



## MEMBER SEARCH

Search for a member using the criteria below.

Member ID:

or

Member Last Name:

Member Birthdate:

(mm/dd/yyyy)

Search

Enter the member ID  
(the MHCP Subscriber).

# Selecting a Request Type

Case Level Member ID Case ID (Reference ID)	Status	Request Info	Service Type	Service Date(s)	Providers
		Select request type:	<input type="text" value="Outpatient"/>	<input type="button" value="Create Request"/>	<input type="button" value="Cancel"/>
		Select sub contract:	<input type="text" value="Minnesota SUD"/>		

For residential and outpatient services, always choose “Outpatient” and “Minnesota SUD”

		Select request type:	<input type="text" value="Inpatient"/>	<input type="button" value="Create Request"/>	<input type="button" value="Cancel"/>
		Select sub contract:	<input type="text" value="Minnesota SUD"/>		

For withdrawal management, always choose “Inpatient” and “Minnesota SUD”

# Requesting Provider information

## INPATIENT SERVICES REQUEST

- Patient Detail
- Requesting Provider**
- Facility
  - Attending Physician
  - Service Detail
  - Procedures
  - Diagnoses
  - Clinical Information
  - Attached Documents
- Questionnaires

### REQUESTING PROVIDER

<b>Name</b>	AICDC WITHDRAWAL MANAGEMENT
<b>Provider ID</b>	1558781633
<b>Provider Type</b>	62 - CHEMICAL HEALTH
<b>Address</b>	1800 CHICAGO AVE S MINNEAPOLIS MN 55404-
<b>Phone</b>	612-790-4258

Providers in receipt of Faxed determination letters: Official communication of service authorization will be sent to the fax number entered below.

**Fax \***

*\* denotes required field*

I understand that precertification does not guarantee payment. I understand that precertification only identifies medical benefits.

Because 1115 providers are using the portal, you do not need to put in a fax number. You can use 111-111-1111 if you prefer.

# Attending Physician information not needed

HOME REQUESTS SEARCH MANAGEMENT REPORTS MY ACCOUNT HELP

## INPATIENT SERVICES REQUEST

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### ATTENDING PHYSICIAN

Optional: Use the search below in order to add an attending physician to this request.

Find Show Preferred

Previous Next

I understand that precertification does not guarantee payment. I understand that precertification only identifies medical necessity and does not identify benefits.

Save Save for later Cancel Request Submit

This page is not required.

# Service Detail page

## OUTPATIENT SERVICES REQUEST

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**Service Type \***

**Request Type**

**FIPS Code**

*\* denotes required field*

Admission = beginning treatment  
Concurrent = client is currently receiving treatment  
FIPS code is not needed.

# Add the Procedure Code to the request

Procedure Search

Code Type: CPT

Code Starts with: H2035

Description:

Smart Search:

Find

Code	Description	Action
H2035	A/d tx program, per hour	Select

Close

Code Type: CPT  
(check with your billing person on  
which one you use)

Click on "Find"  
And then, "Select"

# Add the date, quantity, and any modifiers

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### PROCEDURES

Use the search below to add procedures to this request

H2035 - A/d tx program, per hour [remove]

Date: \*   to  

Qty: \*  -Frequency-  Rate:

MOD(S): -MOD-

Find

Show Preferred

\* denotes required field

Previous

Next

Add any modifiers that may be needed. You may need to click "Save" if the 2<sup>nd</sup>, 3<sup>rd</sup>, or 4<sup>th</sup> modifier boxes do not immediately populate.

Warning: A Required questionnaire has been added for you to complete

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### PROCEDURES

Use the search below to add procedures to this request

0919 - BEHAVIORAL HEALTH TREATMENTS/SERVICES - EXTENSION [remove]

Date: \* 09/08/2021

Rate:

MOD(S): -MOD- ▾

-MOD-

HH

HK

HN

HQ

TF

TG

U4

U5

U6

U8

U9

UA

UB

UC

UD

Find

Show Preferred

\* denotes required field

Previous

Next

I understand that precertification does not guarantee payment. I understand that this information only identifies medical necessity and does not identify benefits.

Save

Save for later

Cancel Request

Submit

To get a 2<sup>nd</sup>, 3<sup>rd</sup>, or 4<sup>th</sup> modifier box to populate after the 1<sup>st</sup> one, click "Save" at the bottom of the screen.



Error: You must complete the questionnaire before submitting the request

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### DIAGNOSES

Use the search below in order to add diagnoses to this request

Primary	Type	Code	Description	
<input checked="" type="checkbox"/>	ICD10	F10.12	ALCOHOL ABUSE WITH INTOXICATION	[remove]

Find

Show Preferred

Previous

Next

I understand that precertification does not guarantee payment. I understand that precertification only identifies medical necessity and does not identify benefits.

Save

Save for later

Cancel Request

Submit

Add the appropriate diagnosis. You may add as many as pertinent to this client.

Error: You must complete the questionnaire before submitting the request

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Please click Save button before proceeding to the next section of the case submission process.

### CLINICAL INFORMATION

Unable to enter modifier, please add...

Your screen to communicate with the reviewers.

Previous

Next

Use the clinical information box to communicate with the review team. No need to write a synopsis of care received or being provided since you'll be attaching clinical documentation.

# Adding Required Documents

**INPATIENT SERVICES REQUEST**

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**ATTACHED DOCUMENTS**

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

Attach New Document (25 MB size limit):  
 No file chosen

Acceptable File Types: pdf, tif, doc, docx, xls, xlsx, txt, rtf, gif, jpg, jpeg.

Document Type (required):

(Select a file and document type to activate 'Attach Selected Document' button)

Larger files will take longer to upload/download. Please be patient.

Attached:  
modified kepro 1115 workflow.pdf Other [remove]

I understand that precertification does not guarantee payment. I understand that precertification only identifies medical necessity and does not identify benefits.

- Just a reminder, we will be looking for:
- (1) Assessment and Placement Grid
  - (2) The Comprehensive Assessment
  - (3) Initial Treatment Plan
  - (4) Treatment Plan Review
  - (5) Discharge plan/summary

\* Please submit items 1-4 as soon as possible. We will pend the case and let you know the initial outcome while awaiting the discharge (if applicable).

# Questionnaire

## SUD Provider - Treatment

1. *What is the Highest Level of Care (LOC) recommended for this client?*

(Please select one.)

- 1.0
- 2.1
- 3.1
- 3.3
- 3.5
- WM-3.2
- WM-3.7

2. *Is the ASAM recommended Level of Care the same as the received Level of Care?*

(Please select one.)

- Yes
- No

3. *Please select any ancillary services the client is receiving:*

(Please select between 1 and 4 items.)

- Housing**
- Vocational services**
- Transportation assistance**
- Other**

4. *Would Partial Hospitalization (LOC 2.5) be appropriate if available?*

(Please select one.)

- Yes
- No

5. *Has a medical consultation addressed if this client would benefit from Medically Assisted Therapy (MAT)?*

(Please select one.)


- Yes
- No

This is occasionally updated.  
Don't forget to mark as completed.

# Request Overview with Case Information

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## REQUEST OVERVIEW

**CASE INFORMATION** [PRINT CASE](#) 

<b>Case ID:</b> 212510015	<b>Case Submit Date:</b> 9/8/2021 5:32 PM	<b>SRV Auth:</b> N/A	<b>Reference ID:</b> N/A
<b>Member ID:</b>	<b>Member Name:</b>	<b>Gender:</b>	<b>DOB:</b>

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**PROCEDURES**

LOS	Length of Stay	<b>Status:</b> Submitted	<b>Reason:</b> N/A
<b>Admit Date:</b>	9/8/2021		
	<b>Requested</b>	<b>Certified</b>	
<b>Procedure Date:</b>	9/8/2021	N/A	<b>Mod:</b> N/A <b>Rate:</b> N/A
<b>End Date:</b>	9/14/2021	N/A	

**Errors:**

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0919	BEHAVIORAL HEALTH TREATMENTS/SERVICES - EXTENSION	<b>Status:</b> Submitted	<b>Reason:</b> N/A
		<b>Requested</b>	<b>Certified</b>

Case ID is listed here for tracking purposes.

To extend a case, you will want to click on the [\[extend\]](#) option.

212092097 (N/A) <a href="#">[Procedures]</a> <a href="#">[Diagnosis]</a>	Contract: Minnesota SUD	Submitted Approved: 4 Denied: 0 Pending: 0 Void: 0	Outpatient Letters: 0 Messages: 2	SUD OP - Substance Abuse	10/14/2021 - 12/16/2021	<a href="#">[Servicing]</a>	<a href="#">[Select]</a> <a href="#">[Extend]</a> <a href="#">[Copy]</a>
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### REQUESTING PROVIDER

**Name** EFFECTIVE LIVING CENTER INC  
**Provider ID** 1124133475  
**Provider Type** 62 - CHEMICAL HEALTH

**Address**  
821 W ST GERMAIN  
ST CLOUD MN 56301-

**Phone** 320-259-5381

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**Fax \***

*\* denotes required field*

Previous

Next

Extending the case will pre-populate all of the information you had previously entered.

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### PROCEDURES

**IF ADDITIONAL PROCEDURE CODES NEED TO BE ADDED TO THIS REQUEST, PLEASE USE THE CLINICAL INFORMATION SCREEN TO PROVIDE THOSE DETAILS AND KEPRO STAFF WILL UPDATE THE REQUEST FOR YOU**

**H0038 - Self-help/peer svc per 15min** [remove]

Date: \* 12/17/2021  to 

Qty: \*  -Frequency-  Rate:

MOD(S): U8

-MOD-

**H2035 - A/d tx program, per hour** [remove]

Date: \* 12/17/2021  to 

Qty: \*  -Frequency-  Rate:

MOD(S): HH

-MOD-

Go to the “Procedures” page. Update the dates and quantities that you are requesting. If you need to add add’l procedures codes, reach out to us and let us know which ones you are requiring.



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Document Type (required):

(Select a file and document type to activate 'Attach Selected Document' button)

Larger files will take longer to upload/download. Please be patient.

Go to the “Attached Documents” page. Add the new clinical information to support ongoing services.

I understand that precertification does not guarantee payment. I understand that precertification only identifies medical necessity and does not identify benefits.

Save

Save for later

Cancel Request

Submit

After you have attached the new clinical information, don't forget to check the above box and submit the request.

The case ID for this client will stay the same and you do not need to complete the questionnaire again.