COLORADO
Department of Health Care Policy & Financing

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PARs Pause: Frequently Asked Questions

March 8, 2022

The following frequently asked questions provide guidance to providers following the Department of Health Care Policy & Financing (the Department) pausing prior authorizations request (PAR) requirements for a series of pediatric long-term home health services and home health therapies. The pause on the requirement to submit a PAR extends through March 2024 and includes:

- Pediatric long-term home health CNA services
- Pediatric long-term home health therapies: occupational therapy, physical therapy, and speech-language pathology therapy
- Pediatric long-term home health intermittent skilled nursing

What is Utilization Management?

Utilization management (UM) helps ensure that patients have the proper care and the required services without overusing resources. It reviews services to ensure that they are medically necessary, provided in the most appropriate care setting, and at or above quality standards. Health First Colorado (Colorado's Medicaid program) relies on UM to look at services members are receiving so that Regional Accountable Entities and Case Management Agencies can support members by determining further or more appropriate services and locating providers, services, and resources. UM also includes a review of Medicaid policy, state rules, and federal requirements.

What can a member do after they get a PAR denial?

A member has the right to file an appeal on any full or partial PAR denial and their Appeal Rights will be included in their determination letter(s). A member will file an appeal with the Office of Administrative Courts, and the Department will be notified. Please see page 29 of the Member Handbook or page 62 of the Provider Manual.

What options do providers have when a PAR is denied?

For any full or partial technical or medical necessity denial, providers can request a PAR Reconsideration (see page 61 in the Kepro Provider Manual). A Reconsideration request must

be submitted to Kepro within 10 business days of the initial denial. Providers may upload additional supporting documentation for the case. Additionally, after an adverse decision, ordering providers may request a Peer-to-Peer (P2P) review within 10 business days of the review determination (see page 61 in the Kepro Provider Manual). A P2P allows the ordering provider to discuss the case with a Kepro physician reviewer. Feedback to Kepro and the Department indicates this is helpful for the ordering provider to provide clarification or additional information, or to gain clearer understanding why a request was denied. Recent improvements in the P2P process provide a dedicated scheduler to confirm a mutually agreed upon date and time for the P2P call to take place.

If a primary care physician says something is necessary, why does the Department need to determine if it is medically necessary?

Items "necessary" to a member or family, unfortunately, do not always meet the definition of "medically necessary," which is the federal and state standard required for Health First Colorado to cover benefits (see page 19 of the Health First Colorado Member Handbook). Medical necessity reviews also include a review of Medicaid policy, state rules, and federal requirements. Medically necessary services include any program, product or service that is delivered in the most appropriate setting required by the member's condition and does not cost more than other equally effective treatment choices. They include services that will (or are reasonably expected to) prevent, diagnose, cure, correct or improve - or, in the case of services for children and youth under the age of 21, ameliorate - the condition and are provided in a manner consistent with accepted standards of medical practice. Please see the Health First Member Handbook for additional information.

How do we know when changes are made to policy or billing manuals?

Providers are notified of updates to the billing manual via the monthly Provider Bulletin. The bulletin will contain the updated policies and will remind providers to reference the billing manual.

Why does Kepro "pend" PARs? Why does Kepro ask for additional clinical documentation not explicitly mentioned in the provider billing manual?

PARs are "pended" (meaning, review is temporarily stopped) when Kepro needs additional information to make a determination. Kepro uses nationally recognized, industry standard criteria including Interqual and MCG, except in some instances where the state has developed criteria. When reviewing a PAR for medical necessity, Kepro has both the authority and responsibility to require sufficient documentation to support medical necessity determinations. Examples of sufficient documentation include recent/timely medical notes to support the scope, frequency and duration of services requested. This is consistent with industry standard best practices.

How can we get more clarity on the reason for the Pend?

Providers may contact the coproviderissue@kepro.com mailbox with a subject line, "Pend Inquiry: Case ID XXXX." This escalates inquiries to the appropriate Kepro clinical personnel. If this does not provide resolution, providers should contact UM inbox for additional assistance.

Why am I waiting on hold for long periods and/or do not get an answer from Kepro's customer service?

The Department monitors Kepro's customer service performance metrics daily and weekly to ensure they are meeting established contract and Department Service Level Agreements (SLAs). However, if you have specific examples of waiting on hold and/or not receiving resolution from Kepro's customer service, please send those to the UM inbox to be addressed.

Previously with eQHealth, providers could receive more than one request for additional information, or pend, but with the new contract with Kepro, there is only one pend to request additional information prior to a denial (administrative or medical necessity) being issued. Why is that?

The limitation of one "pend" (Kepro requesting additional information to appropriately complete a medical necessity review) was based on provider feedback prior to Kepro's implementation to simplify the review process. The goal was to limit pends (or information requests) to increase efficiency and decrease turnaround time for determinations. Based on provider feedback and recognizing the operational need to adjust this workflow, Kepro implemented an additional pend process. The second pend option (one at nurse review level, one at physician review) allows additional opportunity to collect sufficient information to render a determination.

Why was it acceptable to the Department that Kepro's turnaround time for determinations exceeds 10 days, sometimes reaching 30 days?

During the initial implementation with Kepro, timeliness standards were not met. This was largely from review volumes exceeding the Department's and Kepro’s expectations. Kepro quickly addressed and fully resolved timeliness concerns. By early September 2021, Kepro has consistently met performance standards, as illustrated in the chart attached/below. They have met and exceeded turn-around time (TAT) requirements of no more than 10 business days. This performance has been achieved in the following ways: in collaboration with the Department, Kepro has increased utilization of review automation within their

system, increased staffing, and cross-trained reviewers to be able to work in multiple benefit areas or review queues. The Department closely monitors TAT on a daily, weekly, and monthly basis.

Why were there no reports available for providers in Atrezzo to view PARs in process and status?

The Department recognized the need for a Provider report. We worked with Kepro to develop a provider report in Atrezzo to view case and determination status outcomes and other information. Please reference the quick reference guide.

Why do messages in Kepro's system, Atrezzo, disappear and I can't respond to messages?

It is accurate that messages in the portal do not continually appear once they have been viewed. However, these notes do not disappear. Once you read a message in the inbox, it can be viewed within the individual case ID for the member. Based on provider feedback, Kepro developed a provider reporting tool so you can track the status of all cases submitted.

Why can I not upload more than 15 pages in the PAR portal, Atrezzo?

There is no page limit in the PAR portal in Atrezzo. However, there is a file size limitation of 10MB for each attachment, and providers should review how their files are saved and the file size before submitting. This document here walks through the process of how to upload supporting documentation and includes information on the file size limitation.

My request was submitted as Expedited but Kepro changed it to Rapid. Why did Kepro do this and is Kepro able to do this?

Definitions for Expedited and Rapid reviews were established by the Department (see page 11 in the Kepro Provider Manual). If a Provider submits a PAR to Kepro as Expedited or Rapid and Kepro determines, based on the information provided with the PAR, that the request does not meet the definition, Kepro has been given direction by the Department to change the request type.

Is the P2P process confusing, difficult, and time-consuming?

In response to stakeholder feedback about responsiveness, the Department made recent improvements in the Peer-to-Peer (P2P) process. This involves having a dedicated scheduler confirm a mutually agreed upon date and time for the P2P call. After an adverse decision, ordering Providers may request a P2P review within 10 business days of the review determination. A P2P allows the ordering Provider to discuss the case with a Kepro physician reviewer. Feedback to Kepro and the Department indicates this is helpful for the ordering

Provider to provide clarification or additional information, or to gain clearer understanding why a request was denied. P2P reviews may result in either the denial being upheld or overturned depending on the conversation between the ordering Provider and Kepro physician reviewer.

Why does Kepro disregard or ignore statements from the PCP including letters of medical necessity?

Kepro considers statements from PCPs in determining medical necessity and it is one source of supporting information and documentation. Please see page 19 of the Health First Colorado Member Handbook.

How do I modify an eQ PAR?

Please visit ColoradoPAR.com to see instructions for modifying PARs, including this link to the change request form.

How do I locate the PAR number? Why do the letters NOT give the Authorization Number?

The Department is working with Kepro on this issue of populating PAR numbers on determination letters. In the meantime, providers may search Atrezzo (the PAR portal) by case ID and find the PAR number under the header of "SRV AUTH."

What is the timeframe to respond to a pend?

When Kepro pends a PAR for additional information, Providers have seven (7) business days to respond.

How do I change the NPI on a PAR?

NPI numbers on PARs do not affect approval or denial of a PAR. Please submit new claims and PARs under the current/active NPI, however there is no need to go back and update NPIs on old PARs. If providers have issues submitting claims due to their new NPI, please email COproviderissue@kepro.com.

What do I do when a partial approval is changed to full approval, however the update is not showing in Atrezzo?

Please contact Kepro directly at coproviderissue@kepro.com. If Kepro does not resolve the issue, please contact hcpf_um@state.co.us.

Why won't Kepro let me void a PAR?

Providers can void PARs if a determination has not been made. Once a determination has been made, providers cannot void PARs.

Does the Department respond to or use information that providers send via the UM email address about complaints and problems with Kepro?

Yes. In addition to the support provided by Kepro's customer service and provider relations teams, the UM Team responds to provider inquiries through a dedicated Utilization Management inbox (hcpf_um@state.co.us). This allows the UM Team to quickly identify issues and concerns and either address them directly with providers, members and/or other key stakeholders, or identify areas that require additional guidance, clarification, or instruction. This is the foundation of the UM Team's continuous improvement process.

Since Kepro has taken over the UM program, the HCPF UM Team has used provider feedback to provide guidance, instructions and implement changes and improvements to the UM program and process, including:

- Develop and implement a provider report in Kepro's prior authorization system
- Improve the clarity and instructions of the language utilized by Kepro when requesting additional information and supporting documentation (or ""pending"" a request) to ensure the provider has a clear, consistent understanding of what documentation and information is needed to support a medical necessity review
- Improve the process for requesting, scheduling and completing a Peer-to-Peer (P2P) request
- Investigate cases that require consultation with Department subject matter experts such as our Policy Team (including Certified Coders), Legal Division and Claims/Systems staff
- Increase the TAT on PARs for members pending discharge from the hospital and increased automation and/or temporarily holding PAR requirements for COVID-related supplies

The UM Team is committed to offering best in class service to Medicaid's providers; thus, we will continue to respond to individual provider inquiries and through stakeholder forums to identify issues and provide resolution to improve the program for all Medicaid members and providers. The Department appreciates the continued support of existing processes to address stakeholder concerns, questions and issues utilizing the UM inbox to ensure timely and efficient responses.

When are habilitative services covered?

Coverage details of habilitative outpatient PT/OT and Speech Therapy is found in the applicable billing manuals.

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