Hello and welcome to the benefit specific training for durable medical equipment providers.

Today we will discuss EPSDT, Acentra Health and our scope of services, Acentra Health services for providers, provider responsibilities, the prior authorization request, submission, general requirements, DME PAR requirements, submission requirements, continuous and bilevel airway pressure devices, disposable supplies, diabetic supplies, mobility equipment, CRT, documentation requirements, modifier requirements, the PAR determination process, turnaround times, Medicaid rule for medical necessity, the PAR revision, the change of provider form and 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.

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 coproviderissue@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 would 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 reconsiderations and or 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 seven 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, the servicing provider or billing providers national provider identifier if it is different than the requesting providers, the number of units requested and any supporting documentation. Requests for additional information will be initiated by Acentra if or when there is not enough substantial supporting documentation to complete the review.

Health First Colorado covers durable medical equipment, prosthetics, orthotics and supplies.

Durable medical equipment 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 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 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.

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 year less one day.

Exceptions for decreased span dates less than one year are allowed in certain circumstances, such as short-term rental or WIC application period.

Dates must not exceed one 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 physician, physician assistant or nurse practitioner with either a wet signature or a valid CMS compliant E signature.

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

If a device is replaced within five 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 years, there must be a face-to-face evaluation by the members treating physician within six 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 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 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.

Disposable supplies are a benefit of health First Colorado for use by the member in his or 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.

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.

PARS for CGM supplies will be limited to a six month time span when requesting a CGM in the online PAR portal.

Providers will be asked whether the Member has received or if there is documented plan to receive diabetes education specifically related to CGMS.

CGM replacement policy states that repairs and replacement parts are covered under the following conditions:

The item was purchased by Medicaid or the item is owned by the member members family or guardian.

The item is used exclusively by the member.

The items need for repair was not caused by members misuse or abuse, and the item is no longer under the manufacturer warranty.

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 primary device and when deemed necessary, one secondary device within a 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.

For repairs and modifications, all PARS submitted with multiple pieces of equipment on the same request will be denied. Each wheelchair or scooter that requires prior authorization 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.

The equipment type indication, whether it's a manual or power wheelchair or a scooter. The manufacturer make and model of the equipment, the serial number of the equipment, and if available, the original wheelchair purchase date or PAR number.

You must also include the RA or RB modifier depending on the request.

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 and the appropriate field on the prior authorization request. The PAR will not be processed without this disclosure.

Complex rehabilitation technology 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.

There are two 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 the 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.

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. It is required for a new custom contoured seating system or modification and it is required for an addition of power seating or alternative drive control to a wheelchair.

Overlapping PAR request dates for same items will not be accepted.

All PAR requests require a physician's order that includes the items being requested. Questionnaires and specialty evaluations will be required as appropriate.

Documentation to support medical necessity should be included with every review.

Please refer to the billing manual under PAR requirements to find the full list of required documentation.

The PAR duration is limited to 365 days.

DME providers are allowed 90 calendar days from the date of delivery to submit the prior authorization request.

Retroactive authorizations are not accepted by Acentra health however, exceptions may be made by HCPF.

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.

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.

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

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 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 . 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, Acentra 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 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.

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 web page 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.