Acentra HEALTH

On behalf of

HEALTH FIRST COLORADO

Private Duty Nursing (PDN) 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: 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
  - Receive notifications when the case status has changed

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Provider Responsibilities (con't)

- 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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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.

- If submitted beyond the 10 business days the dates will be adjusted to account for this delay according to 10 C.C.R. 2505-10, Section 8.540.7.A

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PAR Submission: General Requirements

- PAR submissions will require providers to provide the following:
  - Member ID
  - Name
  - Date Of Birth
  - CPT/HCPCS/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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Documentation Requirements

The following is a list of required information that must be uploaded at the time of submission:

10 CCR 2505-10 8.540.7
A. Order

1. Orders must specify how often treatment or visits will be and the length of visit
2. A verbal order is acceptable if it specifies who gave the order and when it was given and is signed by the person who received the verbal order
3. The order can be inclusive of the Plan of Care or an independent order
4. Time submitted that is outside of or different from the order will be deducted and the units adjusted accordingly.

B. A completed Plan of Care/485 with a physician's signature or documented verbal order that includes:

1. Signed nursing assessment
2. Current clinical summary or update of the member's condition
3. Physician's plan of treatment
4. Hospital discharge summary shall be included if there was a hospitalization since the last PAR

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Documentation Requirements (con't)

Further medical documentation may include:

- Sixty (60) day assessment that systematically reviews each body system and reflects progress and problems encountered in the period and outlines plans for recertification period.

- The duties, treatments and tasks performed by the nurse.
  PRN, as needed, interventions should be accompanied with notes or logs from the 60-day assessment (60-day oxygen, medication, seizure tracking and interventions)
- Nursing notes reflecting the nature of care provided during the 60-day assessment.
- Physician specialty notes reflecting current treatment recommendations in the plan of care if relevant. (e.g. Gastroenterology, Neurology, Pulmonology)
- Medication Administration Records (MAR)

Codes and Descriptions

- 0552 RN providing services 1 unit = 1 hour
- 0559 LPN Providing services 1 unit = 1 hour
- 0580 Group RN rate (e.g. siblings) 1 unit = 1 hour
- 0581 Group LPN rate (e.g. siblings) 1 unit = 1 hour
- 0582 Blended Rate 1 unit = 1 hour
- The "blended" rate is available on request for a Home Health Agency that provides PDN to multiple clients in group care settings. All PDN provided in those settings is billed at the same rate and revenue code, irrespective of whether the service is provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

PDN Benefit Regulations

- 8.540.2.B A pediatric client may be approved for up to 24 hours per day of PDN services if the client meets the Utilization Review Contractor medical necessity criteria. PDN for pediatric clients is limited to the hours determined medically necessary.

- 8.540.2.D Adult clients may be approved up to 23 hours per day through the Department's ulitilization management process.

Pediatrics are defined as ages 0-20 years.
Adults are defined as ages 21 years and up.

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Continuous vs. Intermittent Nursing Care

- 8.540 Private Duty Nursing (PDN) means face-to-face skilled nursing that is more individualized and continuous than the nursing care that is available under the home health benefit or routinely provided in a hospital or nursing facility.

- 8.520.1.M. Intermittent means visits that have a distinct start time and stop time, and are task oriented with the goal of meeting a client's specific needs for that visit.

Continuous vs. Intermittent Nursing Care (con't)

Continuous Nursing (PDN Benefit)	**Intermittent Nursing (Home Health Benefit)**
Nursing is continuously applied throughout the shift; nurse is continually assessing, planning, evaluating and implementing interventions	Nursing is intermittently applied to complete a task – assessment, planning, implementation and evaluation are conducted intermittently
Continuous interventions require the skills and knowledge of a skilled nurse and cannot be delegated	Intermittent interventions require the skills and knowledge of a skilled nurse and cannot be delegated
Documentation reflects continuous nature of skilled nursing care	Documentation reflects intermittent nature of nursing care

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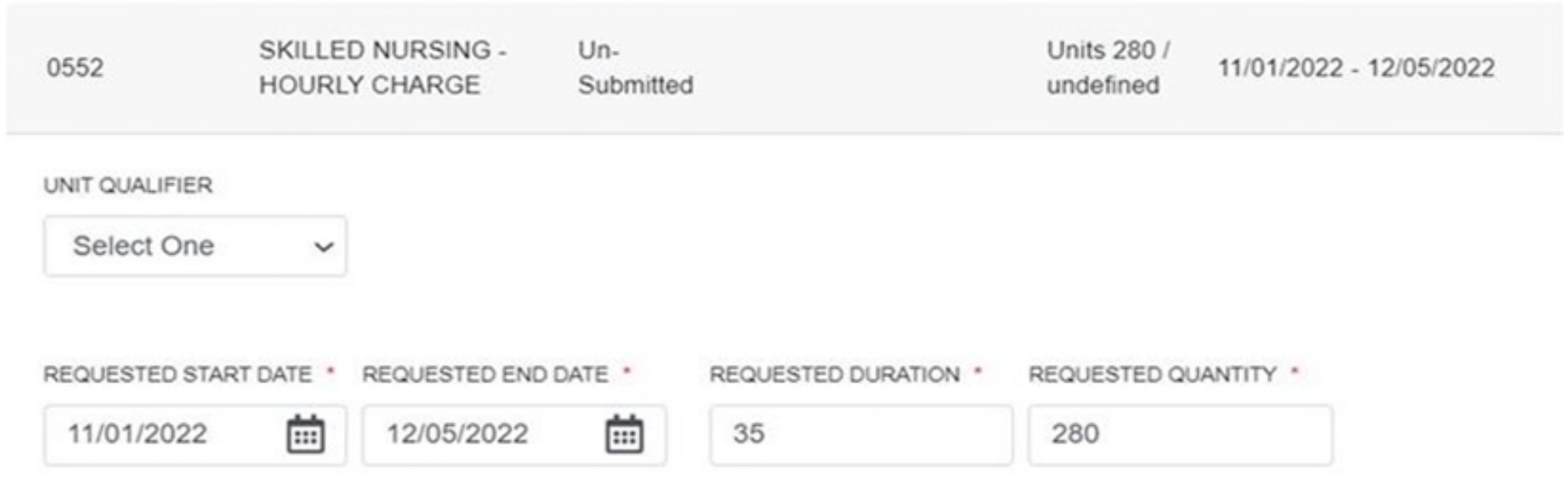
PDN Unit Calculation

When requesting units for PDN services you must enter the total units for the entire length of the PAR in the “Requested Quantity” section.

For example:

The order is for 8 hours a day of REV code 0552 for 35 days.
8 hours (units) x 35 days = 280 total units needed.

The system will not calculate the units for you, you must calculate the total number of units needed for the entire duration.



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Tips to Reduce Pends and Denials

- 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 20 hours per week for 26 weeks.
    20 hours x 26 weeks = 520 total units needed.

- Completing the change of provider form in its entirety and with correct end dates to avoid overlap.

- Ensuring the plan of care is signed by the Physician and the nurse. If the plan of care is not signed by the physician , then make sure to submit a standalone order for services that specify the frequency and duration needed for the request that has either a wet or electronic physician signature. Verbal orders are accepted.
- If submitting a verbal order for services, make sure the verbal order contains the service being requested, the frequency and duration of the request, who gave the order and when, and who received the order and the signature of the person who received the order.

- Submitting all required documentation at the time of the request.

- Check for overlapping PARs prior to submission

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Helpful Links &Tips

- https://hcpf.colorado.gov/bulletins
    - Submit Only Relevant Documentation

✓ Current Plan of Care

✓ Physician Order

✓ Specialist notes related to needs

✓ Most recent nursing notes

Ø PDN Tool

Ø Duplicative Documents

Ø Documentation over a year old

Ø Specialty notes not related to needs

Ø Nursing notes over 30-60 days old

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

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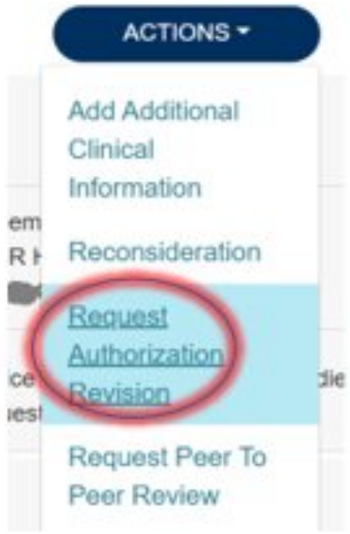
PAR Revision Con't

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 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
- Acentra Health Customer Service: (720) 689-6340
- PAR Related Questions: coproviderissue@acentra.com

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