On behalf of

HEALTH FIRST COLORADO

Medical Surgeries Utilization Review

COLORADO
Department of Health Care
Policy & Financing

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Early and Periodic Screening Diagnostic Treatment (EPSDT)

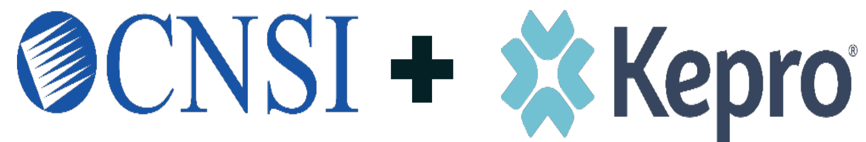
- Acentra Health follows the EPSDT requirements for all medical necessity reviews for Health First Colorado members.

- 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



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:**

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.

Our mission is to continually innovate solutions that deliver maximum value and impact to those we serve.

About Acentra Health (cont'd…)

In addition to Utilization Management (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

Scope of Services

- Audiology
- Diagnostic Imaging
- Durable Medical Equipment
- Inpatient Hospital Review Program (IHRP 2.0)
- **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

Acentra Health's Services for Providers

- 24-hour/365 days **provider portal** accessed at: https://portal.kepro.com
- **Provider communication and support** email: coproviderissue@kepro.com
- Provider education and outreach, as well as system **training materials** (including Video recordings and FAQs) 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

Provider Responsibilities

- Providers must request Prior Authorization for services through Acentra'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 Prior Authorization is not required
- **Always verify** the Member's eligibility for Health First Colorado prior to submission by contacting Health First Colorado
- The generation of a Prior Authorization number does not guarantee payment

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

PAR Submission: General Requirements

- PAR submissions will require providers to provide the following:
  - Member ID
  - Name
  - Date Of Birth
  - CPT or HCPCS 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

Submission Requirements At a Glance

Duration	PAR limited to 90 days
Provider Timely Submission Requirement	Prior to rendering services
Retroactive Authorization	Not accepted by Acentra
(Member not eligible at time of service)	*Exceptions may be made by HCPF
Servicing Provider / Billing Provider	Facility or Provider performing procedure that will be submitting claims
Requesting Provider	Physician, Physician Assistant, Nurse Practitioner

*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.

Learn more at: https://hcpf.colorado.gov/med-surg-manual

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.

Covered Surgery Benefits – Bariatric Surgery

Health First Colorado covers bariatric surgery for the treatment of clinically severe obesity, when medically necessary

- Bariatric surgery is preferably performed under the guidance of a multidisciplinary team (including surgeon, physician, dietician, and licensed qualified mental health professional) particularly experienced in the performance of bariatric surgery and the pre- and post-operative management of bariatric surgery.

- Health First Colorado will reimburse participating providers for no more than one bariatric procedure per Member lifetime, unless a revision is appropriate based one of the complications identified below.

- PRIMARY PROCEDURES INCLUDE: 1. Roux-en-Y Gastric Bypass; 2. Adjustable Gastric Banding; 3. Biliopancreatic Diversion with or without Duodenal Switch; 4. Vertical-Banded Gastroplasty; 5. Vertical Sleeve Gastroplasty.

Covered Surgery Benefits - Bariatric Surgery Revision

REVISION OF SURGERY FOR CLINICALLY SEVERE OBESITY:

Revision of a surgery for clinically severe obesity is used to correct complications such as slippage of an adjustable gastric band, intestinal obstruction, stricture following one of the above procedures, and other conditions.

DOCUMENTATION FOR REVISION OF BARIATRIC SURGERY:

1. Initial height and weight.
2. Initial surgery – type, date.
3. Weight loss history after the surgery.
4. Present weight.
5. Dietary assessment by registered dietician regarding current eating habits.
6. X-ray or endoscopic report that demonstrates the staple line has failed, the pouch has enlarged, or one of the above-listed conditions is present.
7. Copy of the psychiatric or psychological opinion ruling out psychiatric contraindications to the procedure.

Bariatric Surgery PAR Requirements

All bariatric surgical procedures require prior authorization.

Documentation Requirements:

1. Height, weight, BMI with duration.
2. Co-morbid conditions – list and describe each, with attention to any contraindication which might affect the surgery. Include all objective measurements.
3. Detailed account of the member's clinically supervised weight loss attempt(s), including duration, medical records of attempts, identification of the supervising clinician (physician, registered dietitian, nurse practitioner, or physician assistant), and evidence of successful completion and compliance.
4. A copy of the current psychiatric or psychological assessment as described in the next slide. Include a statement about presence or absence of contraindication to surgery based on member's mental health assessment.
5. A statement written or agreed to by the member detailing for the interdisciplinary team the Member's:
   - Commitment to lose weight;
   - Expectations of the surgical outcome;
   - Willingness to make permanent life-style changes; and
   - If female, Member's statement that she is not pregnant or breast-feeding and does not plan to become pregnant within 2 years of surgery.
     - Anticipatory Guidance: The Member must be informed that should she choose to breastfeed following her bariatric procedure, she will need closer monitoring for her and her child because her nutritional aspects may have changed.
6. A description of the post-surgical follow-up program.
7. For members under the age of 18, include a statement verifying the attainment of physiologic maturity, as defined above.

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Bariatric Surgery Psychiatric or Psychological Assessment

Per 10 CCR 2505-10 8.300:

Medical and psychiatric contraindications to the surgical procedure must have been ruled out through:

- A complete history and physical conducted by or in consultation with the requesting surgeon; and

- A psychiatric or psychological assessment, conducted by a licensed behavioral health professional, no more than three months prior to the requested authorization. The assessment must address both potential psychiatric contraindications and member's ability to comply with the long-term postoperative care plan.

Bariatric Surgery PAR Requirements for members 20 years and under

Members 20 and under must meet one of two criteria :

The client is clinically obese with one of the following:

- BMI of 40 or class 3 obesity (>140% of the 95th percentile for age and sex, whichever is lower)
- BMI of 35-40 class 2 obesity, (>120% of the 95th percentile for age and sex, whichever is lower) with objective measurements documenting one or more of the following co-morbid conditions:
  - Severe Cardiac Disease;
  - Type 2 Diabetes Mellitus;
  - Obstructive Sleep Apnea(AHI .5)- other Respiratory Disease;
  - Pseudo-Tumor Cerebri or other Intercranial Hypertension
  - Hypertension;
  - Hyperlipidemia;
  - Severe Joint or Disc Disease that interferes with daily functioning; includes SCFE, Slipped Capital Femoral Epiphysis; Blout's Disease
  - Intertriginous Soft-Tissue Infections,
  - Nonalcoholic Steatohepatitis,
  - Stress Urinary Incontinence,
  - Recurrent or Persistent Venous Stasis Disease,
  - GERD, Gastroesophageal Reflux Disease;
  - Significant impairment in Activities of Daily Living (ADL).

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Bariatric Surgery PAR Requirements for Members 20 Years and Under (con't…)

In addition to the previous slide the following conditions must be met:

The BMI level qualifying the client for surgery (>40 or >35 with one of the above co-morbidities) must be of at least two years' duration. A client's BMI may fluctuate around the required levels during this time period, and will be reviewed on a case-by-case basis, pediatric growth charts are essential to review and;

The client must have made at least one clinically supervised attempt to lose weight lasting at least six consecutive months or longer within the past eighteen months of the prior authorization request, monitored by a registered dietician that is supervised by a physician, nurse practitioner, or physician's assistant and;

Medical and psychiatric contraindications to the surgical procedure must have been ruled out.

Non-Covered Services – Bariatric Surgery

Bariatric Surgery is not covered for the following instances:

- For members with clinically diagnosed COPD (Chronic Obstructive Pulmonary Disease), including Chronic Bronchitis or Emphysema;
- Repeat procedures not associated with surgical complications;
- Cosmetic Follow-up: Weight loss following surgery for clinically severe obesity can result in skin and fat folds in locations such as the medial upper arms, lower abdominal area, and medial thighs. Surgical removal of this skin and fat for solely cosmetic purposes is not a covered benefit; or
- During pregnancy

Covered Surgery Benefits- Gender Affirming

Members with a clinical diagnosis of gender dysphoria are eligible for the gender affirming services benefit, subject to the service-specific criteria and restrictions detailed in 10 CCR 2505-10 8.735.4:

- Member has a clinical diagnosis of gender dysphoria;
- Requested service is medically necessary, as defined in section 8.076.1.8;
- Any co-existing physical and behavioral health conditions do not interfere with diagnostic clarity or capacity to consent, and associated risks and benefits have been discussed;
- Member has given informed consent for the service;

Covered Surgery Benefits- Gender Affirming (con't…)

- Subject to the exceptions in C.R.S. §13-22-103, if member is under 18 years of age, member's parent(s) or legal guardian has given informed consent for the service.

- Requests for services for members under 21 years of age are evaluated in accordance with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program criteria detailed in section 8.280.

- Requests for surgery for members under 18 years of age will be reviewed by HCPF and considered based on medical circumstances and clinical appropriateness of the request.

Covered Surgery Benefits – Gender Affirming (con't…)

Surgical Procedures

- Gender-Affirming Surgery is a covered service for a client who:
- a. Meets the criteria at Section 8.735.4.A.1.–4;
- b. Is 18 years of age or older;
- c. Has completed six (6) continuous months of hormone therapy, unless hormone therapy is not clinically indicated or is inconsistent with the client's desires, goals, or expressions of individual gender identity;
- i) This requirement does not apply to mastectomy surgeries;
- ii) Twelve (12) continuous months of hormone therapy are required for mammoplasty, unless hormone therapy is not clinically indicated or is inconsistent with the client's desires, goals, or expressions of gender identity;
- d. Understands the potential effect of the Gender-Affirming Surgery on fertility.

Covered Surgery Benefits – Gender Affirming (con't…)

Surgical Procedures

Covered Gender-Affirming Surgeries include:

- Genital surgery;
- Breast/chest surgery; and
- Facial and neck surgery.

Requests for other medically necessary Gender-Affirming Surgeries will be reviewed by the Department and considered based on medical circumstances and clinical appropriateness of the request.

Pre- and post-operative services are covered when:

- Related to a surgical procedure covered under Section 8.735.4.F; and
- Medically necessary, as defined in Section 8.076.1.8.

Gender Affirming PAR Requirements

For ***hormone therapy services***, in addition to the above general requirements, the member's health care provider shall provide any information requested by the Fiscal Agent including, but not limited to:

- Member name, Health First Colorado identification number, and birth date;
- Name of the drug(s) requested;
- Strength and quantity of drug(s) requested; and,
- Prescriber's name and medical license number, Drug Enforcement Administration number, or National Provider Identifier

Covered Surgery Benefits - Transplant

All transplants EXCLUDING cornea and kidney REQUIRE Prior Authorization (PAR).

PAR duration – 365 days.

- Organ procurement and transplantation are benefits only when prior authorized. Corneal and kidney transplants are benefits and do not require prior authorization.
- Donor expenses (i.e., organ procurement associated surgical and laboratory costs) for living organ donations are covered for kidney and liver transplants.
- Living organ donations for liver transplants require the transplant recipient to have received prior authorization for a living organ transplant procedure.

Important: Organ transplants are not a covered benefit for non-citizens.

For more information visit: https://hcpf.colorado.gov/med-surg-manual#benOver

Medical Surgeries - Modifiers

Bilateral Procedures - modifier 50

- Unless otherwise identified in the CPT-4 listings, bilateral procedures requiring a separate incision that are performed at the same operative session should be identified by the appropriate five-digit code describing the procedure with modifier 50 added to the procedure code.
- Use of this modifier should be limited to procedure for which "bilateral" services are appropriate.

Two Surgeons - modifier 62

- When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons.
- Each surgeon should report the co-surgery once using the same procedure code
- If additional procedure(s) including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added.

Additional Surgeon – modifier 80

- If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80, as appropriate.

Medical Surgeries - Modifiers

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

Request 01
Submitted 1/0

19318 Submitted
01/26/2024 - 04/24/2024 1 / 1

Add Procedure

19318 BREAST REDUCTION Submitted Units 1 / 1 01/26/2024 - 04/24/2024

Certification

COPY FIELDS

MODIFIER		UNIT QUALIFIER
50	Select One	Select One

REQUESTED START DATE *	REQUESTED END DATE *	REQUESTED DURATION *	REQUESTED QUANTITY *	REQUESTED FREQUENCY
01/26/2024	04/24/2024	90	1	Select One

CERTIFIED START DATE *	CERTIFIED END DATE *	CERTIFIED DURATION *	CERTIFIED QUANTITY *	CERTIFIED FREQUENCY
01/26/2024	04/24/2024	90	1	Select One

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.

PAR Determination Process (cont'd…)

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 (TAT) - 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 HCPF’s partners (i.e., Regional Accountable Entities, Case Management Agencies, etc.)

*For additional information pends: the provider will have 10 business days to respond. If there is no response or there is an insufficient response to the request, Acentra will complete the review and technically deny for Lack of Information (LOI), if appropriate.

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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 4 business hours.

Rapid review: a PAR that is requested because a longer TAT 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 member's inpatient hospital discharge.
- Same Day Diagnostic studies required for cancer treatments.
- Genetic or Molecular testing requiring amniocentesis

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 10 business days.

Definition of Medical Necessity

10 CCR 2505-10; 8.076.1.8

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).**

PAR Revision

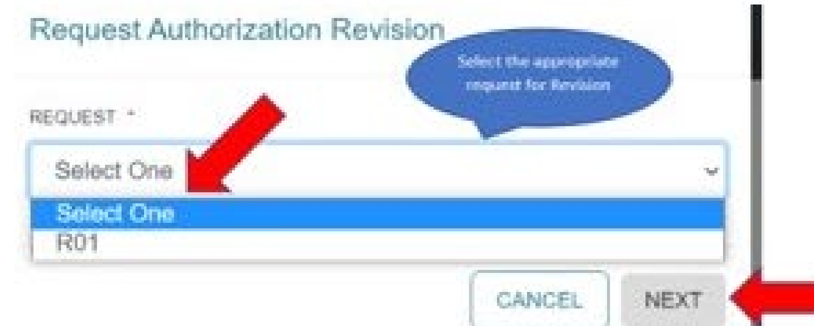
If the number of approved units needs to be amended or reallocated, the provider must submit a request for a PAR revision prior to the PAR end date.

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

PAR Revision

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 you are requesting
- Upload additional documentation to support the request as appropriate



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.

- This form is located on the Provider Forms webpage under the Prior authorization Request (PAR) Forms, drop-down menu, along with "How to Complete Change of Provider Form. "

Acentra Health Services for Providers - Recap

- Our provider portal, Atrezzo is accessible 24-hours/365 days at: https://portal.kepro.com

- System Training materials (including Video recordings and FAQs) and the **Provider Manual** are located at: https://hcpf.colorado.gov/par

- Provider Communication and Support email: coproviderissue@kepro.com

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@kepro.com