Hello and welcome to the benefit specific training for diagnostic imaging providers.

Today we will discuss EPSDT, Acentra Health and our scope of services, Acentra Health services for providers, provider responsibilities, PAR submission, general requirements, diagnostic imaging PAR requirements, submission requirements, timely submission, covered diagnostic imaging benefits, specific non covered DI benefits, preventative lung cancer screening, the PAR determination process, turnaround times, Medicaid rule for medical necessity, PAR revisions, the change of provider form and then have a brief recap.

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.

In 2021, Kepro was awarded the Department of Health Care policy and financing contract for utilization management and Physician Administered Drug Review.

With over 6 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 and our mission is to continually innovate solutions that deliver maximum value and impact to those we serve.

In addition to UM review Acentra Health will administer or provide support in a client overutilization program, annual HCPCS code review, a quality program, reporting, review criteria selection, customer service line, appeals, Peer to Peer and reconsiderations, as well as fraud and false claims reporting.

Our scope of services include audiology, diagnostic imaging, durable medical equipment, the inpatient Hospital Review program, medical services, molecular and genetic testing, out of state inpatient services, outpatient physical, occupational and speech therapy, pediatric behavioral therapy, private duty nursing, personal care services and physician administered drugs.

Our provider portal ATREZZO is available 24 hours a day, 365 days a year and can be accessed at portal.kepro.com.

For provider communication and support please email Coprovidersissue@kepro.com.

For provider education and outreach as well as system training materials and the provider manual please visit the Colorado PAR website at hcpf.colorado.gov/par.

Providers must request prior authorization for services through Acentra's Portal, Atrezzo. A fax exempt request form may be completed 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 prefer to submit a PAR via fax, or the provider is visually impaired.

Utilization of the Atrezzo portal allows the provider to request the prior authorization for services, to upload clinical information to aid in the review of the prior authorization request, and to submit reconsideration and/or a peer to peer requests for services denied.

If a PAR is not required, the system will give a warning.

You should always verify the Member's eligibility for Health First Colorado prior to submission by contacting Health First Colorado.

As always, the generation of a prior authorization number does not guarantee payment.

PAR requests submitted within the business hours of 8:00 AM to 5:00 PM Mountain time will have the same day submission date.

While the Atrezzo portal is accessible 24 hours a day/7 days a week, requests submitted after business hours, on holidays, or on days following state approved closures will have a receipt date of the following business day.

When submitting a PAR request, you will need to provide the Members ID, name and date of birth, the CPT or HCPCS codes to be requested, the dates of service, the ICD 10 code for the diagnosis, and the servicing provider or billing providers national provider identifier (NPI) if it is different than the requesting providers.

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

All information on prior authorization requirements can be found in the billing 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.

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 and enrolled as a Health First Colorado provider.
The PAR duration is limited to 90 days.

You must request the prior authorization prior to rendering services.
Retroactive authorizations are not accepted by Acentra.

Exceptions may be made by HCPF if the member is not eligible at the time of service.

The servicing provider, or the billing provider would be the outpatient hospitals and free standing radiology and X-ray facility centers.

The requesting provider would be the physician, the physician assistant or the nurse practitioner.

When a Member's eligibility is determined after the date of service, the member is issued a load letter.

This load letter must be submitted with the supporting clinical documentation for the PAR for a retroactive request to be processed.

A detailed step by step process for submitting both outpatient and inpatient requests can be found in the provider training manual.

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

The image on the screen shows where the placement for the modifiers belong within the review.

The RT modifier should be used for any right sided imaging requests, the Lt modifier should be used for any left sided imaging requests, and the 50 modifier should be used for any bilateral imaging requests.

CT of sinuses for acute uncomplicated rhinosinusitis is not covered.

Cardiac CT for quantitative evaluation of coronary artery calcification is not covered.

Virtual colonoscopy is covered at a frequency of once every five years.

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.

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

Procedures for cosmetic treatment or infertility treatment are not covered.

Procedures considered, experimental or not, approved by the Food and Drug Administration are not covered.

Procedures not ordered by the members attending or treating physician are not covered.

Procedures which are part of a clinical study are not covered.

Any requests submitted for Members under the age of 21 will be reviewed for medical necessity under EPSDT.

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 per 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 1st, 2021.

The HCPCS code G0297 has been replaced with HCPCS code 71271.
This code must be used and always requires a prior authorization.

The ICD 10 diagnosis Code Z 12.2 must be reported on the claim.

The benefit is limited to 1 screening per state fiscal year.

The Member must meet all of the following criteria to be eligible for the benefit:

They must be between 50 and 80 years of age.

They must be asymptomatic.

They must have a history of cigarette smoking of at least 20 packs per year.

They must be a current smoker, or one who has quit smoking within the last 15 years and they must receive a written order for LDCT lung cancer screening from a qualified physician or non-physician practitioner.

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

An approval. This means the request met criteria and was approved at either first level review or at physician level.
A request for additional information. This means that the information needed to make a determination was not included and the vendor requests this to be submitted in order to complete the review.

A technical denial. Health First Colorado policy is not met for reasons including but not limited to the following:
The request was submitted untimely.
The requested information was not received or a lack of information.
The request is a duplicate to another request approved for the same provider or the request was previously approved with another provider.

A medical necessity denial. This means that physician level reviewer determines that medical necessity had not been met and has been reviewed under appropriate guidelines. The physician may fully or partially deny a request.

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 review.

For the reconsideration request.
The servicing provider may request the reconsideration to Acentra Health within 10 business days of the initial denial.

If the reconsideration is not overturned, the next option would be the peer-to-peer or physician to physician review.

For the peer-to-peer request an ordering provider may request the peer-to-peer review within 10 business days from the date of the medical necessity adverse determination.

To do so, you would need to place the request in the case notes providing the physicians 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 review.

The turnaround time for completion of a PAR review ensures a thorough and quality review of all PARS by reviewing all necessary and required documentation when it is received, it decreases the number of unnecessary pends to request additional documentation or information and it improves care coordination and data sharing between Acentra Health and the department's partners like the regional accountable entities and case management agencies.

For additional information pends, the provider will have 10 business days to respond.

If there is no response, or if there is an insufficient response to the request Acetra will complete the review and technically deny for lack of information if appropriate.

A PAR that is expedited is because a delay could jeopardize the life or health of a member, It could jeopardize the ability of the member to regain maximum function, and/or subject the member to severe pain.

These requests will be completed and no more than four business hours.

A rapid review is a PAR that is requested because a longer turnaround time 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 the Health First Colorado member's inpatient hospital discharge, same day diagnostic studies required for cancer treatment and genetic or molecular testing requiring amniocentesis.

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

A standard review is the review that the majority of cases would fall under as a prior authorization request is needed.

These requests will be completed in no more than 10 business days.

Medical necessity means a medical assistance program good or service that 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.

It is provided in accordance with generally accepted professional standards for health care in the United States.

It is clinically appropriate in terms of type, frequency, extent, site and duration.

It is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker or provider.

It is delivered in the most appropriate setting required by the client's condition.

It is not experimental or investigational and it is not more costly than other equally believe 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.

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.

Acentra Health cannot make modifications to an expired PAR or a previously billed PAR.

To make a revision, you would simply select request revision under the actions drop down.

You would then select the request number and enter a note in the existing approved case of what revisions you are requesting.

You can also upload any additional documentation to support the request as appropriate.

When a member receiving services changes providers during an active PAR certification, the receiving provider will need to complete a change of provider form 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 forms drop down menu along with instructions on how to complete the change of provider form.

The provider portal Atrezzo, is available 24 hours a day, 365 days a year, and can be accessed at portal.kepro.com .

For system training materials and the provider manual, please visit the Colorado PAR website at hcpf.colorado.gov/par.

For provider communication and support, please email coproviderissue@kepro.com.
For any escalated concerns, please contact HCPF_um@state.co.us.

For Acentra Health customer service, please call 720-689-6340.

For any PAR related questions, you can email coproviderissue@kepro.com.

This concludes today's presentation. Thank you for your time and participation.