Acentra HEALTH

On behalf of

HEALTH FIRST COLORADO

DME Benefit Specific Training

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

- 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** 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 Health'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
- 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
  - HCPCS codes to be requested
  - Dates of service(DOS)
  - ICD10 code for the diagnosis
  - Number of units requested
  - Servicing provider (billing provider) National Provider Identifier (NPI) if different than the Requesting provider

https://hcpf.colorado.gov/par

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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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Covered Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Benefits

- Durable Medical Equipment (DME) is defined as equipment that can withstand repeated use and that generally would be of no value to the member in the absence of a disability, illness, or injury.
- Prosthetics and Orthotics (P&O or O&P) are defined as replacement, corrective, or supportive devices that artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body.
- Disposable Medical Supplies (Supplies) are defined as supplies that are specifically related to the active treatment or therapy for an illness or physical condition; they are non-durable, disposable, consumable and/or expendable.
- **Some supply items and most DME items require prior authorization.**
- Prior Authorization Requests must be submitted and approved before services are rendered. The service must be rendered by the identified supplier on the approved PAR. Services rendered must match the approved services exactly including any billed modifiers.

Submission Requirements

- All PARs must be submitted by the supply provider that intends to submit the claim for the service and have an attached prescription from the prescribing authority and any other required documentation.
- Prior Authorization Request dates typically have a date span for one (1) year less one (1) day. Exceptions for decreased span dates less than one (1) year are allowed in certain circumstances such as short-term rental or WIC application period. Dates must not exceed one (1) year and must match the dates on individual line items, or the PAR will be denied.
- All submissions must include an order for specific items and quantities with dates that match the dates of the PAR request. All orders must be signed by the MD/NP/PA/DO with either a wet signature or valid CMS compliant E-signature.

Submission Requirements At a Glance

Duration	**PAR limited to 365 days**
Provider Timely Submission Requirement	Allowed 90 calendar days from date of delivery
Retroactive Authorization (Member not eligible at time of service)	Not accepted by Acentra *Exceptions may be made by HCPF
Servicing Provider / Billing Provider	Supply provider, some pharmacies, Prosthetic/Orthotic only suppliers
Requesting Provider	Physician, Physician Assistant, Nurse Practitioner
Billing Manual Link	https://hcpf.colorado.gov/DMEPOS-manual

*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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Continuous and Bilevel Airway Pressure Devices (CPAP/BiPAP)

- CPAPs and BiPAPs require a trial (rental) period of 30-90 days, in which the member must demonstrate compliance, before a purchase request will be approved.

CPAP/BiPAP Replacement and Supplies

- If a device is replaced within five (5) years because of loss, theft, or irreparable damage there is no requirement for a new sleep test or trial period.
- If a device is replaced after five (5) years, there must be a face-to-face evaluation by the members treating physician (within six (6) months of the request) that documents that the beneficiary continues to use and benefit from the device. There is no requirement for a new sleep test or trial period.
- When supplies are needed for a member-owned device, the PAR must include either a download from the device that demonstrates compliance or a face-to-face evaluation by the members treating physician (within six (6) months of the request) that documents that the beneficiary continues to use and benefit from the device.
- Compliance is defined as usage that is 4 hours per night on 70% of nights during a consecutive thirty (30) day period anytime during the approved trial/rental period.
- If a member received a device prior to enrollment with Health First Colorado and needs a new device or supplies, then documentation that the beneficiary had a sleep test must be provided with the initial PAR. There is no requirement for a new sleep test unless the documentation from the prior test cannot be provided.
- Requests for replacement devices solely due to the device being older than five years are not medically necessary and will not be covered.

Disposable Supplies

Disposable supplies are a benefit of Health First Colorado for use by the member in his/her home. With the exception of gloves, the Home Health agency is responsible for providing all supplies necessary to meet the universal precaution requirement during a visit.

Trans-Anal Irrigation Systems

Beginning April 1, 2025, the information below should be used when billing for these products. A4459 no longer includes catheters. Prior authorization is required for these HCPCS codes.

- HCPCS A4459: Manual trans-anal irrigation system, includes water reservoir, pump, tubing, and accessories, without catheter, any type.
- HCPCS A4453: Rectal catheter with or without balloon, for use with any type transanal irrigation system, each.

Diabetic Supplies

Most diabetic supplies, such as glucose testing meters, test strips and other related supplies are a benefit with a prescription from a physician, physician assistant or nurse practitioner. Diabetic supplies are available for insulin, and non-insulin dependent members. Diabetic supplies MUST be billed as DMEPOS. Pharmacies billing supplies must follow Supply billing procedures and will not be reimbursed if billed as a pharmacy claim using NDC codes.

Continuous Glucose Monitor (CGM) Benefit Coverage

PARs, including requests for CGM supplies, will be limited to a 6-month period.

CGMs and related supplies are covered by Health First Colorado when all of the following coverage criteria are met:

- The beneficiary has diabetes mellitus; and
- The beneficiary is insulin-treated with multiple (three [3] or more) daily administrations of insulin or a continuous subcutaneous insulin infusion (CSII) pump; and,
- The beneficiary's insulin treatment regimen requires frequent adjustment by the beneficiary on the basis of BGM or CGM testing results; and,
- Within six (6) months prior to ordering the CGM, the treating practitioner has an in-person visit with the beneficiary to evaluate their diabetes control and determines that criteria (1-3) above are met; and,
- Every six (6) months following the initial prescription of the CGM, the treating practitioner has an in-person visit with the beneficiary to assess adherence to their CGM regimen and diabetes treatment plan.

Diabetic Supplies con't

CGM replacement policy per 8.590.2.J. Repairs and replacement parts are covered under the following conditions:

- The item was purchased by Medicaid; or
- The item is owned by the member, member's family or guardian; and
- The item is used exclusively by the member; and
- The item's need for repair was not caused by member misuse or abuse; and
- The item is no longer under the manufacturer warranty

An upgrade to a new model or different brand of CGM may be deemed medically necessary in the following situations:

- There is documentation that the current device is no longer functional either partially or entirely, and therefore is no longer clinically effective, or
- The requested upgrade is different in its capability and would be expected to provide better clinical outcomes than the current device, and
- The member has been using their current device for at least three (3) years.
- If the current CGM requires repair or replacement that is no longer possible because it is obsolete, requests may be approved in cases where use is less than three (3) years. PARs may be pended to gather additional details regarding the device being obsolete.

For requests to upgrade a CGM where the new device has the same manufacturer and procedure code as the current device, the upgrade request may be approved regardless of the devices condition, functionality and length of use. Cases will continue to be reviewed for medical necessity and may include ensuring compatibility of the new device with the member's insulin pump.

Mobility Equipment (Manual Wheelchairs, Power Wheelchairs and Scooters)

- All mobility equipment purchases require a PAR and must be accompanied by a signed letter of medical necessity from a physician, physician assistant or nurse practitioner
- Members who meet medical criteria guidelines may receive one (1) primary device and, when deemed necessary, one (1) secondary device within a five (5)-year time period. Replacement of stolen equipment requires a police report that conforms to criteria outlined in the Colorado Revised Statutes. Primary and secondary equipment cannot be duplicates.

Mobility Equipment Repairs and Modifications

PARs submitted with multiple pieces of equipment on the same request will be denied; each wheelchair or scooter that requires PAR must be submitted on separate requests.

- **The following information must be included in the request; requests lacking any of the following information will result in a denial or will be returned to the provider for the missing information:**
- Equipment type indication: manual, power; or scooter and
- Manufacturer, make, and model; and
- Serial number: PARs for repair and modification must identify the serial number of the base equipment in field 16 (paper) or field 12 (electronic) on the PAR form; and
- If available, the original wheelchair purchase date or PAR number; and
- Beginning July 1, 2017, the PAR must contain the RA or RB modifier depending on the request.
- **Note:** Repairs for members residing in a nursing facility may be covered if the wheelchair was owned by the member prior to entering the facility. In this instance, the PAR must indicate that the member is residing in the nursing facility by checking "yes" in the appropriate field on the PA request. The PAR will not be processed without this disclosure

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Complex Rehabilitation Technology (CRT) PARs

Complex Rehabilitation Technology (CRT) includes individually configured manual wheelchair systems, power wheelchair systems, adaptive seating systems, alternative positioning systems, standing frames, gait trainers, and specifically designed options and accessories classified as DME. Only qualified CRT suppliers may bill CRT procedure codes.

Prior Authorization Requests (PARs)

- There are two (2) levels of documentation requirements associated with PARs for CRT:
- **Basic Documentation**
  - This level of documentation does not require a specialty evaluation. Basic documentation requirements apply to all CRT wheelchairs and wheelchair-related items that require a PAR.
- **Specialty Evaluation Documentation**
  - This level of documentation provides further details in order to establish medical necessity. A specialty evaluation is an assessment performed by a licensed/certified medical professional (such as a Physical Therapist, Occupational Therapist, or physician) who has no financial relationship with the DME supplier and who has specific training and experience in complex rehab technology wheelchair evaluations. **NOTE:** Specialty evaluation is not required for CRT repair.

Specialty evaluation is required for:

- A new CRT wheelchair or a replacement CRT wheelchair after the 5th year mark for adults and 3rd year mark for children.
- A new custom contoured seating system or modification.
- An addition of power seating or alternative drive control to a wheelchair.

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Modifier Requirements

Modifier codes must be included as appropriate for all DMEPOS requests. The same modifiers used on the PAR must be used on the claim, in the same order.

BO	Orally administered nutrition, not by feeding tube
KH	DMEPOS item, initial claim, purchase or first month rental KI DMEPOS item, second or third month rental.
KR	Rental item, billing for partial month
MS	Six (6) month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty
RR	Rental (use the RR modifier when DME is to be rented)
SC	Medically Necessary Service or Supply - **To be used with MSRP priced codes only**
TT	Individualized service provided to more than one (1) member in same setting TW Secondary or back-up equipment
UB	Invoice cost - **To be used with "By Invoice" priced codes only**
NU	New Equipment
UE	Used Equipment
RA	Replacement of a DME, orthotic or prosthetic item
RB	Replacement of part of a DME, orthotic or prosthetic item furnished as part of a repair
KF	Item designated by the FDA as a Class III device

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 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 a HFC member's inpatient hospital discharge.

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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Tips to Reduce Pends and Denials

- Complete change of provider form in its entirety including signatures from the member(member's guardian) and the receiving provider.
- Check for duplications prior to submission.
- Ensure the order submitted supports dates of services requested.
- Be sure to place the required modifiers in the case upon submission.
- Submit clinical documentation to support medical necessity of requested item(s).
- Attach required questionnaires if applicable.
- If a case is returned for additional information, make sure to respond to all questions at once. If the pend is responded to without all the required information, Acentra Health will review the case and technically deny for lack of information if appropriate.

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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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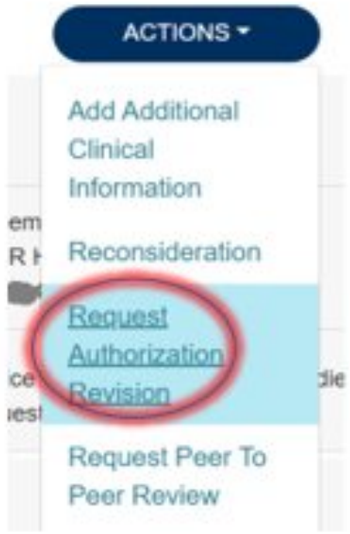
PAR Revision Con't

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 any 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 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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