Acentra HEALTH

On behalf of

HEALTH FIRST COLORADO

Adult Long-Term Home Health

COLORADO
Department of Health Care Policy & Financing

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CNSI + Kepro

In 2021, Kepro was awarded the Department of Health Care Policy and Financing (HCPF) contract for Utilization Management and Physician Administered Drug (PAD) review.

With over six decades of combined experience, CNSI and Kepro have **come together to become:**

Acentra HEALTH

Our purpose is to accelerate better health outcomes through technology, services, and clinical expertise.

Our vision is to be the vital partner for healthcare solutions in the public sector.

Our mission is to continually innovate solutions that deliver maximum value and impact to those we serve.

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About Acentra Health

In addition to UM review, Acentra Health will administer or provide support in:

- Client Overutilization Program (COUP)
- Annual HCPCS code review
- Quality Program
- Reporting
- Review Criteria selection
- Customer Service Line
- Appeals, Peer-to-Peer, and Reconsiderations
- Fraud & False Claims reporting

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Scope of Services

- **Adult Long-Term Home Health**
- Audiology
- Diagnostic Imaging
- Durable Medical Equipment
- Inpatient Hospital Transition (IHT)
- Medical Services including, but not limited to, select surgeries such as bariatric, solid organ transplants, transgender services, and elective surgeries
- Molecular/Genetic Testing
- Out-of-State Inpatient Services
- Outpatient Physical and Occupational Therapy
- Outpatient Speech Therapy
- Pediatric Behavioral Therapy
- Private Duty Nursing
- Personal Care Services
- Physician Administered Drugs

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Acentra Health's Services for Providers

- 24-hour/365 days **provider portal** accessed at: https://portal.kepro.com
- **Provider Communication and Support** email: coproviderissue@acentra.com
- Provider Education and Outreach, as well as system **training materials** (including Video recordings and FAQs) are located at: https://hcpf.colorado.gov/par
- **Prior Authorization Review (PAR)**
- Retrospective Review (when allowed by CO HCPF)
- PAR Reconsiderations & Peer-To-Peer Reviews
- PAR Revisions
- Access to provider reports and case statuses with Atrezzo Portal
- Provider Manual is posted at: https://hcpf.colorado.gov/par

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Provider Responsibilities

- Providers must request Prior Authorization for services through Acentra's portal, **Atrezzo.** A Fax Exempt Request form may be completed here if specific criteria is met such as:
  - The provider is out-of-state or the request is for an out of area service
  - The provider group submits on average 5 or fewer PARs per month and would prefer to submit a PAR via fax
  - The provider is visually impaired
- Utilization of the Atrezzo portal allows the provider to:
  - Request prior authorization for services
  - Upload clinical information to aid in review of prior authorization requests
  - Submit reconsideration and/or peer-to-peer requests for services denied

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Provider Responsibilities (cont'd…)

- The system will give warnings if a PAR is not required
- **Always verify** the Member's eligibility for Health First Colorado prior to submission by contacting Health First Colorado
- The generation of a Prior Authorization number does not guarantee payment

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Prior Authorization Review Submission

- Atrezzo portal is accessible 24/7
- PAR requests submitted within business hours: 8:00AM – 5:00PM (MT) will have the same day submission date
  - *After business hours*: will have a receipt date of the following business day
  - *Holidays*: will have a receipt date of the following business day
  - *Days following state approved closures (i.e., natural disasters)*: will have a receipt date of the following business day

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PAR Submission: General Requirements

- PAR submissions will require providers to provide the following:
  - Member ID
  - Name
  - Date Of Birth
  - Rev codes to be requested
  - Dates of service(DOS)
  - ICD10 code for the diagnosis
  - Servicing provider (billing provider) National Provider Identifier (NPI) if different than the Requesting provider

https://hcpf.colorado.gov/par

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Adult Long-Term Home Health (ALTHH) Documentation Requirements

All ALTHH PAR submissions must include:

1. The complete and current plan of care using the HCFA-485 or other document that is identical in content which must include a clear listing of:
   - Member's diagnoses that will be addressed by Home Health
   - The specific frequency and expected duration of the visits for each discipline ordered
   - The duties/treatments/tasks to be performed by each discipline during each visit

The plan of care must be created by a registered nurse employed with the Home Health Agency. The plan of care must be signed by the member's attending physician prior to submitting the final claim for a certification period. For additional information on Health First Colorado plan of care requirements refer to the Home Health Services Benefit Coverage Standard referenced in 10 C.C.R 2505-10 8.520 – HOME HEALTH SERVICES

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Adult Long-Term Home Health (ALTHH) Documentation Requirements (con't)

2. The Adult Long-Term Home Health PAR form located on the Provider Forms Web Page under the PAR Forms drop-down menu.

3. All other supporting documentation to support the request including but not limited to physician's orders, treatment plans, nursing summaries, nurse aide assignment sheets, medications listing, etc. Any other documentation deemed necessary by the Department or its authorizing agency.

4. All supporting documentation must be within 60 days of the start of the PAR

More information can be found in the billing manual Here

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REV Codes and Units

- Rev Code 551 is a standard visit. This is a unique visit in which a complete assessment is done. Additional time may be spent but care is only paid for up to 2.5 hours.
- Rev Code 590 is brief and shorter than 551 and is limited to the first visit of the day. Only one of these may be billed a day and must be a separate visit from anything else.
- Rev code 599 is just like 590 but is for a second (or additional) visit in the same day.
- You must have a 590 or a 551 to have a 599.
- PRN visits can be standard or brief if needed.
- Refer to the Fee Schedule for maximum daily cap.

ALTHH Rev Codes (21+)	551	590	599	571	579
Code Description	RN or LPN 2.5 hours	Brief RN/LPN visit. First visit of day	Brief RN/LPN visit. Second visit same day or any visit thereafter	HHA visit. First one-hour visit.	HHA Visit. Every 30-minute increment after the first hour visit.
Unit Description	1 unit = up to 2.5 hours	1 unit= 1 hour visit	1 unit = 1 hour visit	1 unit = 1 hour day.	1 unit = up to 30 minutes

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Submission Requirements At a Glance

Duration	**PAR limited to 365 days**
Provider Timely Submission Requirement	Up to 10 business days after start of services
Retroactive Authorization	Not accepted by Acentra Health
(Member not eligible at time of service)	*Exceptions may be made by HCPF
Servicing Provider / Billing Provider	Home Health Agency
Requesting Provider	Physician, Physician Assistant, Nurse Practitioner , Home Health Agency

*When a member's eligibility is determined after the date of service, the member is issued a Load Letter. The Load Letter must be submitted with the supporting clinical documentation for the PAR for a retroactive request to be processed.

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Timely Submission

- A detailed step by step process for submitting both outpatient and inpatient requests can be found in the provider training manual at hcpf.colorado.gov/par

- Timely Submission means entering the request before services are rendered and with enough advanced notice for the review to be completed.

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Reimbursable Home Health Services

The licensed and certified Class A Home Care Agency shall not utilize staff that has been excluded from participation in federally funded health care programs by the US Department of Health and Human Services (HHS)/Office of Inspector General (OIG) and shall be in good standing with the Colorado Department of Regulatory Agencies (DORA) or other regulatory agency:

Certified Nurse Aides (CNA) must have a current, active license in accordance with the DORA Colorado Nurse Aide Practice Act at § 12-38-111, C.R.S.

Long-Term Home Health: Skilled certified nurse aide visits are reimbursed based on the amount of time the CNA is providing skilled care to a member. If a certified nurse aide provides care for at least 15 minutes but not more than 60 minutes, the agency shall bill a basic unit with revenue code 571. For every additional 30 minutes the certified nurse aide provides hands-on assistance to the member, the agency may bill an extended CNA unit with revenue code 579. A unit of time that is less than 15 minutes shall not be reimbursable as a basic unit and at least 15 minutes must elapse before an agency may bill an extended unit.

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Reimbursable Home Health Services (con't)

Registered Nurses (RN) and Licensed Practical Nurses (LPN) must have a current, active license in accordance with the DORA Colorado Nurse Practice Act at § 12-38-111, C.R.S.

Long-Term Home Health: Nursing services provided during Long-Term Home Health shall be billed using the appropriate revenue codes based on the purpose and complexity of the nursing visit. Standard, infrequent or complicated nursing visits may be billed using revenue code 551. Nursing visits that are uncomplicated in nature or visits that are uncomplicated with frequent revisits completed by the nurse shall be billed using revenue codes 590 and 599.

Long-Term Home Health nursing visits for the **sole** purpose of assessing a member may be reimbursed for a limited time when managing, and reporting to the member's physician on specific conditions and/or symptoms which are not stable.

Non-Reimbursable Home Health Services

- Supplies used for routine Home Health are not reimbursed separately through the Home Health or Durable Medical Equipment (DME) benefit. Non-routine or member specific supplies must be reimbursed through the member's DME benefit.

- Nursing Visits for purpose of psychiatric counseling

- Certified nurse aide visits for the purpose of providing only unskilled personal care and/or homemaking services.

- Nursing or CNA visits provided in a shift (visits lasting more than 4.5 consecutive hours)

- Nursing visits for the sole purpose of providing supervision of the CNA or other Home Health staff

- Nursing visits for the sole purpose of completing the Home Health plan of care/recertification

- Long-Term Home Health nursing visits for the sole purpose of teaching the member or their family member

- Long-Term Home Health nursing visits for the **sole** purpose of assessing a stable member where management, and reporting to physician of specific conditions and/or symptoms which are not stable

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ALTHH Unit Calculations

Total number of units must be entered in the requested line for each Rev Code.
The system does not calculate the units for you, you must enter the total number of units for the time frame requested.

For example: The Provider is requesting 2 non-consecutive visits per day each lasting 2 hours for 180 days. (2 units of 0571 and 4 units of 0579)

0571 2 units per day x 180 days = 360 total units should be requested.
0579 4 units per day x 180 days = 720 total units should be requested.

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Questionnaire

Adult Long Term Home Health

1 . Is this an initial request for home health or has the member previously had LTHH services? *

(●) Yes ( ) No

2 . Is this a revision request? *

( ) Yes ( ) No

3 . Is this a change of provider request? *

( ) Yes ( ) No

4 . Is the member receiving services through a waiver? *

( ) Yes ( ) No

5 . Is the member also receiving Personal Care Services or Private Duty Nursing? *

( ) Yes ( ) No

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Questionnaire

6 . Has duplication of services been reviewed? *

○ Yes ○ No

7 . Is there a signed physician order included on the plan of care with frequency and duration uploaded to the case? *

○ Yes ○ No

8 . Are the duties/treatments/tasks to be performed by each discipline during each visit listed on the plan of care? *

○ Yes ○ No

9 . Is Documentation supporting medical necessity attached? *

○ Yes ○ No

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Questionnaire

10 . Adult Long Term Home Health Submission Requirements - Please confirm by checking the boxes that all requirements are satisfied. *

- [ ] I have attached the written order from a qualified physician or allowed practitioner.
- [ ] I have uploaded the HCFA-485
- [ ] I have uploaded documentation supporting the medical necessity for the request.
- [ ] I have verified that the services requested on this PAR meet the regulations outlined at 10 CCR 2505-10 8.520.
- [ ] I certify that all documentation and statements included in this request are true and accurate.
- [ ] I am aware that this request and the services provided are subject to post-payment review.

Autosaved

MARK AS COMPLETE >

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Definition of Medical Necessity

10 CCR 2505-10; 8.076.18

Medical necessity means a Medical Assistance program good or service:

a. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability.

This may include a course of treatment that includes mere observation or no treatment at all;

b. Is provided in accordance with generally accepted professional standards for health care in the United States;

c. Is clinically appropriate in terms of type, frequency, extent, site, and duration;

d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider;

e. Is delivered in the most appropriate setting(s) required by the client's condition;

f. Is not experimental or investigational; and

g. Is not more costly than other equally effective treatment options.

- **For EPSDT, medical necessity includes a good or service that will or is reasonably expected to, assist the member to achieve or maintain maximum functional capacity in performing one or more Activities of Daily Living, and meets the criteria, Code of Colorado Regulations, Program Rules (10 CCR 2505-10.8.280.4.E.2).**

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PAR Revision

- While LTHH PARs are approved for a specific number of units of each code, in certain cases LTHH providers must re-allocate approved units of 571 and 579 on a particular Review. (Note: Units may be changed, but the total number of approved hours must remain the same.)
- In order to reallocate units, you must provide
  - The balance available per revenue code at the time of request with the total hours as well as
  - The exact amount of units you want allocated to revenue codes with NEW TOTALS FOR THE ENTIRE DURATION OF THE AUTHORIZATION PERIOD.
- If the number of approved units needs to be amended or reallocated, the provider must submit a request for a PAR revision prior to the PAR end date.
  - Changes requested after a PAR is expired will not be made by the Department or the authorizing agency.

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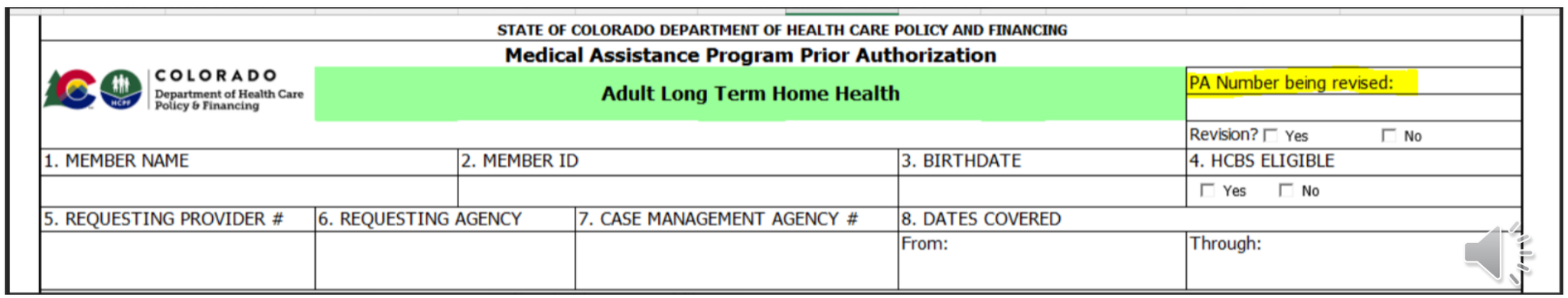
PAR Revision

To make a revision on a PAR that was not submitted via the Atrezzo portal:

- Create a new case in Atrezzo with a start date within 10 business days of the date of submission for the member
- Select “yes” on the questionnaire stating it is for a revision
- Place a note in the case specifying the original start date and if the request is for a reallocation of units or for an increase in units.
- Submit the total number of units for each Rev Code for the entire duration of the PAR
- If the request is for an increase in units, submit documentation to support the increase.
- The existing prior authorization number must be placed on the required Prior Authorization Form here



STATE OF COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

Medical Assistance Program Prior Authorization

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Adult Long Term Home Health

PA Number being revised:

Revision? ☐ Yes ☐ No

1. MEMBER NAME	2. MEMBER ID	3. BIRTHDATE	4. HCBS ELIGIBLE
			☐ Yes ☐ No

5. REQUESTING PROVIDER #	6. REQUESTING AGENCY	7. CASE MANAGEMENT AGENCY #	8. DATES COVERED	
			From:	Through:

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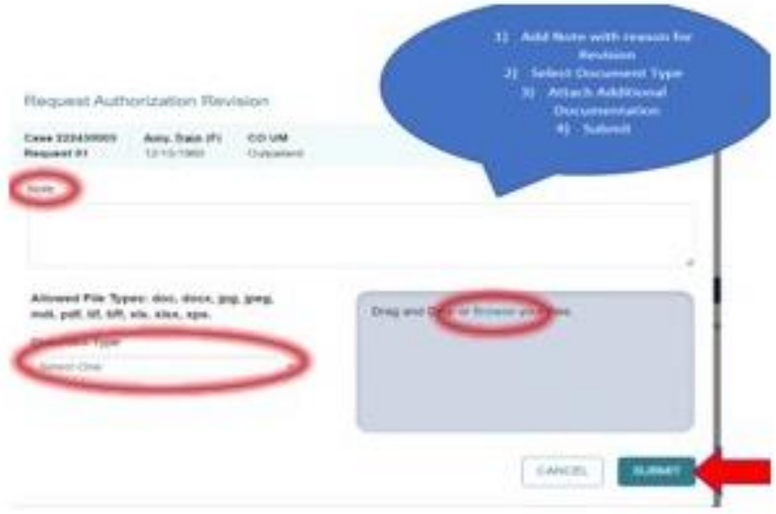
PAR Revision

To make a revision on PARs submitted via Atrezzo:

- Select “Request Revision” under the “Actions” drop-down
- Select the Request number and enter a note in the existing approved case of what revisions/reallocations you are requesting
- Upload the required PAR form and additional documentation to support the request as appropriate



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Change of Provider Form

- When a member receiving services, changes providers during an active PAR certification, the receiving provider will need to complete a Change of Provider Form (COP) to transfer the member's care from the previous provider to the receiving agency.

- This form is located on the Provider Forms webpage under the Prior authorization Request (PAR) Forms, drop-down menu.

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Acentra Health Services for Providers - Recap

- 24-hour/365 days provider **Atrezzo Portal** may be accessed at: https://portal.kepro.com

- System Training materials (including Video recordings and FAQs) and the **Provider Manual** are located at: https://hcpf.colorado.gov/par

- Provider Communication and Support email: coproviderissue@acentra.com

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Thank you for your time and participation!

- **For Escalated Concerns please contact:** homehealth@state.co.us
- **Acentra Health Customer Service:** (720) 689-6340
- **PAR Related Questions:** coproviderissue@acentra.com

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