Hello and welcome to Acentra Health's provider benefit specific training for physician administered drug utilization review.

Today we will discuss EPSDT, Acentra Health and our scope of services. Acentra Health's services for providers, provider responsibilities, the PAR submission process, general requirements, the PAR process, response times, PAD PAR guidance, PAD unit calculations, reimbursable and non-reimbursable PADs, nonpaid benefits, Medicaid's rules for medical necessity, the PAR revision process, the change of provider form and then have a brief recap.

Acentra Health follows the early and periodic screening diagnostic treatment 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 preventative and treatment components, as well as those services which may or may not be covered for other members in the Colorado State plan.

With over 6 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 and our mission is to continually innovate solutions that deliver maximum value and impact to those we serve.

In 2021, Kepro was awarded the Department of Health Care Policy and Financing contract for utilization management and Physician Administered Drug Review.

This includes outpatient, inpatient, specialty and EPSDT.

In 2023, Kepro merged with CNSI and rebranded to become Acentra Health.

In addition to UM review, Acentra Health will administer or support in a client over utilization program, annual HCPCS Code review, a quality program, reporting, review criteria selection, customer service line, appeals, peer to peer and reconsiderations, as well as fraud and false claim reporting.

Acentra Health's scope of services include audiology, diagnostic imaging, durable medical equipment, the inpatient Hospital Review program, medical services, molecular and genetic testing, out of state inpatient services, outpatient physical, occupational and speech therapy, pediatric behavior therapy, private duty nursing, personal care services and physician administered drugs.

Our provider portal Atrezzo, is available 24 hours a day, 365 days a year and can be accessed at portal.kepro.com .

For provider communication and support, please email Coproviderissue@kepro.com.

For provider education and outreach, as well as system training materials and the provider manual, please visit the Colorado PAR website at hcpf.colorado.gov/par

Providers must request prior authorization for services through Acentra's provider portal, Atrezzo.

A fax exempt request form may be completed 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, or the provider is visually impaired.

Utilization of the Atrezzo portal allows the provider to request the prior authorization for services, to upload clinical information to aid in the review of prior authorization requests and to submit reconsiderations and/or peer to peer requests for services denied.

The system will give warnings if a PAR is not required.

You should always verify the members eligibility for Health First Colorado prior to submission by contacting Health First Colorado. The generation of a prior authorization number does not guarantee payment.

PAR requests submitted within business hours of 8:00 AM to 5:00 PM Mountain time will have the same day submission date. While the Atrezzo portal is accessible 24 hours a day seven days a week, requests submitted after business hours, on holidays or on days following state approved closures, will have a receipt date of the following business day.

PAR submissions will require providers to provide the Members ID, the members name, date of birth, CPT or HCPCS codes to be requested, the dates of service, the ICD10 code for the diagnosis, the servicing provider or the billing providers NPI if it is different than the requesting providers, the number of units requested, an order signed by the physician, the nurse practitioner or the physician assistant, and any supporting documentation. Requests for additional information will be initiated by Acentra Health if or when there is not substantial supporting documentation to complete the review.

A detailed step by step process for submitting both outpatient and inpatient requests can be found in the provider training manual.

Timely submission means entering the request before services are rendered and with enough advanced notice for the review to be completed.

After submission of a request, you will see one of the following actions occur:

An approval: This means it met the criteria applied for the service requested at first level review or was approved at physician level.

A request for additional information. This means that information for determination was not included and the vendor request this to be submitted to complete the review.

A technical denial. Health First Colorado policy is not met for reasons including but not limited to the following reasons, an untimely request, the requested information was not received or lack of information, the request was a duplicate to another request approved for the same provider, or the service was previously approved with another provider.

You could also see a medical necessity denial. The physician level reviewer determines that medical necessity has not been met and has been reviewed under the appropriate guidelines.

The physician may fully or partially deny a request.

If the technical denial is determined, the provider can request a reconsideration.

If a medical necessity denial was determined, the provider may request a reconsideration and/or a peer to peer review.

For a reconsideration request, the servicing provider may request a reconsideration to a center Acentra Health within 10 days of the initial denial.

If the reconsideration is not overturned, the next option would be the peer to peer review.

For the peer to peer request, an ordering provider may request a peer to peer review within 5 days from the date of the medical necessity adverse determination.

To do so, you would place the request in the case notes, providing the physicians 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 contact customer service at 720-689-6340 to request the peer to peer.

The turnaround time for a completion of a PAR review ensures a thorough and quality review of all PARS by reviewing all necessary and required documentation when it is received, it decreases the number of unnecessary pends to request additional documentation or information, and it improves care coordination and data sharing between Acentra Health and the department's partners like the regional accountable entities and case management agencies.

A PAR that is expedited is because the delay could jeopardize the life or health of a member and or

jeopardize the ability of the member to regain maximum function. In PAD, these requests will be completed in no more than four hours.

Most cases will fall under the standard review category as a prior authorization request is needed. These requests and pad will be completed in no more than 24 hours.

If more information is requested and we pend for additional information, the provider will have 72 hours to respond.
If there is no response, Acentra Health will technically deny the review for insufficient information.

When the provider responds with requested information, Acentra Health will have 24 hours to review that information and make a determination.

The prior authorization request cannot exceed 365 days.

For timely submission, you must submit the PAR request prior to the start date of service.

Retroactive authorizations are not allowed. However, exceptions may be approved by Health First Colorado.

The servicing provider is the billing provider.

The servicing provider on the prior authorization request must be the billing provider on the claim.

The table below shows the HCPCS codes of the physician administered drugs that currently require a par.

It is important to know that the units requested must be for the entirety of a prior authorization request duration.

For example, if the PAR is for one year the provider will need to calculate the anticipated number of units for the entire year, excluding any amount of waste or drug not administered to the Member.

Total units will need to be entered in the requested line for each CPT code.

The system does not calculate units, so you must calculate the units and enter the total number for the time frame requested.

For example, if the member is receiving 100 units of Botox every 12 weeks, you would need to request 400 units for the entire year.

Another example, the member is starting IV Entyvio. They will be receiving 5 doses of 300 milligrams over a six-month time frame. For this you would need to request 1500 units for 180 days.

Providers must ensure a PAD is being used for US Food and Drug Administration approved indication or an indication that is supported by certain compendia identified in section 1927(g)(1)(B)(i) of the Social Security Act.

Pad prior authorizations will apply to fee for service Medicaid members and does not include outpatient hospital claims-only professional claim types.

PAD resources can be found in the PAD billing manual and the fee schedule. All can be located on the Colorado PAR website.

The following are not benefits of the Health First Colorado program:

DESI drugs and any drug if by its generic makeup and route of administration is identical, related or similar to a less ineffective drug identified by the FDA.

Drugs classified by the US Department of Health and Human Services FDA as “investigational” or “experimental”.

Drugs manufactured by pharmaceutical companies not participating in the Colorado Medicaid Drug Rebate program.

Fertility Drugs

IV equipment

Personal care items such as mouthwash, deoderants, talcum powder, bath powder, soap, dentifrices, etcetera.

Spirituous liquors of any kind or drugs used for erectile or sexual dysfunction.

The following are not pad benefits of the Health First Colorado program:

Durable medical equipment. These are managed through the DME benefit.

Pads when administered in a Member's home or in a long term care facility, or when self-administered must be built to the pharmacy benefit.

Please refer to the Colorado Par website For more information on those benefits.

Medical necessity means a medical assistance program good or service:

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.

It is provided in accordance with generally accepted professional standards for healthcare in the United States.

It is clinically appropriate in terms of type, frequency, extent, site and duration.

It is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker or provider.

It is delivered in the most appropriate setting required by the clients condition.

It is not experimental or investigational and it 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 and performing one or more activities of daily living and meets the criteria code of Colorado regulations program rules.

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.

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

To make a revision, you would simply select request revision under the actions drop down.
Then you would select the request number and enter a note in the existing approved case of what revisions you are requesting.

From there you would upload any additional documentation to support the request as appropriate.

When a member receiving services changes providers during an active PAR certification, the receiving provider will need to complete a change of provider form to transfer the members care from the previous provider to the receiving agency.

This form is located on the provider forms web page under the prior authorization request forms drop down menu along with instructions on how to complete the change of provider form.

The provider portal Atrezzo, is available 24 hours a day, 365 days a year can be accessed at portal.kepro.com .

For system training materials and the provider manual, please visit hcpf.colorado.gov/par .

For provider communication and support please email coproviderissue@kepro.com.

For any escalated concerns, please contact the department at hcpf_um@state.co.us

For Acentra Health customer service please call 720-689-6340.

For any PAR related questions, please email Coproviderissue@kepro.com.

This concludes our presentation.

Thank you for your time and participation.