On behalf of

HEALTH FIRST COLORADO

Physician Administered Drug (PAD) 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**
- Psychiatric Residential Treatment Facility (PRTF) and Qualified Residential Treatment Program(QRTP)

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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.

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PAD PAR Guidance

Submission Requirements At-a-Glance:

- PA Approval Length: Up to 1 year

- Provider Timely Submission Requirement: Prior to requested date of service

- Retroactive Authorization: Not allowed. Exceptions may be approved by Health First Colorado

- Servicing Provider (Billing Provider): The servicing provider on the PAR must be the billing provider on the claim

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

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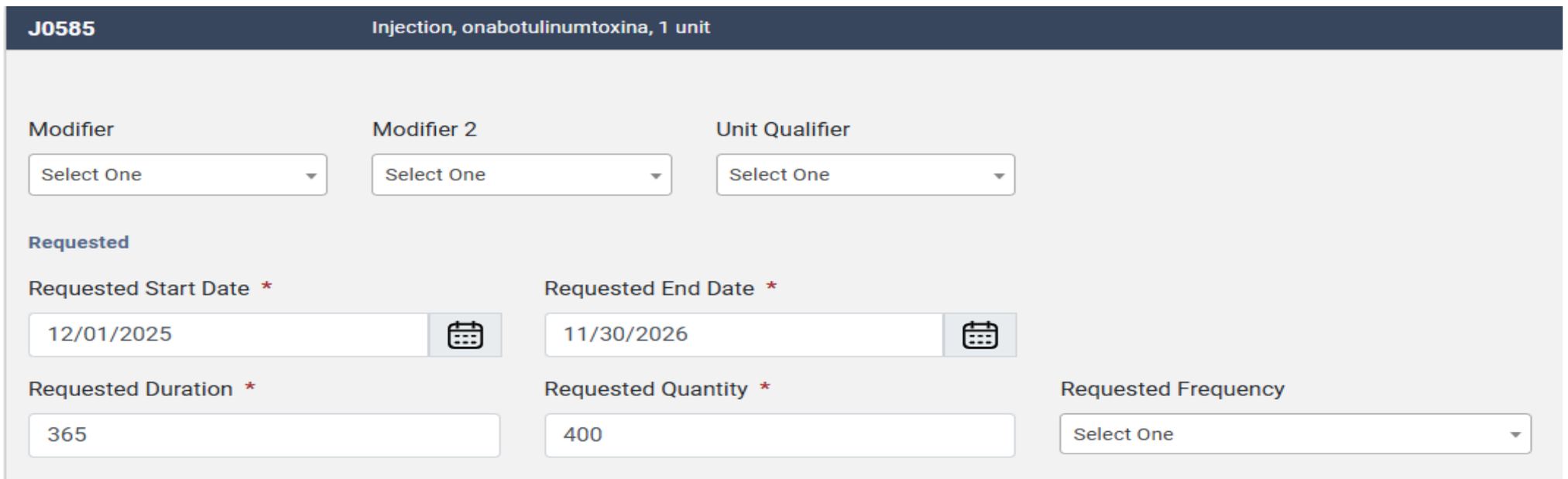
PAD Unit Calculations

• It is important to note that the units requested must be for the entirety of the 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 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.

• CPT -J0585 (Botox) • DX -N32.81 -Overactive Bladder • Dosing -100 units every 12 weeks



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Unit Calculations Example 2

- CPT –J3380 (Entyvio)
- DX –K50 –Crohn's Disease
- Dosing –Initiation of therapy –300 mg IV infusion at 0, 2, and 6 weeks then every 8 weeks (5 doses in 6-month period)

J3380	Inj vedolizumab iv 1 mg

MODIFIER: Select One | Select One

UNIT QUALIFIER: Select One

REQUESTED START DATE *	REQUESTED END DATE *	REQUESTED DURATION *	REQUESTED QUANTITY *
12/01/2025	12/01/2025	180	1500

STANDARD RATE: $

REQUESTED FREQUENCY: Select One

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Reimbursable PADs

Providers must ensure a PAD is being used for a U.S. Food and Drug Administration (FDA) 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 PAs will apply to fee-for-service Medicaid members and does not include outpatient hospital claims-only professional claim types.

- PAD resources can be found at the following: https://hcpf.colorado.gov/physician-administered-drugs

- PAD Billing Manual (under the CMS 1500 dropdown) and Appendix X (under the appendices dropdown) https://hcpf.colorado.gov/billing-manuals

- Fee Schedule link: https://hcpf.colorado.gov/provider-rates-fee-schedule

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Non-Reimbursable PADs

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, it is identical, related, or similar to a less than effective drug identified by the FDA

•Drugs classified by the U.S.D.H.H.S. FDA as "investigational" or "experimental“

•Drugs manufactured by pharmaceutical companies not participating in the Colorado Medicaid Drug Rebate Program

•Fertility drugs

•IV equipment (for example, Venopaks dispensed without the IV solutions)

•Personal care items such as mouth wash, deodorants, talcum powder, bath powder, soap (of any kind), dentifrices, etc.

•Spirituous liquors of any kind

•Drugs used for erectile or sexual dysfunction

Non-PAD Benefits

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

•Durable Medical Equipment (DME), these are managed through the DME benefit, refer to https://hcpf.colorado.gov/DMEPOS-manual

•PADs when administered in a member's home or in a long-term care (LTC) facility, or when self-administered must be billed to the Pharmacy Benefit. Please see pharmacy provider resources
link: https://hcpf.colorado.gov/pharmacy-resources

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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.

1. **Request for additional information (PEND)**: Information for determination is not included and vendor requests this to be submitted to complete the review.
2. **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

3. **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 the life/health of member and/or
- Jeopardize the ability of the member to regain maximum function.
  - o These requests will be completed in no more than 4 hours.

Standard Review: Most cases will fall under this category as a Prior Authorization Request is needed.

- o These requests 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, and 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.

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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 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 on Acentra Health cannot make revisions to the modifiers or NPI numbers.

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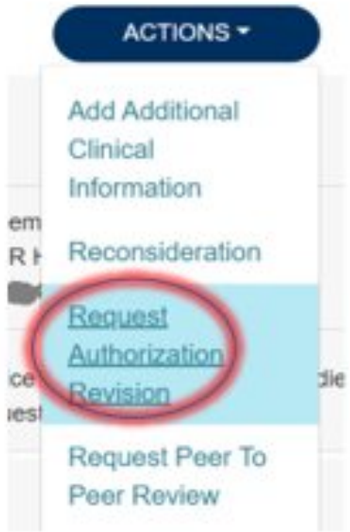
PAR Revision Con't

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/reallocations you are requesting
- Upload the required PAR form for adults and 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: atrezzo.acentra.com

- System Training materials 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 or homehealth@state.co.us
- Acentra Health Customer Service: (720) 689-6340
- PAR Related Questions: coproviderissue@acentra.com

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