Acentra HEALTH

On behalf of

HEALTH FIRST COLORADO

Long-Term Home Health

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
  - 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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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.

- Long Term-Home Health providers have a 10-business day window to submit a case to Acentra Health once services have begun. If submitted beyond the 10-business days, the dates will be adjusted to account for this delay according to 10 C.C.R. 2505-10 Section 8.520.8C 6.a

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Nursing Services Definitions

Benefit	**Certified Nurse Aide (CNA)**	**Brief Nursing Visit (RN/LPN)**	**Standard Nursing Visit (RN/LPN)**	**Private Duty Nursing (PDN)**
Benefit Summary	Skilled Activities of Daily Living (ADLs) provided by a CNA / supervised by an RN	Uncomplicated & Brief Skilled Tasks	Complicated Skilled Tasks & Full Patient Assessment	Complex and Continuous Medically-Necessary Nursing Services
Agency Licensure Requirements	Licensed Class A Home Health Agency (HHA) as required by § 25-27.5-103(1), C.R.S.; Medicare Certified pursuant to 42 U.S.C. § 1395bbb			
Worker Licensure Requirements	Certified Nurse Aide (CNA)	Registered Nurse (RN) or Licensed Practical Nurse (LPN)		
Type of Service	Intermittent Skilled Nursing			Continuous Skilled Nursing
Visit Increments	1 hour (15-30 min extended units may be available)	At least 15 minutes	Up to 2.5 hours	1 hour
Adult Limit	Intermittent Services may not exceed $454.92 per day			23 hours per day
Pediatric Limit	Services must be medically necessary per HCPF benefit and EPSDT regulations; not to exceed 24 hours per day of care			
Service Authorization	Prior authorization is required for medical necessity prior to service delivery			

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Benefit Rules:

- 8.540.4.A A member who meets both the eligibility requirements for PDN and home health shall be allowed to choose whether to receive care as either a PDN or Home Health benefit. The member may choose a combination of the two benefits if the care is not duplicative and the resulting combined care does not exceed the medical needs of the member.
- Documentation of both PDN and LTHH services should be present in the 485/POC. Identification of the overlapping services should be documented in the review.

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Long-Term Home Health (LTHH)

Intermittent Home Health services required for the care of chronic long-term conditions, and/or on-going care that exceeds the acute home health period (61st calendar day of Home Health service).

0571	0579	0551	0590	0599
1st hour of each independent HHA visit	For HHA visits lasting more than one hour, extended units of 15-30 minutes	RN/LPN one visit up to 2.5 hours	Brief nursing visit . 1st visit of the day	Brief nursing visit. 2nd or more visit(s) of the same day

For specific information when providing home health care, providers should refer to the Code of Colorado Regulations, Program Rules (10 C.C.R. 2505-10 8.520)

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RN/LPN Services - Standard Visit

- 1st medication box fill (medication pre-pouring) of the week.
- 1st visit of the day.
- Insertion or replacement of indwelling urinary catheters.
- Colostomy and ileostomy stoma care.
- Treatment of decubitus ulcers (stage 2 or greater).
- Treatment of widespread, infected or draining skin disorders.
- Wounds that require sterile dressing changes.
- Visits for foot care.
- Nasopharyngeal, tracheostomy aspiration or suctioning, ventilator care.
- Bolus or continuous nasogastric tube and/or gastrostomy (G-tube) feedings.
- Complex Wound care requiring packing, irrigation, and application of an agent prescribed by the Physician or Allowed Practitioner.

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RN/LPN Services - Brief Visit

- Brief visits can be utilized in Assisted Living facility (ALF), Alternative Care Facilities, (ACFs), Group Homes, Host Homes, etc. specifically when there are consecutive visits for two or more Members who reside in the same location and are seen by the same HH Agency nurse.
  - Excluding the first visit of the day
- Intramuscular, intradermal and subcutaneous injections when required multiple times daily.
  - Excluding the first visit of the day.
- Insulin administration
  - If the sole reason for a daily visit or multiple visits per day.

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RN/LPN Services - Brief Visit Cont'd

- Additional visits beyond the first visit of the day where catheter irrigation is the sole reason for the visit.
- Additional visits beyond the first visit of the day where external catheterization, or catheter care is the sole purpose for the visit.
- Bolus or continuous nasogastric tube and/or gastrostomy (G-tube) feedings of prepared formula only when there is no willing or able caregiver and it is the sole purpose of the visit.
- Medication box refills or changes following the first medication pre-pouring of the week.
- Other non-complex nursing tasks as deemed appropriate by the Department or its Designee when documented clinical findings support a brief visit as being appropriate.

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LTHH Registered Nurses (RN) and Licensed Practical Nurses (LPN)

- **Registered Nurses (RN) and Licensed Practical Nurses (LPN)** must have a current, active license in accordance with the DORA Colorado Nurse Practice Act at § 12-38-111, C.R.S.

- Long-Term Home Health: Nursing services provided during Long-Term Home Health shall be billed using the appropriate revenue codes based on the purpose and complexity of the nursing visit. Standard, infrequent or complicated nursing visits may be billed using revenue code 551. Nursing visits that are uncomplicated in nature or visits that are uncomplicated with frequent revisits completed by the nurse shall be billed using revenue codes 590 and 599).

- **Long-Term Home Health nursing visits for the sole purpose of assessing a member may be reimbursed for a limited time when managing, and reporting to the member's physician on specific conditions and/or symptoms which are not stable.

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LTHH Certified Nurse Aides (CNA)

Certified Nurse Aides (CNA) must have a current, active license in accordance with the DORA Colorado Nurse Aide Practice Act at § 12-38-111, C.R.S.

Long-Term Home Health: Skilled certified nurse aide visits are reimbursed based on the amount of time the CNA is providing skilled care to a member. If a certified nurse aide care for at least 15 minutes but not more than 60 minutes, the agency shall bill a basic unit with revenue code 571. For every additional 30 minutes the certified nurse aide provides hands-on assistance to the member, the agency may bill an extended CNA unit with revenue code 579. A unit of time that is less than 15 minutes shall not be reimbursable as a basic unit and at least 15 minutes must elapse before an agency may bill an extended unit.

Reimbursable Home Health Services

The licensed and certified Class A Home Care shall not utilize staff that has been excluded from participation in federally funded health care programs by the US Department of Health and Human Services (HHS)/Office of Inspector General (OIG) and shall be in good standing with the Colorado Department of Regulatory Agencies (DORA) or other regulatory agency.

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Non-Reimbursable Home Health Services

- Supplies used for routine Home Health are not reimbursed separately through the Home Health or Durable Medical Equipment (DME) benefit. Non-routine or member specific supplies must be reimbursed through the member's DME benefit.
- Nursing Visits for purpose of psychiatric counseling
- Certified nurse aide visits for the purpose of providing only unskilled personal care and/or homemaking services.
- Nursing or CNA visits provided in a shift (visits lasting more than 4.5 consecutive hours)
- Nursing visits for the sole purpose of providing supervision of the CNA or other Home Health staff
- Nursing visits for the sole purpose of completing the Home Health plan of care/recertification
- Long-Term Home Health nursing visits for the sole purpose of teaching the member or their family member
- Long-Term Home Health nursing visits for the **sole** purpose of assessing a stable member where management, and reporting to physician of specific conditions and/or symptoms which aren't stable.

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LTHH Documentation Requirements

All LTHH (RN and CNA services) PAR submissions must include:

The complete and current plan of care using the HCFA-485 or other document that is identical in content which must include a clear listing of:

- Member's diagnoses that will be addressed by Home Health
- The specific frequency and expected duration of the visits for each discipline ordered
- The duties/treatments/tasks to be performed by each discipline during each visit
- The plan of care must be created by a registered nurse employed with the Home Health Agency or, when appropriate, by a physical, occupational or speech therapist. The plan of care must be signed by the member's attending physician prior to submitting the final claim for a certification period.

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LTHH Documentation Requirements (con't)

All other supporting documentation to support the request including but not limited to physician's orders, treatment plans, nursing summaries, nurse aide assignment sheets, medications listing, etc.

1. Any other documentation deemed necessary by the Department or its authorizing agency
2. All supporting documentation must be within 60 days of the start of the PAR

For additional information on Health First Colorado plan of care requirements refer to the Home Health Services Benefit Coverage Standard referenced in 10 C.C.R 2505-10 8.522 –

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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.

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

1. Calculate and request the total units needed for the duration of the request. The system does not calculate this for you.

   For example, the member needs 1.5 hours of HHA 3 times per week for one year. This would be 3 units of 0571 weekly and 3 units of 0579 weekly. 3 x52 = 156 total units needed for both 0571 and 0579.

2. Ensure the plan of care is signed by both the nurse/therapist (if appropriate) and the physician. If the plan of care is not signed by the physician, make sure to include a separate stand-alone order that is signed by the physician.

3.Verbal orders are accepted but they must specify the discipline being requested, the frequency and the duration ordered, the name of the person who gave the order and when they gave it, and the name and signature of the person who received the order. This must be placed in one area.

   For example, Verbal order received from Jane Doe at Dr. Smiths office on 6/1/2025 for 4 Skilled nursing visits daily for 26 weeks taken by Nurse Joe . And then include Nurse Joe’s signature.

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Tips to Reduce Pends and Denials (con't)

4. Submit all required documentation at the time of submission.

5. If requesting more hours/visits than the nurse assessor's acuity tool supports, be sure to include documentation to support the medical necessity of the additional visits.

6. Make sure to request the appropriate code for the visits. For example, if the nurse is coming in to for a short amount of time, be sure to request 0590 or 0599 depending on which visit of the day it is and not 0551.

7. If applicable, be sure to complete the change of provider form in its entirety.

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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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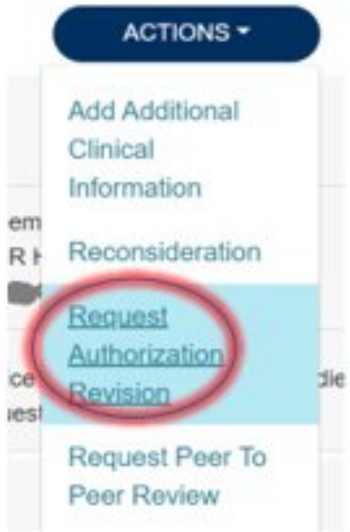
PAR Revision Con't

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 for adults and 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 or homehealth@state.co.us
- Acentra Health Customer Service: (720) 689-6340
- PAR Related Questions: coproviderissue@acentra.com

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