



DOCUMENTING PROPHYLAXIS D1110 IN ATREZZO

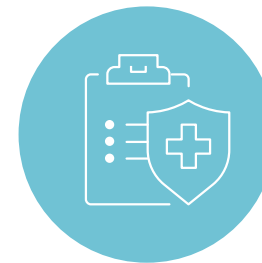
Our Mission



KEPRO's mission is to improve lives through healthcare quality and clinical expertise.



We work on behalf of government and private healthcare payers to maximize healthcare quality, improve accuracy and increase efficiency.



As a result, we drive real change in the healthcare system that allow healthcare dollars to reach more people by ensuring the right care is delivered at the right time.

Provider Benefits

- ❖ Secure submittal of Service Authorization Request (SAR) and additional clinical documentation.
- ❖ Receipt of a Kepro Case ID# to confirm all requirements have been met and Kepro has successfully received your submission.
- ❖ Tracking of case status (approval, denial or pended -for additional information requests).
- ❖ Kepro Questionnaires to help reduce “pends” of additional clinical Information.
- ❖ Search and review requests by date of submission.

Retrospective “Retro” Requests



Please submit Retrospective Requests manually. We are unable to auto-approve Dates of Service with today's date or prior to today. Prior authorization requests must have a future date.

Entering Prophylaxis D1110

ENTERING INFORMATION AND UPLOADING DOCUMENTATION FOR A PROPHYLAXIS D1110 IN ATREZZO IS A SIMPLE PROCESS. IT IS ESSENTIAL THAT ALL QUESTIONS BE ANSWERED CORRECTLY AND ACCURATELY BASED ON THE SOAP NOTES AND ANY ADDITIONAL CLINICAL INFORMATION UPLOADED TO THE ATREZZO CASE.

ONCE COMPLETED AND SIGNED, THE INFORMATION IN THIS QUESTIONNAIRE IS LEGALLY BINDING AND MAY BE USED AS EVIDENCE IN AN APPEAL AND IS ALSO SUBJECT TO ROUTINE AUDITS.

IN THE EVENT YOU HAVE QUESTIONS OR CONCERNS ABOUT ANY OF THE REQUESTED INFORMATION, PLEASE STOP AND REFER YOUR CONCERN TO THE CLINICIAN WHO COMPLETED THE PROCEDURE. (PLEASE REFER TO YOUR MHCP MANUAL IF YOU HAVE QUESTIONS REGARDING ROUTINE POLICIES OR PROCEDURES.)

OUTPATIENT SERVICES REQUEST

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

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 (4 MB size limit):

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.

To attach documents:

1. Select the **Attached Documents** menu option.
2. Click the **Browse...** button.
3. **Locate correct file document.**
4. **Double-click the file document** to populate "Attach New Document" field
5. Click on **Attach Selected Document** button.
6. Click **Next** button to repeat above steps until all documentation is attached.

Question #1:

Prophylaxis D1110

1. Does this patient meet DHS Criteria for additional Prophylaxis (D1110) for any of the following? Please check all that apply.

(Please select between 1 and 7 items.)

- Physically disabled
- Residing in a supported residence (including nursing homes or group home setting)
- Patient physically unable to adequately perform daily oral hygiene without support
- Have a cognitive impairment or brain injury
- Have a medical condition that puts them at high risk for complications, including xerostomia
- Taking medications known to cause gingival hyperplasia or xerostomia
- Have a mental health condition
- N/A

Please check **ONLY** the options that are supported by the clinical documentation SUBMITTED that apply to this recipient

Question #2:

2. *Is this Solely for Cosmetic purposes?*

(Please select one.)

- Yes
- No

Indicate the correct answer to Question #2.

Question #3:

Instructions: WARNING: Attached documentation is subject to audit. Insure all information below is submitted. Level of plaque Level of calculus Tissue condition
Periodontal class type Education/oral hygiene instruction

3. *Please provide the date the first prophylaxis of this calendar year was completed. (Please attach the SOAP note to this case.*

Date: 07/12/2019



WARNING: Documentation is required and subject to audit.

Question #4:

4. *Is the Clinicians recommended recall frequency stated clearly in the clinical notes?*

(Please select one.)

- Yes
- No

4.1.1. *Recall Frequency*

(Please select one.)

- 3 month
- 4 month
- 6 month

**If you selected
 Yes
please indicate the
frequency.**

Question #5:

5. *What length of approval is being requested 1 year or 2 year?*

(Please select one.)

- 1 Year
- 2 Year


**Indicate the correct
answer to Question #5.**



REVIEW YOUR ANSWERS!!!

Review all answers to ensure complete and accurate information and remember to save any changes that you make to the questionnaire

HOME | REQUESTS | SEARCH | MANAGEMENT | REPORTS | MY ACCOUNT | HELP

Please save all answers prior to printing
PRINT QUESTIONNAIRE 

Edit Questionnaire

Status: Incomplete

Save Changes [Return To Request](#)

Remember to "Save Changes" to the questionnaire.

Electronic Signature

- ❖ (Attest and certify that the information provided is true and accurate!)

Signature

1. By checking "I agree" and typing my name in the "Electronic Signature" field, I understand that I am electronically signing this form. In addition, I attest and certify that I have verified the profile change against an acceptable form of identification and that the information provided above is true and accurate. **I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. 325L.07)**

(Please select one.)

I agree

2. *Electronic Signature*

Denise Rinell

**Please select
 I agree
and type in your name.**

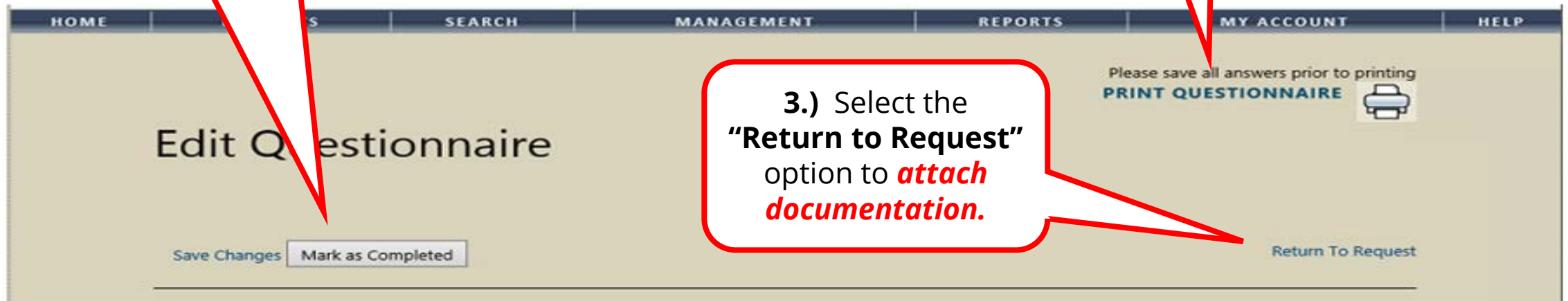
Mark as Complete and Print Copy

1.) Once the questionnaire is complete, click the **“Mark as Completed”** button.

IMPORTANT!
No further edits to the questions will be allowed after this step!

2.) **Print a copy** of the questionnaire for your records.

3.) Select the **“Return to Request”** option to **attach documentation**.



Attached Documents

Questionnaires

Document Type (required): (Select One)

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

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

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

Once ALL documents have been attached:

1. Click the **white box** at bottom(left) of screen (*you must attest that you understand this submission is not a guarantee of payment*).
2. Click **Submit** button.



For additional assistance, please contact:

Kepro Customer Service Department

1-866-433-3658

OR

Refer to the **Provider User Guide**

located in the "HELP" tab within
the Atrezzo Provider Portal system.



QUESTIONS?

COMMON FAQs



Thank
You