Acentra HEALTH

On behalf of

HEALTH FIRST COLORADO

Pediatric Long-Term Home Health Therapies

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-day window to submit a case to Acentra Health once services have begun. If submitted beyond the 10 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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Pediatric 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).

0421	0431	0441
PT LTHH one visit up to 2.5 hours	OT LTHH one visit up to 2.5 hours	ST LTHH one visit up to 2.5 hours

For specific information when providing home health care, providers should refer to *10 C.C.R. 2505-10 8.520*

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Reimbursable Home Health Services

10 CCR 2505-10-8.130.35

- The licensed and certified Class A Home Care Agency 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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Physical Therapy

- **Physical Therapists (PT)** must have a current, active license in accordance with the Colorado Physical Therapy Practice Act at § 12-41-107, C.R.S.
- **Long-Term Home Health:** Physical therapy is available to pediatric members when prior authorized and deemed medically necessary. Physical therapy is reimbursed on a per visit basis using revenue code 421.

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Occupational Therapy

- **Occupational Therapists (OT)** must have a current, active registration in accordance with the DORA Colorado Occupational Therapy Practice Act at § 12-40.5-106, C.R.S.
- **Long-Term Home Health:** Occupational therapy is available to pediatric members when prior authorized and deemed medically necessary. All Home Health occupational therapy is reimbursed on a per visit basis using revenue code 431.

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Speech Therapy

- **Speech/Language Pathologists (SLP)** who have a current, active certification from the American Speech-Language-Hearing Association (ASHA).
- **Long-Term Home Health:** Speech therapy is available to pediatric members when prior authorized and deemed medically necessary. All Home Health speech therapy is reimbursed on a per visit basis using revenue code 441.

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Coordination of Benefits

- 8.520.9.D. Restrictions

4. In the event of limited resources for a Home Health Agency, two agencies may coordinate care and provide services to the same member as long as there is no duplication of services on the same date(s) of service and the Home Health Agencies comply with the following:

- A. The Home Health Agencies shall document the need and reason for two Home Health Agencies to render services to a member

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Coordination of Benefits Con't

- 8.520.9.D. Restrictions Con’t

B. The Home Health Agencies shall coordinate the member’s Plan of Care and maintain the Plan of Care and documentation on all services rendered by each provider in the Member’s records.

C. Each Home Health Agency shall obtain prior authorization, identify to the URC the coordinated Plan of Care and revise the PAR as needed to ensure coverage.

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Coordination of Benefits

8.520.7.E.

10. Documented evidence of Care Coordination with the Member's other providers;

11. When the Member is receiving additional services (skilled or unskilled) evidence of Care Coordination between the other services shall be documented and include an explanation of how the requested Home Health Services do not overlap with these additional services;

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LTHH Documentation Requirements

All LTHH PAR submissions must include:

1. 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 or allowing practitioner prior to submitting the final claim for a certification period.

LTHH Documentation Requirements cont.

1.(See previous slide)
2. 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.

3. Any other documentation deemed necessary by the Department or its authorizing agency

4. All supporting documentation must be submitted 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 – 8.520.4

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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 2 visits per week of physical therapy for 26 weeks. 2 units x 26 weeks = 52 total units needed.

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 2 visits weekly of speech therapy for 52 weeks taken by Nurse Joe . And then include Nurse Joe’s signature.

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

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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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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

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 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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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, Acentra Health cannot revise the modifiers or NPI numbers.

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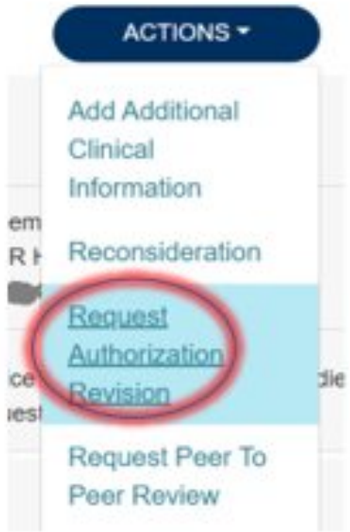
PAR Revision Con't

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 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 be responsible for completing 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 (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 escalating concerns please contact: homehealth@state.co.us
- Acentra Health Customer Service: (720) 689-6340
- PAR Related Questions: coproviderissue@acentra.com

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