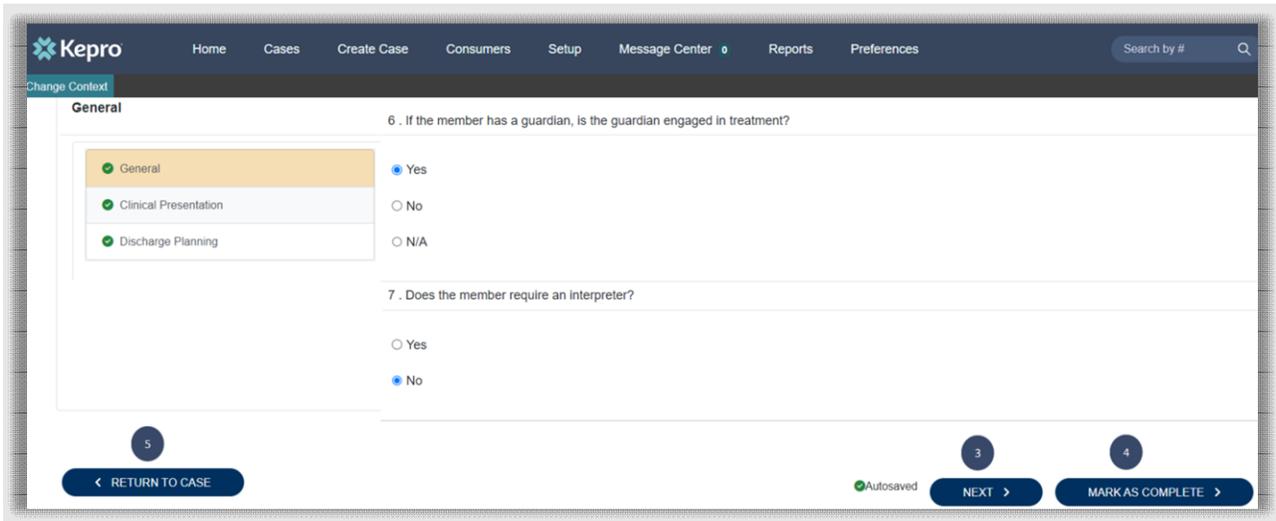


2. The questionnaire will open in a separate window. Complete all questions within each section of the questionnaire. When all information has been completed, the

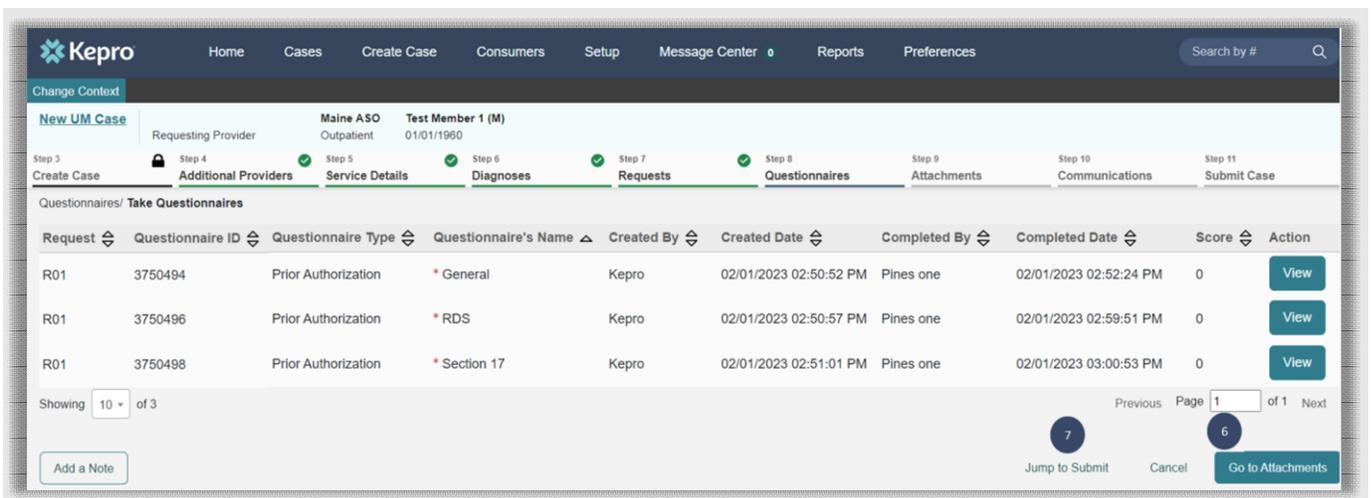
sections will show with a green check mark next to it. A gray check mark next to each section indicates not all fields have been completed.

The screenshot shows the 'Create Questionnaire / General' page in the Kepro system. The top navigation bar includes 'Home', 'Cases', 'Create Case', 'Consumers', 'Setup', 'Message Center', 'Reports', and 'Preferences'. The case information at the top indicates 'Test Member 1 (M)' with a date of birth of 01/01/1960 (63 Yrs), 'Maine ASO' as the plan, and '00000001A' as the Member ID. The 'General' section is active, showing a progress indicator with a green checkmark and the number '2'. The form contains three questions: 1. A yes/no question about a new treatment/episode of care, with 'Yes' selected. 2. A text input field for describing the use of requested units, with the placeholder text 'Provider will...'. 3. A question about the member's current living situation.

3. When you have finished the section, click on Next to navigate to the next section of the questionnaire.
4. When you have finished filling out the questionnaire, click on **Mark as Complete** at the bottom of the screen.
5. Please note, if you are submitting a **Referral**, all questions within the questionnaire ***must*** be filled out prior to submission, however you **WILL NOT** mark the questionnaire as complete. Instead, you will click on **Return to Request** after inputting all information. ***Please Note: Marking the questionnaire as complete will not allow for future changes to be made such as a change in referral source or change in member's address. If you mark a referral questionnaire as complete and changes are needed in the future, you will be required to enter in a new questionnaire.***

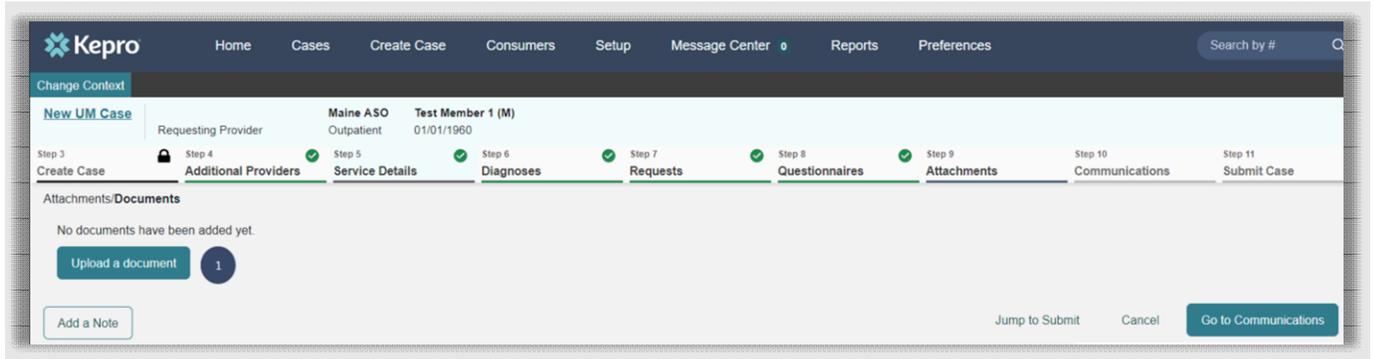


6. When you have completed all the questionnaires that are listed, click on **Go to Attachments**.
7. If your request does not require you to attach documents, you may click on **Jump to Submit**. Please note: If you click jump to submit and your request requires an attached document, your request may be put in a pending status for more provider information.

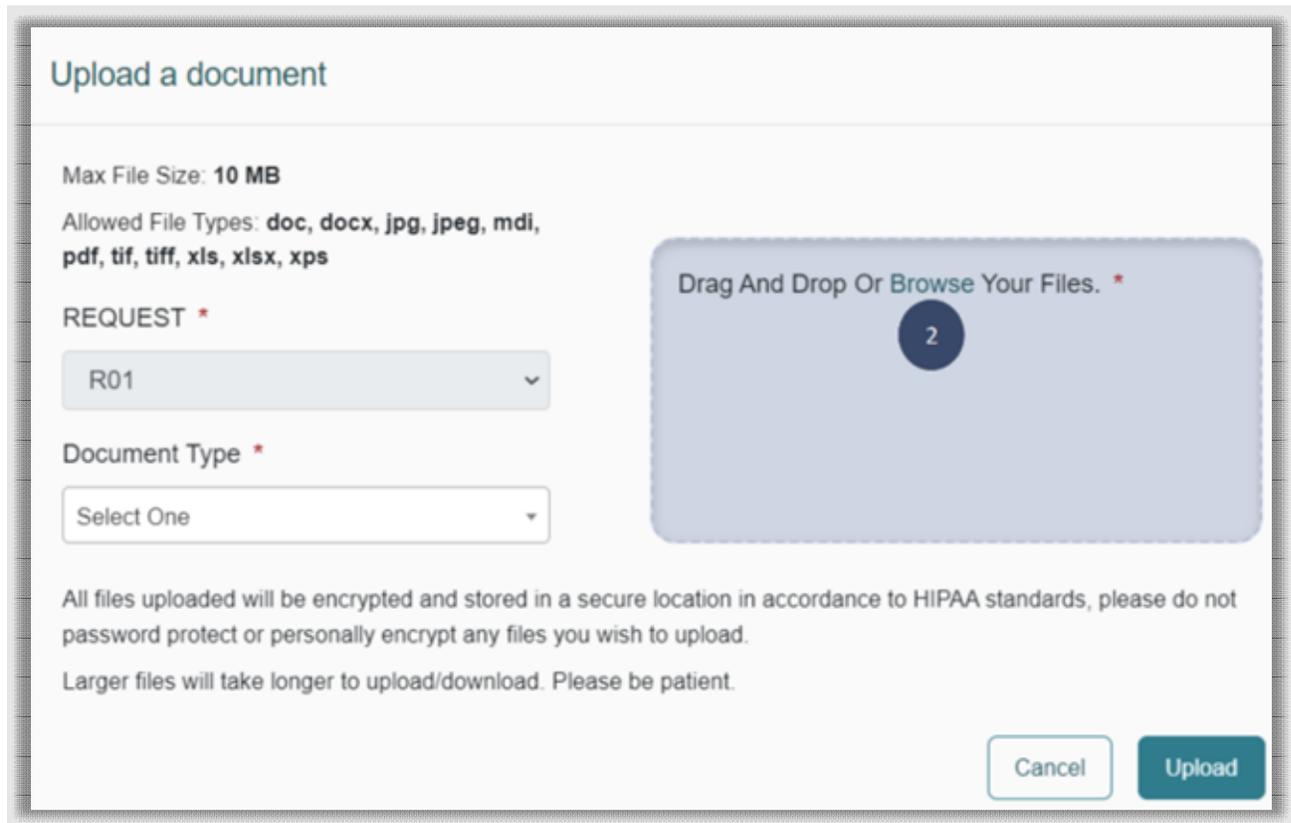


Step 9 – Attachments

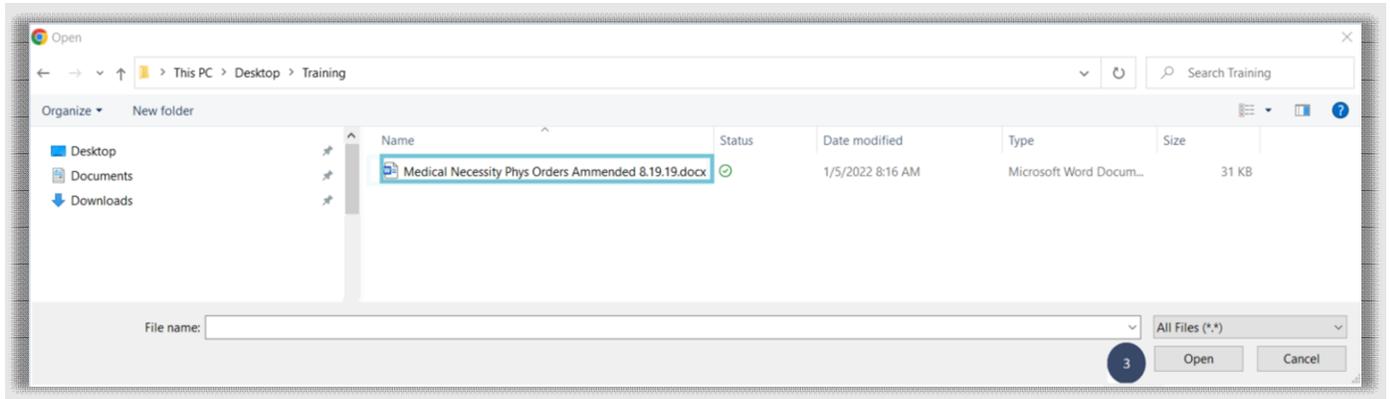
1. To upload documents, click **Upload a document**. This will open a document upload window.



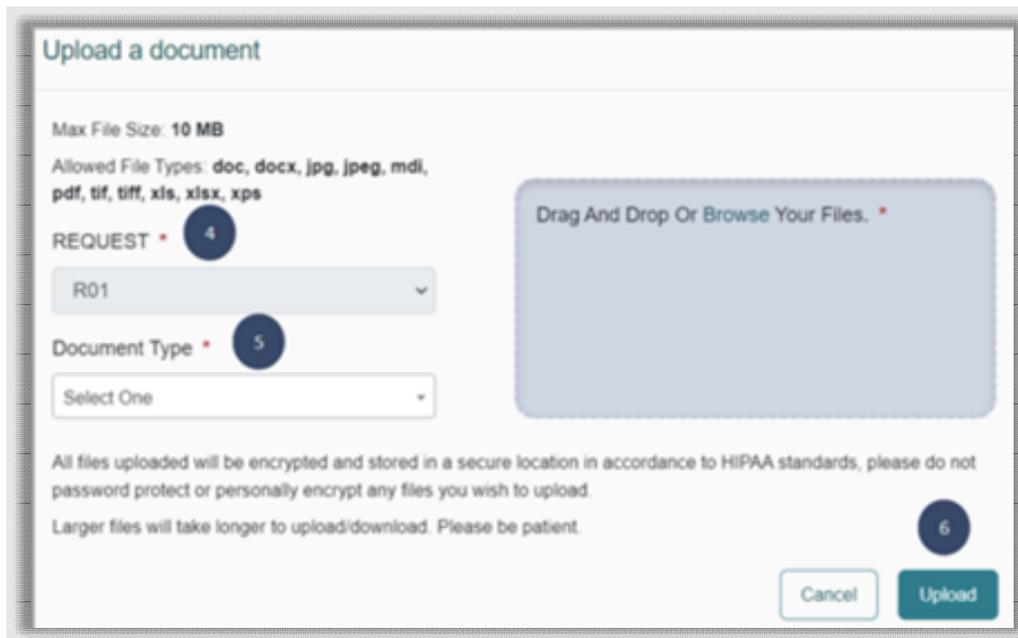
2. In the Upload a document window, click on **Browse** to select the place where you have saved the document that is being uploaded.



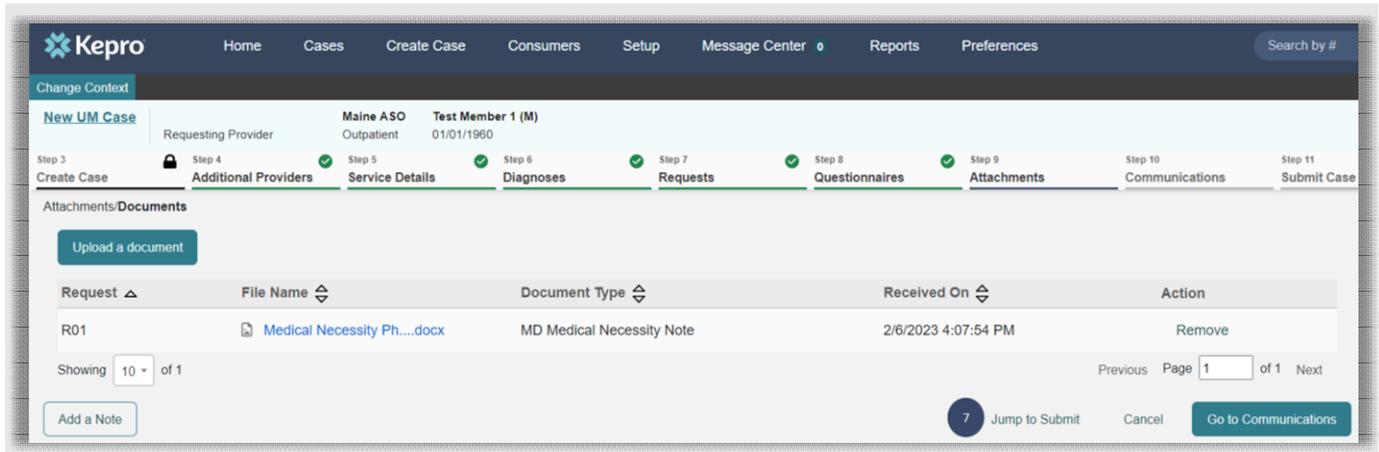
- When you have located the document you are uploading, click on the document and then click **Open**.



- Select the **Request** number. R01 equals the first request, R02 equals the first CSR, etc.
- Select the type of document you are uploading from the **Document Type** drop down.
- Click **Upload**. Repeat these steps for each document you are uploading.

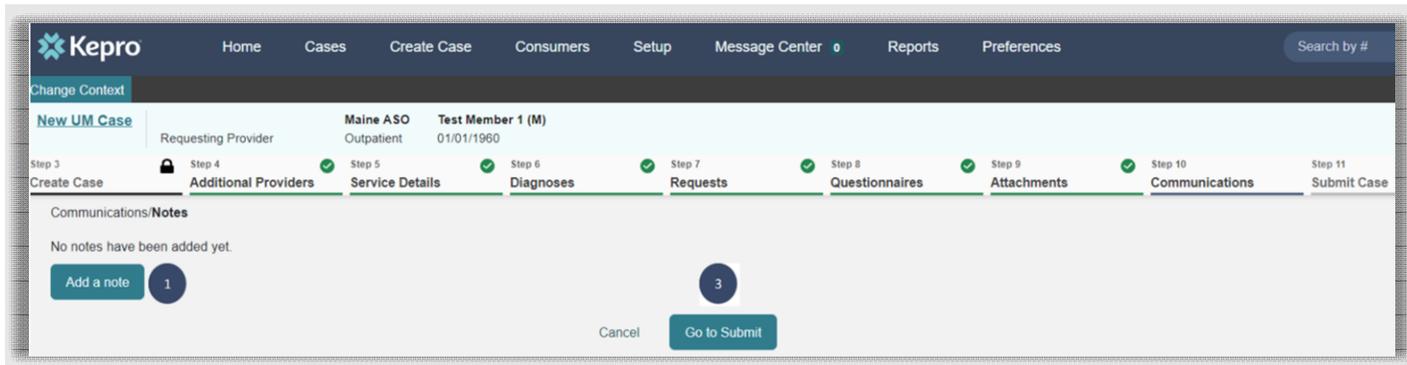


- When you have finished attaching/uploading all documents, click on **Jump to Submit**. Please note: The Communications step is not required as all required submission information will be collected through the questionnaires and attached document sections.



Step 10 – Communications

- If there is information you need to convey to Acentra Health that cannot be documented in the questionnaires or through the attached documents, you may add a note in the Communications tab. Click **Add a Note**.
- Type your note in the text box and then click **Add Note**.
- Click **Go to Submit**



Add a note

Note Type *

External

Note *

2

Notes cannot be modified or deleted after being saved.

Cancel Add Note

Step 11 – Submit Case

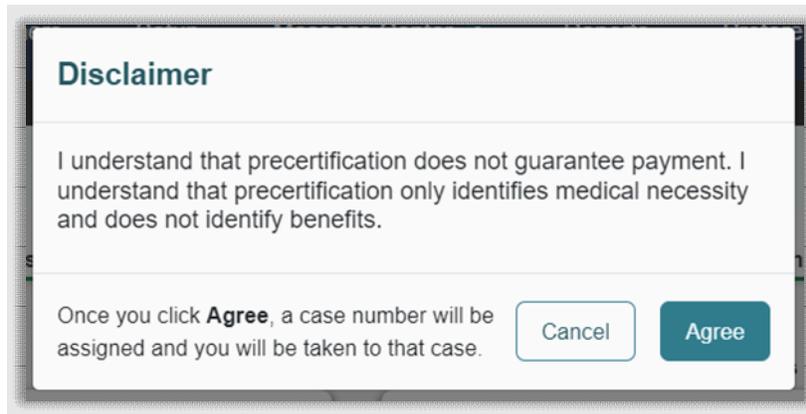
- Once you have completed the request, the information you input will be displayed as tiles. If you need to update information prior to submitting, you can click on the tile to navigate back to that section of the request, or click on the step. In this example, we've shown where you can update the request at the step level or from the tile. Click on **Submit**.

The screenshot shows the 'Submit Case/ Review' screen in the Kepro system. At the top, there is a navigation bar with options like Home, Cases, Create Case, Consumers, Setup, Message Center, Reports, and Preferences. Below this is a progress bar for steps 3 through 11, with Step 7 'Requests' highlighted. The main content area contains several tiles:

- Additional Providers:** Shows 'Requesting PINES HEALTH SERVICES' and 'Servicing PINES HEALTH SERVICES' with an 'Update Providers' button.
- Service Details:** Shows 'Service Type 140 - Section 17 Community Support Services - Adults' with an 'Update Service Details' button.
- Diagnoses:** Shows '1' diagnosis with 'R69' and an 'Update Diagnoses' button.
- Requests:** Shows 'Notification Date 02/06/2023', 'Request Type OBH Funded Review', and '1' procedure with 'H0040'. It includes an 'Update Requests' button.
- Questionnaires:** Shows '3' questionnaires with a 'View Questionnaires' button.
- Attachments:** Shows '1' document with an 'Update Documents' button.
- Communications:** Shows '0' notes with an 'Update Notes' button.

At the bottom right, there are 'Cancel' and 'Submit' buttons.

2. Once you click submit, a Disclaimer popup will appear indicating that precertification does not guarantee payment and precertification only identifies medical necessity and does not identify benefits. Click on **Agree**.



3. If there are no errors, your case will submit and you will receive a case ID number. If there are errors, you will receive a message indicating what the errors are that need to be addressed before the case can be submitted.

Consumers

This section will identify the steps necessary to search for a consumer.

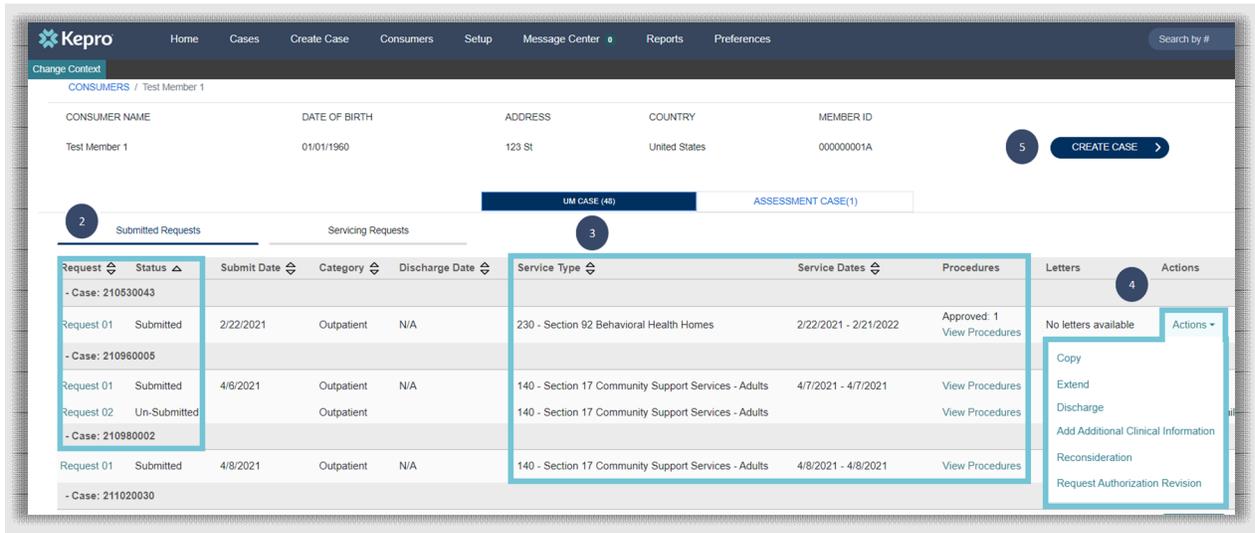
Click on the Consumers tab at the top of the Atrezzo screen. The Consumer default screen will appear providing options to search for a Consumer.

To search by Consumer, enter the required Member information. For results to render, the user must enter either the MaineCare ID in **Consumer ID** box or enter in Last Name and Date of Birth. Click Search.

1. Search results will render below. To view the Consumer page, click on the consumer's name which is a hyperlink.

The screenshot shows the 'Consumers' section of the Kepro application. At the top, there is a navigation bar with links for Home, Cases, Create Case, Consumers, Setup, Message Center, Reports, and Preferences. Below this is a search form with the following fields: CONSUMER ID (containing '00000001A'), LAST NAME, FIRST NAME (MIN 1ST LETTER), and DATE OF BIRTH (with a calendar icon). A 'SEARCH' button is located to the right of the form. Below the search form, there is a note: '*Combination of DOB and Last Name or Member ID'. To the right of the search form is a '+ ADD TEMPORARY CONSUMER' button. Below the search form is a table with the following columns: NAME, DATE OF BIRTH, ADDRESS, CONSUMER ID, CONTRACT, and CASE COUNT. The table contains one record: 'Test Member 1' with a date of birth of '01/01/1990', address '123 St Anywhere, ME', consumer ID '00000001A', contract 'Maine DHHS', and case count '48'. Below the table, there is a pagination control showing 'Previous', '1', and 'Next', and a 'Show 10 Entries' dropdown.

2. Clicking on the Consumer's name will bring you to an overview page for the member. Here you will see both submitted and unsubmitted cases.
3. This section over the overview page will display the service type and service dates for the submitted and unsubmitted cases.
4. From the Actions button, you can complete several functions including extending and discharging a case. **Please note: You are also able to complete these functions by searching just the case ID.**
5. In addition to the Create Case tab, you can also create a case from the Consumer overview page.



Setup

This section will identify the steps for Provider Administrators to manage additional users within the portal. Only users who are setup as Provider Administrators will see this tab. For all other users, this tab will be hidden. For instructions on adding and deleting users, please click here [Adding and Deleting Users](#).

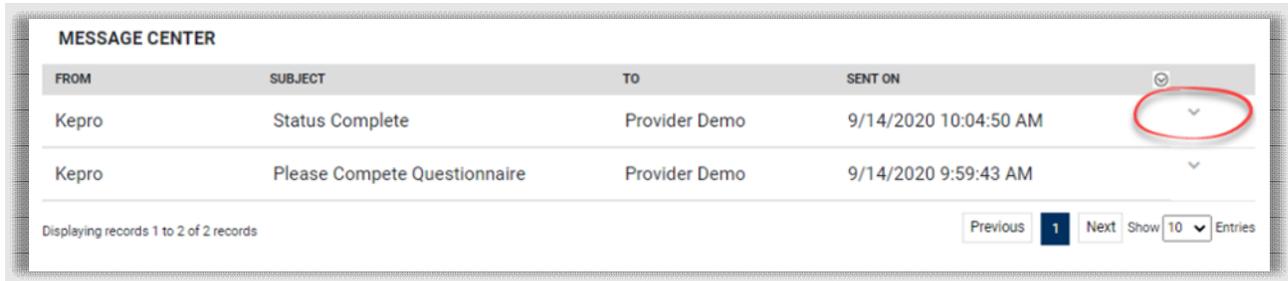
Message Center

This section will identify the steps to view messages. To send messages, you must be inside a specified case. See the Messages section within the case for details on how to send a message.

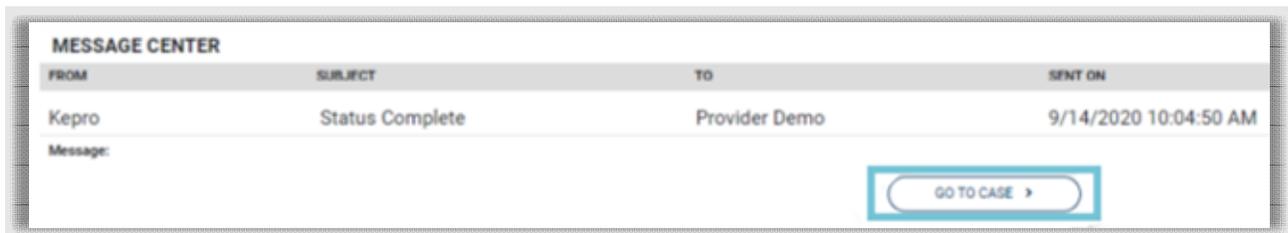
New and unread messages are displayed in the top navigation menu as an alert next to the Message Center. Click on the Message Center to view the message(s).



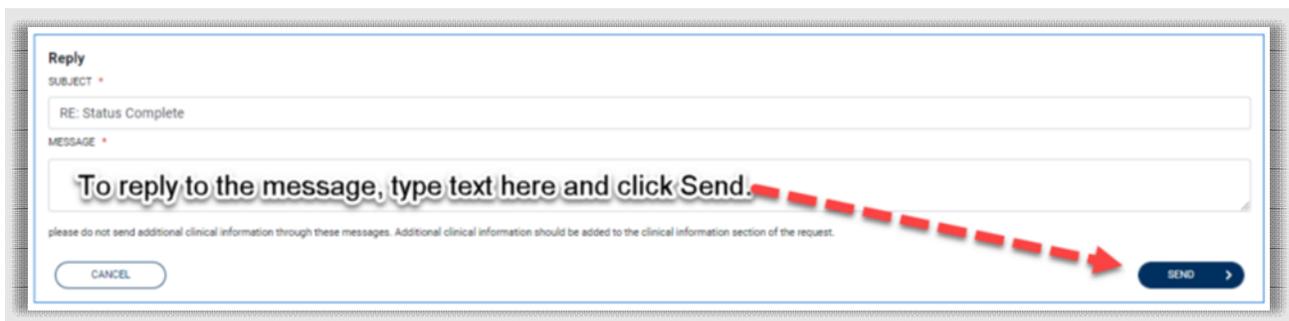
Available messages will be displayed in the message center. To open/view the message, click on the caret in the right-hand corner of the selected message.



To view the selected case, click **Go to Case**. You will be directed to the specified case related to the message.



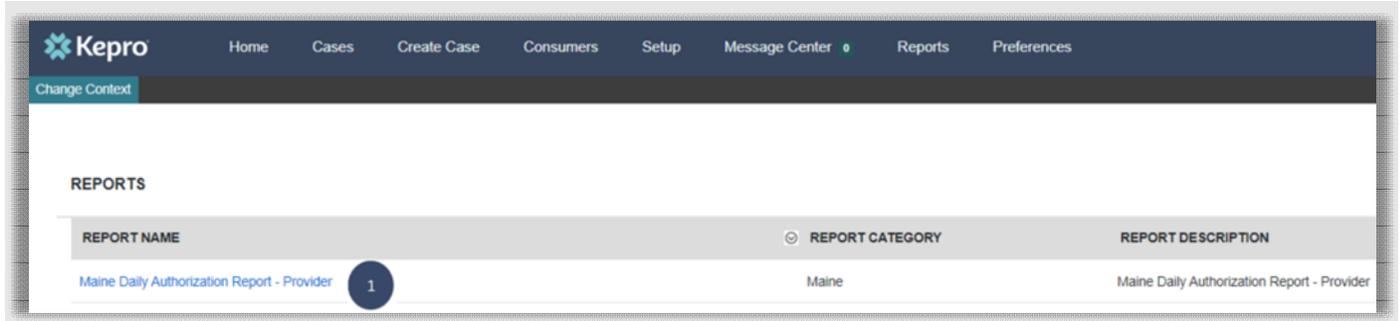
To reply to the message, type text in the Message section and click send.



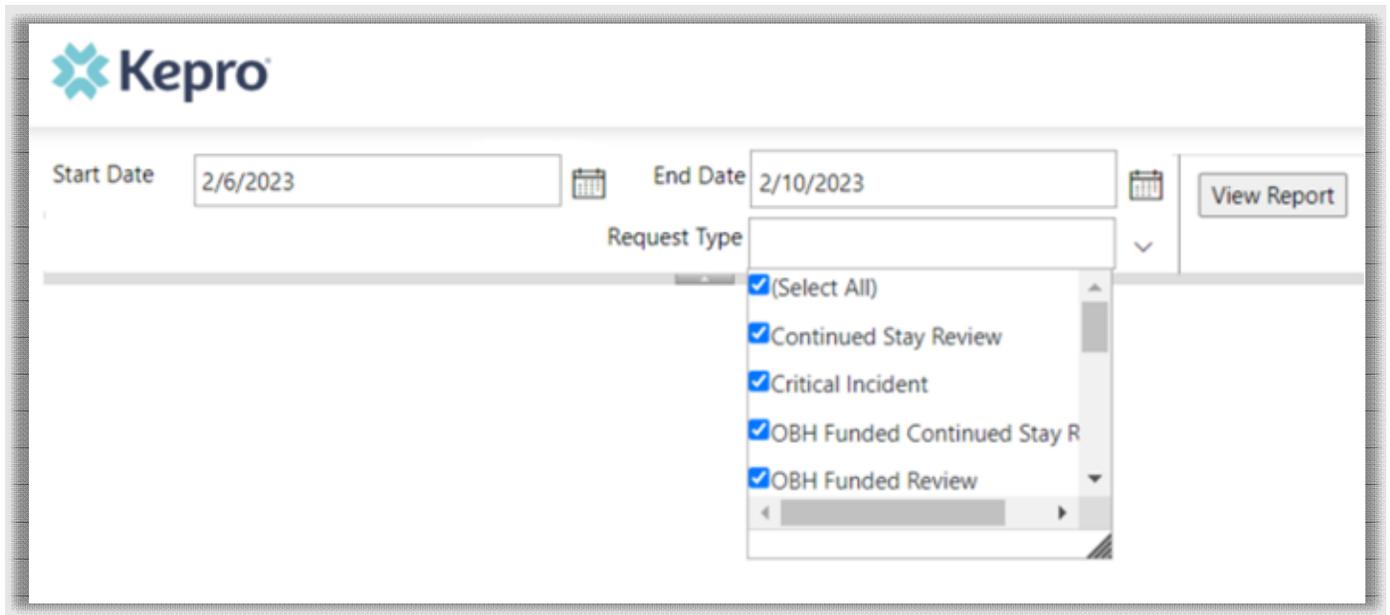
Reports

This section will identify the steps to access available reports, as applicable. Only users who have been set up with a Group Admin + Reports or Admin + Reports users will have the reports tab. The reports tab will be hidden for all other user role types.

1. Click on the report name which will open the report in a new tab within the internet browser.



2. Depending on the type of report you want to view, you may be required to enter in search parameters in order for the report to generate as with the Daily Authorization Report. Once your search parameters have been entered, click **View Report**.



3. The report will run based on the search parameters you have selected. You can view the report in Atrazzo, or you can export it to several different types of files. To export it, click on the  icon and select the type of file you want to open the report in.

Request Actions

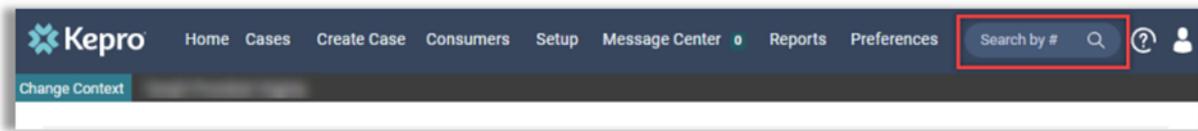
There are several request action items available in the Atrazzo portal once a case has been submitted.

- Copy – Create an identical copy of the submitted case.
- Extend – Creates a Continued Stay Review.
- Actions

- Add Additional Clinical Information – Providers may choose this option to add additional clinical information for cases that are in a Pending, Provider Information status or to request additional units as needed.
- Reconsideration – Providers may choose this option if their case has received an adverse decision and you would like to request a reconsideration with one of our Physician Advisors.
- Request Authorization Revision – Used when there is a need for a revision on a case. All revision requests will be reviewed and updated as long as it falls within our revision guidelines (i.e., backdate requests can only be backdated five (5) calendar days from submit date)

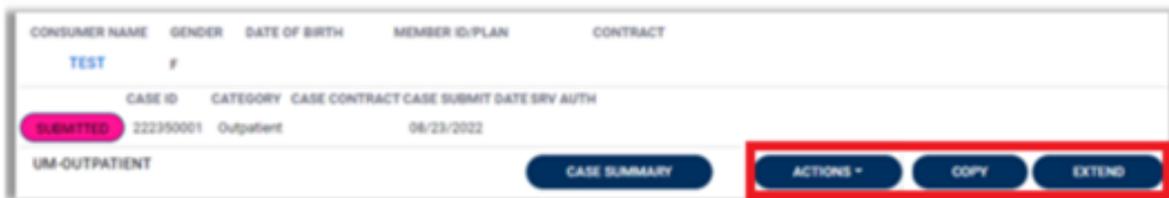
1 Search for Case ID

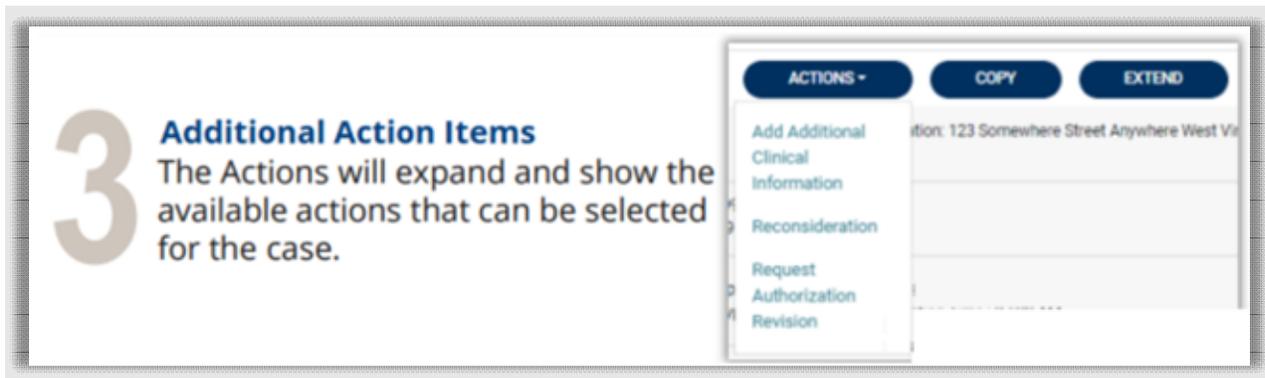
Enter the **Case ID** into the Search Bar. Press enter or click anywhere outside of the box to be navigated to the case.



2 Open Submitted Request

Click on one of the Action items. If clicking on Actions, additional options will be made available to choose from.



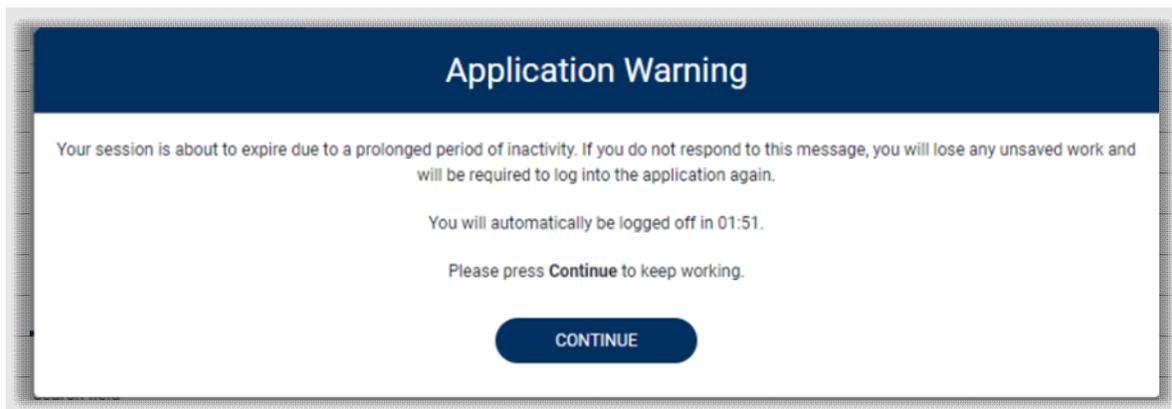


Troubleshooting Tips

This section will identify a few troubleshooting tips to help make navigation of the system easier.

Inactivity Warning

Important Note: After a period of inactivity (15 minutes), a pop up will appear with a two (2) minute countdown to logging out. As long as you are actively working within the system, you will not receive this pop-up warning.

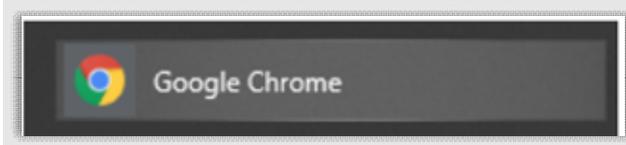


To continue working, select Continue.

If you do not select continue before the countdown reaches zero (0), you will be required to log in again to continue utilizing the system. The system AutoSaves as you navigate and complete fields once you reach a certain point in the request (See **Step 3 – Create Case**). Completed work will not be lost; however, any unsaved work will be lost if the system times out due to inactivity.

Internet Browser

Atrezzo is configured to function in all internet browsers; however, Chrome is best. Chrome users will have the best system functionality performance over other browsers.



Maximize Search Display Options

This section will identify the steps taken in order to view more than ten (10) items in a section or search result response. All search results will default to displaying only ten (10) items. The maximum number retrieved will be 300 results. To navigate, you can choose to view more or navigate multiple pages if preferred.

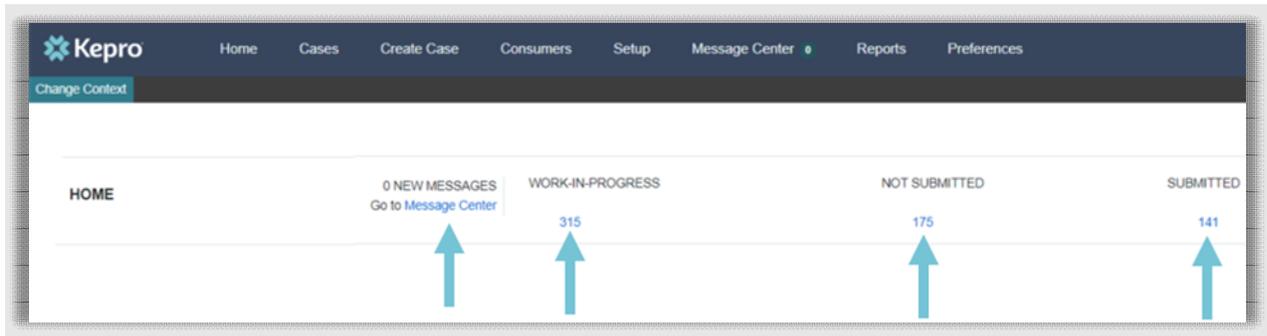
4. View Pages – To view the next page, simply click the **Next** button on the bottom left. The current page number will be highlighted for easier navigation. Search results will only display a maximum of 300 results. For a lesser amount of search results, enter in additional search criteria.

The screenshot shows the Kepro web application interface. At the top, there is a navigation bar with links for Home, Cases, Create Case, Consumers, Setup, Message Center, Reports, and Preferences. Below this, there are statistics for 0 NEW MESSAGES, 315 WORK-IN-PROGRESS, 175 NOT SUBMITTED, and 141 SUBMITTED. The main content area displays a table of search results with columns for CONTRACT, CASE TYPE, CONSUMER ID, CONSUMER NAME, DATE OF BIRTH, and LAST MODIFIED. The table contains 10 rows of data. Below the table, there is a pagination control with 'Previous', '1', and 'Next' buttons, and a 'Show 10 Entries' dropdown menu. Callouts provide instructions: 'Current page results are highlighted.' points to the '1' button; 'Click Next to see the next page of results.' points to the 'Next' button; 'Click Previous to see the prior page of results.' points to the 'Previous' button; 'Click to change the number of results you view.' points to the 'Show 10 Entries' dropdown; and 'Here you will see how many items are displayed and total number of records.' points to the 'Showing records 1 to 10 of 10 records' text.

Hyperlinks

There are hyperlinks throughout the system that will navigate you to another page or location. Any blue underlined text is a hyperlink.

Examples of hyperlinks for reference are detailed below. The arrow in each image will depict a hyperlink. There are just a few examples to demonstrate the various types and location of hyperlinks within the system.



SECTION FOUR

Quality Management



Quality Management and Improvement

One of the benchmarks of a strong utilization management system is a comprehensive Quality Management plan. This means developing a collaborative process of reviewing, measuring and continually improving the quality of services delivered. The plan should support ongoing learning, data-based decision making, and rapid identification and resolution of quality problems to ensure that all members receive clinically appropriate, effective, medically necessary, and cost-efficient treatment.

Reporting and Analysis

The two key functions of the Quality Reporting Department are reporting and analysis. A Acentra Health Quality and Reporting Specialist, in conjunction with the Program Director, the Medical Director, and DHHS, produces reports on mental health and substance abuse services which include the following:

- Aggregate data about demographics and use of services
- Data about the number of authorizations and denials to each level of care by each provider
- Number of grievances or appeals
- Average length of stay
- Re-admissions
- Provider contract performance measures specified by DHHS
- Complaints
- Other reports written into ACENTRA HEALTH contract with DHHS

The data from Atrezzo© and/or other available data sets can be used to assist providers with their own quality initiatives.

Acentra Health develops quarterly reports of services by:

- Provider
- District
- Service type

ACENTRA HEALTH evaluates this information clinically and statistically to identify potential over-utilization or under-utilization of services. The results are reported to DHHS to promote discussion, problem-solving and quality improvement opportunities.

Members who use a high volume of specific services are identified, which allows Acentra Health to work with providers to address unusual needs of these specific members or escalate inappropriate utilization. Acentra Health also analyzes aggregate data about members using a

high volume of service to spot trends and work with DHHS to improve care for these members. An example of this is a report for Maine DHHS about members authorized for over 24 hours a day of Section 21 Agency Home Supports.

Reports Available to Providers

Acentra Health makes numerous reports available to providers, as well as DHHS via Atrezzo portal.

Additional Projects

The Quality Reporting Department has several additional projects. These may include:

- Developing clinical and treatment quality studies for specific services as requested by Maine DHHS
- Conducting a gap analyses of service delivery based on numbers in specific service by district (numerator) and the number of youth or adults with MaineCare in each district (denominator)

SECTION FIVE

**Members
Services**



Member Services

Acentra Health's Member Services department is committed to providing information to members and families or caregivers in a respectful and culturally appropriate way, including telephonic, mailed, and web-based communications. Member Services also supports members, guardians, or other caregivers in navigating the reconsideration and appeal process. Acentra Health has developed a Member Handbook. The handbook is available online or by request.

Acentra Health seeks to involve the member community, families, advocates, and other entities in the decision-making processes as often as possible. Member Services staff may also work closely with the MaineCare Member Services Team to resolve member issues.

Member Services is available to answer questions or concerns members may have about the services Acentra Health authorizes. Acentra Health makes every effort to have translation services available to those members who need them. Acentra Health provides communication for hearing-impaired members or family members through the Sorenson VRS systems.

Member and Family Outreach

Member Services seeks to foster collaboration among members, family members and member advocates throughout Maine. This is accomplished through the Member Advisory Council, and by attending events relevant to members and their families.

Member Handbook

The Member Handbook includes information about the Utilization Review process and how it impacts members. Directions for appealing decisions or initiating a grievance are provided in the handbook. The handbook also includes information on how members can become involved through the Member Advisory Council. The Member handbook is available to members on the Acentra Health/Maine website, or in hard copy by request from Acentra Health Member Services.

Member Liaison

The Member Liaison serves as a key resource for members and families during business hours. The Member Liaison works as an internal resource for members in appeal and grievance matters. The liaison is a self-identified consumer or family member of someone who has direct experience

with behavioral health issues. The Member Liaison can be reached by calling 1-866-521-0027, Option 1.

Member Advisory Council

To ensure that member voices are heard, and that Acentra Health addresses member concerns, Acentra Health maintains a Member Advisory Council (MAC). The MAC consists of people who live in Maine and may include adults, young people or guardians, and other stakeholders. The goals of the MAC are as follows:

- Review materials
- Support and initiate improvements
- Develop and implement a members' training program
- Work with Acentra Health staff to develop recommendations to improve the Utilization Review Process
-

Acentra Health Maine Complaint or Grievance Process

Acentra Health Maine is committed to responding to all provider or member complaints as rapidly as possible. Complaints may come to any staff person, and be concerned with a variety of issues. The following process describes the steps staff will take to ensure complaints are acted upon by the appropriate manager or administrator.

If a staff person receives a complaint, he or she documents the complaint and takes it to their immediate supervisor or manager. Once a staff person receives a complaint, Acentra Health has five (5) working days to respond; if more time is needed to review the complaint Acentra Health may take an additional five (5) days. The person filing the complaint will be notified if Acentra Health is going to take longer than five days.

Please note that a complaint does not include adverse decisions made by Acentra Health staff in the utilization review process. Adverse decisions are handled by the formal appeal and grievance process described previously.