Updated 6/22/23

# IHRP 2.0 Q&A

## General

### Why are we restarting this program if the Public Health Emergency (PHE) has been extended?

The Department must comply with CRS Section 25.5-4-402 which requires us to have an inpatient hospital program. Although the PHE has not ended, the Department has started the "PHE unwind" process of continuous enrollment to decrease member disruption. Because of the greatly reduced volume of reviews required by IHRP 2.0 as well as the potential for improved processes with RAEs, we believe this is the right time to reestablish our inpatient hospital program.

The Department's UM and Clinical teams continue to share feedback from stakeholders on the issue of implementing IHRP 2.0 during the PHE with Department leadership. Based on that input, **we are postponing the requirement to participate in IHRP 2.0 until May 1, 2023.** However, we will "soft launch" IHRP 2.0 as planned on April 3, 2023. This means that hospitals **may** start submitting Pre Admission and Post Admission Reviews in April to test and adjust their processes, but claims will pay regardless of those reviews. **Pre Admission Reviews will be required for claims payment for the specified codes as of May 1, 2023.**

### Are you using 275/278 this time?

During the previous iteration of the program, also known as IHRP 1.0, some hospitals elected to use a 275 or 278 transfer. With the significantly lower volumes of Pre Admission and Post Admission Reviews required in IHRP 2.0, that option will not be offered.

IHRP 1.0 required Pre Admission Review PARs for **all codes** except maternity and long term rehabilitation, which was a significant volume for each facility. The volume of Pre Admission Reviews under IHRP 2.0 is greatly decreased. The Department estimates roughly 2,000 total Medicaid admissions per year will require a Pre Admission Review, reducing the need for electronic data transfer. Additionally, 275/278 data transfer processes render hospital providers unable to utilize the full functionality of Kepro's PAR portal, Atrezzo. For example, automated reviews, where providers may receive an almost-instantaneous approval, would not function with a 275 or 278.

### Will Long Term or Behavioral Health Hospitals need to participate in IHRP 2.0?

Services included in Step 1 of the IHRP 2.0 Infographic requiring a **Pre Admission Review** will require that hospitals enrolled as Provider Type 01 enter PARs.

The Department will evaluate whether it would be useful to include Long Term Acute Care and Behavioral Health Hospitals in **Post Admission Reviews** at a later date.

## What is required for patients with Emergency Medicaid?

IHRP does not require prior authorization for emergency or trauma admits, and professional claims for surgical services with an emergency indicator do not require prior authorization.

Emergency Medical Services (EMS) is a limited benefit that does not cover all medical services. It is also known as "Emergency Medicaid" or "Emergency Services Only." All claims submitted for recipients of Emergency Medicaid Services must have the appropriate emergency indicator on claims forms to indicate the presence of an emergency medical condition as defined in 42 U.S.C. § 1396b(v)(3); Colorado Revised Statutes § 24-76.5-102(1); and, 10 CCR 8.100.3.G.1.g.vii.

For EMS, the provider must use the following claim form fields to confirm that the claimed services relate to emergency medical conditions:

- For CMS-1500/835P forms: Field 24C (EMG)
- For UB-04/8371 forms: Admission Type 1 (Emergency) or 5 (Trauma)

# Pre Admission Review

## What do we have to do an admission review on?

See the infographic for IHRP 2.0, specifically Step 1, for the list of required codes for Pre Admission Reviews.

## What criteria are you using?

Pre Admission Reviews will focus on the place of service/level of care for the small group of codes listed in Step 1 of the IHRP 2.0 infographic.

For the Pre Admission Reviews in IHRP 2.0, Kepro will use MCG. This is the criteria set that the Department asked eQHealth to use during IHRP 1.0, at the request of hospital providers. Our experience from IHRP 1.0, as well as our extensive experience with PARs outside of IHRP has demonstrated that a provider's use of MCG or InterQual or any specific criteria set **was not directly related to their approval or denial rates**. We believe that a hospital provider's use of MCG or InterQual should have **even less** of an impact on IHRP 2.0 outcomes because the Pre Admission Reviews are required for such a small, targeted group of codes.

For the overall ColoradoPAR program, prior to the IHRP 2.0 implementation, the Department and Kepro have partnered to make sure that all requests for additional information and all denial reasons are clear and do not depend on providers using a particular criteria set. The Department continues to monitor for that this is true as we assist providers with PAR issues.

Please note, the outpatient PAR process, including which criteria are used to determine medical necessity for surgical procedures, has not changed and will not change with the implementation of IHRP 2.0.

## Will the state-developed criteria be shared with the hospitals?

State-developed criteria apply to outpatient, non-IHRP services so they are not applicable to IHRP 2.0. For Pre Admission Reviews, Kepro will use MCG, which was the criteria set that the Department asked its prior UM vendor to use during IHRP 1.0. This request was based on feedback from hospital providers.

Please note, if a provider disagrees with a determination, Kepro has peer-to-peer and reconsideration processes (see "Provider Options Following Adverse Decisions" in the Kepro Provider Manual) for all reviews. Additionally, members always have Medicaid appeal rights.

## What is the turnaround time (TAT)?

Under IHRP 1.0, the TAT was one-business day for inpatient PARs. Based on Provider feedback and with approval from our Legal Department, IHRP 2.0 will have a **two-business day TAT for Pre Admission Reviews.** The Department does not anticipate a need for pends on these reviews, however, if there are circumstances that require Kepro to pend a review back to the provider for additional information, they will have five business days to respond before the authorization is denied for lack of information.

## Are you using the Inpatient Only List?

Kepro has identified the codes on the Pre Admission Review list that are also related to the CMS and EAPG Inpatient Only Lists. For these codes, Kepro will NOT manually review the inpatient services prior authorization portion of the review or ask for clinical documentation. If/when CMS or 3M update the Inpatient Only Lists, the Department and Kepro will review and communicate changes at least 30 days prior to implementation. Because the codes do not match 1:1, in the unlikely event that you receive a request for additional clinical information on an Inpatient Only procedure, please respond to Kepro to clarify, and they will update your review.

## Why do we have to re-enter the same information for Admission Review that we entered for the surgery PAR?

We understand the frustration if you are duplicating the work on the surgery and the Pre Admission Review PARs. This as an issue we would like to improve. Unfortunately, we have been unable to do away with the requirement, because the two PARs are required to pay two different claim types (surgical procedure and inpatient stay). Not every provider completes this process in the same way; some surgeons' offices submit only the surgical PAR and not the inpatient PAR (the hospital completes the inpatient PAR). Other providers submit both the surgical and inpatient PAR.

There is a "copy" function in the Atrezzo system that makes the process easier for providers submitting both the surgical and admission PARs. Use of this functionality has been included in the training for IHRP 2.0. The Department and Kepro will continue to work together to make improvements to this process as we are able.

## Can the IHRP Pre Admission Review auth be obtained at the same time the procedure auth is requested?

Once the procedure authorization is approved, then the Pre Admission Review can follow.

## What if someone is already admitted and needs one of the surgeries that requires Pre Admission Review while they are inpatient?

The intention of the Pre Admission Review (see Step 1 on the IHRP 2.0 infographic) is **not** to prevent or delay medically necessary care/procedures from being provided. For members admitted to the hospital in an emergency, if a surgery requiring Pre Admission Review (Step 1 of the IHRP 2.0 infographic) is emergent, claims can be submitted with the emergency indicator and then a PAR is not required. Because of the limited nature of Pre Admission Reviews, the Department expects this to be rare, and we will review the frequency of emergency cases. As needed, the Department will change IHRP 2.0 processes (and communicate those changes to providers) if abuse or misuse of emergency indicators is evident.

Additionally, when an admission is unplanned and a surgery that requires Pre Admission Review is imminent, the Department will allow a PAR to be submitted retroactively. Thus, hospital providers may submit the Pre Admission Review when they become aware that the surgery is necessary.

## Once a Pre Admission Review has been done, must the service be performed inpatient?

If you know that the procedure will be performed inpatient, you may submit that Pre Admission Review PAR once the surgical PAR has been approved. If you are **not sure** if the procedure will be completed outpatient or inpatient, but know there is a good chance that it will need to be completed inpatient, you can get a Pre Admission Review PAR ahead of time. Outpatient services will still pay correctly.

## What impact will this program have on RAC reviews?

The Recovery Audit Contractor (RAC) will review any inpatient medical records which show potential for inappropriately billed inpatient stays or miscoding of claims submitted by Providers. If the Pre Admission Review PAR is approved (when required) and the claim is billed appropriately by the Provider, the claims will not be identified as erroneous.

## If a patient is scheduled for a surgery that needs a Pre Admission Review (and the procedure PAR is already approved) that is NOT intended to be inpatient, but they suffer a complication during surgery and DO need to be admitted, what happens?

Enter a retroactive PAR for the admission along with pertinent clinical information on the complication. This is the existing process for all PAR submissions. DO NOT DELAY CARE TO SUBMIT THE PAR. Please submit as soon as possible, and definitely within existing timely filing.

## Is a Pre Admission Review required for patients who have Medicaid as the secondary payer?

No. When Medicaid is secondary, PARs are not required. IHRP 2.0 is only for members with Medicaid as the primary payer.

## What kind of clinical information is needed for an inpatient PAR?

Typical documentation that supports the need for an inpatient stay includes an order for the inpatient request with a valid signature from an MD, NP, PA or DO and notes that support the higher level of care.

## What happens if I receive an inpatient PAR, but it does not include all of the codes listed on a claim?

The claim will deny.

For example, if the PAR is approved for two ICD 10 PCS Codes 0RBB0ZZ and 01NB0ZZ but the claim includes three ICD 10 PCS Codes that need a PAR, 0RBB0ZZ and 01NB0ZZ and 00NY0ZZ (which was not on the PAR), the claim will deny for lack of PAR.

The provider can go back and revise the PAR to add the additional code (in this case, 00NY0ZZ) prior to submitting the claim to avoid a denial.

## What happens if I receive inpatient PARs for more codes than are listed on the claim?

As long as the code on the claim has a valid PAR, it will pay.

For example, if the PAR is approved for two ICD 10 PCS Codes 0RBB0ZZ and 01NB0ZZ but the claim includes only ICD 10 PCS Code 01NB0ZZ, the claim will pay if all other payment criteria are met.

# Post Admission Review

## What exactly is in the Post Admission Review?

The Post Admission Review includes questions for hospital providers to answer related to:

- Need for RAE coordination
- Whom the RAE should contact
- Identified social determinants of health needs
- Identified comorbidities
- Identified barriers to discharge/transition
- Identified areas transition assistance needed

## Why did HCPF select Day 6 for concurrent review?

The Department and Kepro identified that Day 6 was the appropriate time for Post Admission Reviews based on historical claims involving the filtered Diagnosis Related Groups (DRGs) included in IHRP 2.0.

## Why is HCPF looking at these codes for Day 6 versus other ones?

The Department received feedback during IHRP 1.0 that Post Admission Reviews on Day 4 were problematic to hospital providers. The codes included in the IHRP 2.0 Day 6 Post Admission Review (Step 2) were selected based on that feedback and data analysis of historic claims. Additionally, for Post Admission Review (Steps 2 and 3), the Department and Kepro identified codes where discharge planning/care coordination would be positive for members, as well as addressing the need for assistance transitioning "hard to place" members that was communicated by hospital providers.

## What if a hospital does not submit concurrent reviews?

In lieu of "Concurrent Reviews," IHRP 2.0 requires "Post Admission Reviews" at day 6, and every 30 day increment after admission. Please see the IHRP 2.0 infographic (Steps 2 and 3) for specific codes that fall under these requirements. Post Admission Reviews were selected to enhance information to RAEs for collaboration on discharge and transition planning and care coordination for those members.

If hospital providers choose not to submit Post Admission Reviews, RAEs will not receive enhanced information. Although hospital payments are not be impacted by Post Admission Reviews, the Department will respond to missing reviews on a case-by-case basis.

As part of the Department's ongoing evaluation of IHRP 2.0, we will monitor all of the Steps of the program and in particular Post Admission Reviews. Moving forward, if there is a pattern of non-cooperation between hospital providers sharing Post Admission Review information and RAEs using Post Admission Review information, the Department may need to re-evaluate the design of the program. This could include requesting additional authority to tie claims payment to completion of Post Admission Reviews.

## What if we have an already existing relationship with the RAEs?

The Department is hopeful that most hospitals have relationships with the RAEs. However, IHRP 2.0 requirements will enhance information for care coordination from hospital providers to RAEs, augmenting established processes for collaboration on discharge planning and care coordination for Health First Colorado members.

The information to be transmitted to the RAEs was selected based on input from both hospitals and RAEs, and aligns, as much as possible, with the Hospital Transformation Project. Our intention is that hospitals and RAEs share available information without needing to create major new processes.

## What if the RAEs do not utilize the data sent to them as part of the Program? What is the RAEs' specific requirement to respond on this data sharing?

Kepro will produce reports daily that are sent to RAEs. As noted above, The Department will analyze the method and manner of use of Post Admission Review information by RAEs. Hospitals which request transition assistance and do not receive responses from a RAE may escalate concerns to the ACC Team (assigned Contract Manager) using the following email address: (hcpf_ihrp_acc@state.co.us).

## What if a member does not have any needs identified at Day 6? Do we still have to enter a Day 6 Post Admission review?

The Department requests that hospitals enter Day 6 Post Admission Reviews as outlined in Step 2 of the IHRP 2.0 infographic (sepsis, cellulitis, pulmonary edema, respiratory failure, thoracic and abdominal procedures and NICU) for the following reasons:

1. To evaluate the design of IHRP 2.0, we need to see how it operates (as designed) for at least six months. The Department will share results of our evaluation with stakeholders and consider changes at that time.

2. As part of our ongoing evaluation of IHRP 2.0, we will monitor Post Admission Reviews to ensure the enhanced data sharing improves care coordination and transition planning.
3. The Department believes that the medical complexity of the patients involved in the DRG groups will, in fact, lead to discharge planning and care coordination needs identified at admission.

## Is Continued Stay reviews based on the MS-DRG vs the straight DRG from Medicare? They are two different codes.

The Department uses APRDRGs for inpatient stays affected by IHRP 2.0.

## Will Labor and Delivery require IP notification for both mom and baby?

By Day 6, the hospital provider will know if the baby falls into one of the selected DRG groups and needs a Post Admission Review. This does not apply to the mother.

## In IHRP 1.0 we had issues with members that did not have an ID yet (mostly NICU/babies), what do we do for those that we do not yet have a Medicaid ID?

Hospitals may create a temporary ID in Atrezzo. Kepro will provide a user guide on this topic for your use and post it to the ColoradoPAR webpage under the **Resource Library.**