Acentra HEALTH

On behalf of

HEALTH FIRST COLORADO

Molecular/Genetic Utilization Review

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: https://portal.kepro.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'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
  - 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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Procedure Codes

- Some laboratory procedure codes require a Prior Authorization Request (PAR).
- Reference the current Health First Colorado Fee Schedule for PAR requirements, definitive coverage of specific procedure codes, and rates.
- Services must be reported using HCPCS procedure codes.
- Use procedure codes listed in the most recent HCPCS bulletin located on the Bulletins web page.
- The fiscal agent updates and revises CMS codes through Health First Colorado bulletins.

Handling, Collection and Conveyance Charges

- Specimen collection (including venipuncture) is considered to be an integral part of the laboratory testing procedure when performed by a laboratory and is generally not reimbursable as a separate or additional charge.
- Transfer of a specimen from one clinical laboratory to another is a benefit only if the first laboratory's equipment is not functioning or the laboratory is not certified to perform the ordered tests. Modifier -KX used with procedure code 99001 verifies that the lab's equipment is not functioning or that the laboratory is not certified to perform the ordered test.
- Specimen collection, handling, and conveyance from the member's home, a nursing facility, or a facility other than the physician's office or place of service is a benefit only if the member is homebound, bedfast, or otherwise non-ambulatory **and** the specimen cannot reasonably be conveyed by mail. A physician's statement explaining the circumstances and medical necessity is required.
- Each laboratory will be reimbursed only for those tests performed in the specialties or subspecialties for which it is certified.

Pap Smears

Health First Colorado allows one (1) pap smear screening/examination per 12-month period in women under 40 years of age.

Benefit for more than one (1) pap smear in a 12-month period is allowed for:

- Women ages 40 and over
- Women with a history of diethylstilbestrol exposure in utero
- Women with malignancy of the cervix, vagina, uterus, fallopian tubes or ovaries
- Women with cervical polyps, cervicitis, neoplastic disease of the pelvic organs, vaginal discharge or bleeding of unknown origin, postmenopausal bleeding, or vaginitis
- Or if the physician determines that more frequent testing is needed and is medically necessary.
- Claims will deny if the diagnosis code entered on the claim does not support the testing frequency.

Newborn Metabolic Screening

- Costs associated with Newborn Metabolic Screening (NMS) are included in the inpatient hospital diagnosis-related grouper (DRG) calculation and the birthing center facility payment and may not be billed separately by the hospital or birth center. Billing S3620 while receiving a DRG or facility payment for the delivery is duplicative.
- S3620 may only be billed by providers, not reimbursed for the delivery, who submit a second-specimen screen and are charged for an initial-specimen screen by Colorado Department of Public Health & Environment (CDPHE) because the second specimen could not be linked to an initial-specimen. S3620 does not require a CLIA certification.
- Because the NMS are performed by CDPHE's laboratory and not the provider collecting and submitting the specimen, unbundling the NMS and billing for the individual tests performed by CDPHE's laboratory is not allowed per the Laboratory and X-ray rule found at 10 CCR 2505-10 8.660.

BRCA Screening and Testing

Per the Women's Health Services rule found at 10 CCR 2505-10 8.731, the following are requirements for BRCA screening and testing:

•BRCA screening, genetic counseling and testing is only covered for clients over the age of 18.

•BRCA screening is covered and must be conducted prior to any BRCA-related genetic testing.

•The provider shall make genetic counseling available to clients with a positive screening both before and after genetic testing, if the provider is able, and genetic counseling is within the provider's scope of practice. If the provider is unable to provide genetic counseling, the provider shall refer the client to a genetic counselor*.

•Genetic testing for breast cancer susceptibility genes BRCA1 and BRCA2 is covered for clients with a positive screening.

Genetic Counselors cannot be directly reimbursed for services. A supervising physician may be reimbursed. The services require direct supervision if done by a genetic counselor, with the supervisor on site.

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Prenatal Testing

- Effective July 1, 2022, Genetic Screening, including but not limited to Non-Invasive Prenatal Testing (NIPT), and Genetic Counseling are covered in accordance with nationally recognized standards of care per the American College of Obstetricians and Gynecologists. Screening coverage is available for women carrying a singleton gestation who meet national standard guidelines.

- Coverage of this service was available under more specific criteria prior to June 30, 2022.

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General Laboratory Requirements

- Fees for blood drawing, specimen collection, or handling are generally not reimbursable to laboratories.
- The provider who actually performs the laboratory procedure is the only one who is eligible to bill and receive payment. Physicians may only bill for tests actually performed in their office or clinic. Tests performed by laboratories or hospital outpatient laboratories must be billed by the performing laboratory.
- CPT identifies tests that can be and are frequently done as groups and combinations ("profiles") on automated multi-channel equipment. For any combination of tests among those listed, use the appropriate Level 1 or Level 2 CMS codes.
- For organ or disease-oriented panels (check CPT narrative), use the appropriate Level 1 CMS codes. These tests are not to be performed or billed separately when ordered in a group/combination and must be billed with one (1) unit of service.

Procedure/HCPCS Codes Overview

- The Department accepts procedure codes that are approved by the Centers for Medicare & Medicaid Services (CMS). The codes are used for submitting claims for services provided to Health First Colorado members and represent services that may be provided by enrolled certified Health First Colorado providers.
- The Healthcare Common Procedural Coding System (HCPCS) is divided into two (2) principal subsystems, referred to as level I and level II of the HCPCS.
- Level I of the HCPCS is comprised of Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association (AMA). The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals.
- Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter followed by four (4) numeric digits, while CPT codes are identified using five (5) numeric digits.

Procedure/HCPCS Codes Overview(con't)

- HIPAA requires providers to comply with the coding guidelines of the AMA CPT Procedure Codes and the International Classification of Disease, Clinical Modification Diagnosis Codes. If there is no time designated in the official descriptor, the code represents one (1) unit or session.

- Visit the Bulletins web page for monthly bulletins, which include updates on approved procedures codes and the maximum allowable units billed per procedure. Visit the Provider News web page to sign up for provider bulletin communications.

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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.

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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 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 treatment
- 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 7 calendar days.

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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, 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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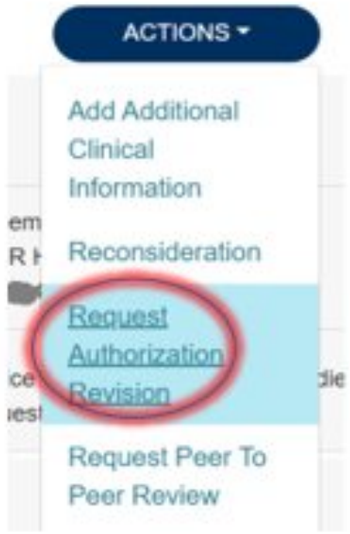
PAR Revision Con't

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 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: 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@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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