Acentra HEALTH

On behalf of

HEALTH FIRST COLORADO

Diagnostic Imaging Utilization Review

COLORADO
Department of Health Care Policy & Financing

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CNSI + Kepro

Acentra HEALTH

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:**

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)
- Long Term Home Health
- 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: atrezzo.acentra.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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Diagnostic Imaging PAR Requirements

Emergency PAR

- Emergency outpatient imaging and radiology procedures are exempt from PAR requirements.

Prior Authorization Requirements and Information: All information can be found in the billing manual:
https://hcpf.colorado.gov/imaging-manual

- Health First Colorado requires all outpatient hospitals and free-standing radiology/X-ray facility centers to obtain a PAR for most non-emergent CT, non-emergent MRI, and all PET scans.

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DI PAR Requirements Con't

Imaging and radiology services are a benefit under the following conditions:

- Services must be authorized and supervised by a licensed physician.
- The services are performed to diagnose conditions and illnesses with specific symptoms.
- The services are performed to prevent or treat conditions that are Health First Colorado covered benefits.
- The services are not routine diagnostic tests performed without apparent relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.
- Radiology services are performed by a provider with equipment certified by the Colorado Department of Public Health and Environment (CDPHE) and enrolled as a Health First Colorado Provider..

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Submission Requirements At a Glance

Duration	PAR limited to 90 days
Provider Timely Submission Requirement	Prior to rendering 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	Outpatient hospitals and free-standing radiology/X-ray facility centers
Requesting Provider	Physician, Physician Assistant, Nurse Practitioner

*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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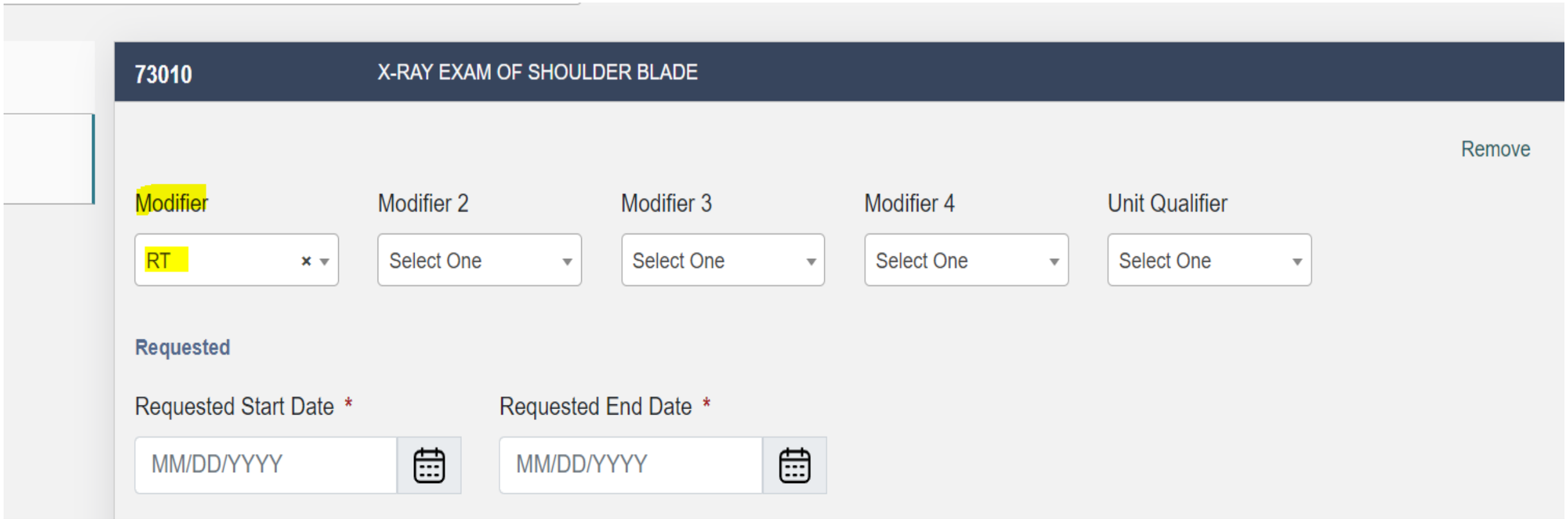
DI Modifier Requirements and Placement

RT: Right side LT: Left side 50: Bilateral

Below is an example of placement for modifiers within the review.



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Covered DI Benefits

Health First Colorado covers procedures including but not limited to: angiograms, computed tomography (CT scans), electrocardiograms (ECG), magnetic resonance imaging (MRI scans), mammograms, positron emission tomography (PET scans), radiation treatment, ultrasounds, and X-rays.

Computed Tomography

- CT of sinuses for acute, uncomplicated rhinosinusitis (ICD-10 J01) is not covered.
- Virtual Colonoscopy (CPTs 74261, 74262, 75263) is covered at a frequency of once every five years.

Magnetic Resonance Imaging

- Imaging of cortical bone and calcifications, and procedures involving spatial resolution of bone and calcifications are not covered.
- Imaging of the same anatomic area to address patient positional changes, additional sequences, or equipment failure is not allowed. These variations or extra sequences are included within the original imaging authorization request.

PET Scans

- All PET and SPECT scan procedures require prior authorization regardless of whether emergency is indicated

Specific Non-Covered DI Benefits

- Procedures for cosmetic treatment or infertility treatment (ICD-10 N97) are not covered.
- Procedures considered experimental or not approved by the Food and Drug Administration (FDA) are not covered.
- Procedures not ordered by the member's attending or treating physician are not covered.
- Procedures which are part of a clinical study are not covered.

** For those requests for under the age of 21, all requests will be reviewed for medical necessity under EPSDT

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Preventative Lung Cancer Screening

Preventive Lung Cancer Low Dose Computed Tomography (LDCT) Screening

- The United States Preventive Services Task Force recommends annual screening for lung cancer with low-dose computed tomography for adults ages 50 to 80 years who have a 20 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.

- The following policies are effective as of January 1, 2021:
  - HCPCS code G0297 has been replaced with HCPCS code 71271.
  - HCPCS code 71271 must be used and always requires Prior Authorization.
  - ICD-10 diagnosis code Z12.2 must be reported on the claim.
  - Benefit is limited to one screening (one billed unit of service) per state fiscal year (July 1 – June 30).
  - Member must meet all of the following criteria to be eligible for the benefit:
    - **Between 50 and 80 years of age.**
    - **Asymptomatic (no signs of lung cancer).**
    - **History of cigarette smoking of at least 20 pack-years.**
    - **Current smoker or one who has quit smoking within the last 15 years.**
    - **Receives written order for LDCT lung cancer screening from a qualified physician or non-physician practitioner.**

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Tips to Reduce Pends and Denials

- Respond to requests for additional information in their entirety and within 10 business days. If a request is not responded to or the response is insufficient, Acentra Health will complete the review and deny for lack of information if appropriate.

- Verify the order matches the procedure in name/code/contrast being requested (e.g., upcoding to include contrast from what was in the original order/revised order not signed). **A new order is required if a change is made to up-code.**

- Make sure the order is signed by the MD/DO/NP/PA/**DDS/DPM/CRNA** with a wet or electronic signature, that it **is current, and it covers the dates of service being requested.**

- Ensure clinical documentation being submitted supports the request, is within the last 12 months and is relevant to why the procedure code is being requested. This documentation should come from the ordering provider.

- Check that all documentation submitted is for the correct member.

- **If the request is for repeat imaging, submit previous imaging results.**

- **Check the latest fee schedule to ensure if the code(s) require a prior authorization.**

Tips to Reduce Pends and Denials

- **Provider may request extension and use the extend feature instead of putting in a new case.**
- **Read the questions on the questionnaire and before checking the box. Reach out to customer service to reset questionnaire if answered incorrectly.**
- **Complete COP form in its entirety, if ending another provider's case.**
- **Ensure that there is not a case submitted already before submitting another case (same provider).**
- **Request authorization revision for changes instead of submitting a new case.**
- **Ensure that the date duration is appropriate- can have up to 90 days.**
- **Ensure that all modifiers are included when submitting. ex. RT for right and LT for left.**
- **Cases submitted using a temporary ID will be voided. You must submit a request using the member's Medicaid ID number. A PAR number cannot be assigned to a case using a temporary ID number.**

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PAR Determination Process

After submission of a request, you will see one of the following actions occur:

1. **Approval**: Met criteria/Code of Colorado Regulations applied for the service requested at first level review or was approved at physician level.

2. **Request for additional information**: Information for determination is not included and vendor requests this to be submitted to complete the review.

3. **Technical Denial:** Health First Colorado Policy is not met for reasons including, but not limited to, the following reasons:

    - Untimely Request
    - Requested information not received or Lack of Information (LOI)
    - Duplicate to another request approved for the same provider
    - Service is previously approved with another provider

4. **Medical Necessity Denial***:* Physician level reviewer determines that medical necessity has not been met and has been reviewed under appropriate guidelines. The Physician may fully or partially deny a request.

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PAR Determination Process (con't)

Denials

- If a **technical denial** is determined, the provider can request a reconsideration.
- If a **medical necessity denial** was determined, it was determined by a Medical Director. The Medical Director may fully or partially deny a request. For a medical necessity denial, the provider may request a reconsideration and/or a Peer-to-Peer.

Steps to consider after a denial is determined:

- **Reconsideration Request:** the *servicing* provider may request a reconsideration to Acentra Health within *10 business days* of the initial denial. If the reconsideration is not overturned, the next option is a Peer-to-Peer (Physician to Physician).
- **Peer to Peer Request:** an *ordering* provider may request a Peer-to-Peer review within *10 business days* from the date of the medical necessity adverse determination.
  - Place the request in the case notes, providing the physician's full name, phone number, and three dates and times of availability.
  - The peer-to-peer will be arranged on one of the provided dates and times for the conversation to be conducted. You may also call Customer Service at 720-689-6340 to request the peer-to-peer.

Turnaround Times – Part 1

Turnaround Time: the turnaround time for completion of a PAR review ensures:

- A thorough and quality review of all PARs by reviewing all necessary & required documentation when it is received
- Decreases the number of unnecessary pends to request additional documentation or information
- Improves care coordination and data sharing between Acentra Health and the Department's partners (i.e., Regional Accountable Entities, Case Management Agencies, etc.)

For additional information pends: the provider will have 7 calendar days to respond. It is important to note due to Federal Interoperability requirements only one pend or request for additional information will be sent. If there is no response or insufficient response to the request, Acentra Health will complete the review and technically deny for Lack of Information (LOI) if appropriate. In addition, expedited requests will no longer receive any requests for additional information, the determination will be made based off the information submitted and technically denied if required documents are not submitted.

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Turnaround Times – Part 2

Expedited review : a PAR that is expedited is because a delay could:

- Jeopardize Life/Health of member,
- Jeopardize ability to regain maximum function
- and/or subject to severe pain.

These requests will be completed in no more than 72 hours. For expedited requests, **no pends or requests for information** will be allowed in order to comply with the interoperability rules requirement for 72 hours.

Rapid review: a PAR that is requested because a longer TAT could result in a delay in the Health First Colorado member receiving care or services that would be detrimental to their ongoing, long-term care.

A Rapid review may be requested by the Provider in very specific circumstances including:

- A service or benefit that requires a PAR and is needed prior to a HFC member's inpatient hospital discharge.
- Same Day Diagnostic studies required for cancer treatments.
- Genetic or Molecular testing requiring amniocentesis

These requests will be completed in no more than 1 business day.

Standard review: the majority of cases would fall under this category as a Prior Authorization Request is needed. These requests will be completed in no more than 7 calendar days.

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Early and Periodic Screening Diagnostic Treatment (EPSDT)

- Acentra Health follows the EPSDT requirements for all medical necessity reviews for Health First Colorado members.

- Medical necessity reviews on treatments, products or services requested or prescribed for all members ages 20 years of age and under are based on compliance with federal EPSDT criteria.

- Medical necessity is decided based on an individualized, child specific, clinical review of the requested treatment to ‘correct or ameliorate’ a diagnosed health condition in physical or mental illnesses and conditions.

- EPSDT includes both preventive and treatment components as well as those services which may not be covered for other members in the Colorado State Plan.

https://hcpf.colorado.gov/early-and-periodic-screening-diagnostic-and-treatment-epsdt

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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

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 agent.
- If a PAR has been billed on Acentra Health cannot make revisions to the modifiers or NPI numbers.

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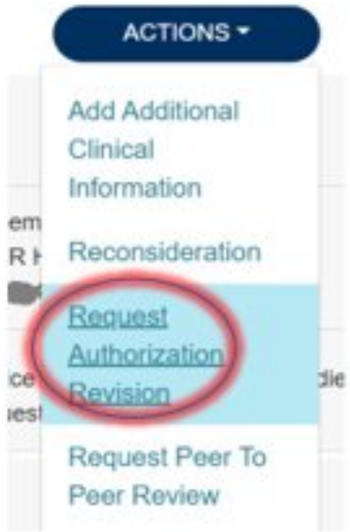
PAR Revision Con't

To make a revision:

- 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.

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Acentra Health Services for Providers - Recap

- 24-hour/365 days provider **Atrezzo Portal** may be accessed at: atrezzo.acentra.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: hcpf_um@state.co.us
- Acentra Health Customer Service: (720) 689-6340
- PAR Related Questions: coproviderissue@acentra.com

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