COLORADO
Department of Health Care Policy & Financing

HEALTH FIRST COLORADO

Outpatient Speech Therapy Utilization Review

The Department of Health Care Policy & Financing administers Health First Colorado (Colorado's Medicaid program), Child Health Plan Plus (CHP+) and other health care programs for Coloradans who qualify.

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EPSDT

Kepro follows the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements for all medical necessity reviews for Health First Colorado members. All 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.

For more information, please review the EPSDT website: https://hcpf.colorado.gov/early-and-periodic-screening-diagnostic-and-treatment-epsdt

About Kepro

In 2021, Kepro was awarded the Colorado Department of Health Care Policy and Financing (HCPF) contract with the state of Colorado for Utilization Management and Physician Administered Drug (PAD) UM review, including outpatient, inpatient, specialty, and EPSDT.

In addition, Kepro will administer or participate in:

- Client Overutilization Program (COUP)
- Annual Healthcare Common Procedure Coding System (HCPCS) code review
- Quality Program
- Reporting
- Review Criteria selection
- Customer Service Line
- Appeals, Peer-to-Peer, and Reconsiderations
- Fraud & False Claims reporting

urac ACCREDITED Health Utilization Management Expires 12/01/2021

urac ACCREDITED Case Management Expires 12/01/2021

urac ACCREDITED Disease Management Expires 10/01/2020

urac ACCREDITED Independent Review Organization: Internal Expires 09/01/2022

426M
In Savings through Care Management

35 YEARS
Serving Government Sponsored Healthcare Programs

1.8M
UM Reviews a year

Scope of Services

- Audiology
- Diagnostic Imaging
- Durable Medical Equipment
- Inpatient Hospital Review Program (IHRP 2.0)
- 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
- Pediatric Private Duty Nursing
- Personal Care Services
- Physician Administered Drugs

Kepro Services for Providers

- 24-hours/365 days provider portal can be accessed at: https://portal.kepro.com
- Provider Communication and Support email: coproviderissue@kepro.com
- Provider Education and Outreach, as well as system training materials (including slide decks and FAQs) 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

Provider Responsibilities

- Providers must request prior authorization for services through our direct data entry portal, **Atrezzo,** unless criteria are met and approved for the fax exempt list.
- The Fax Exempt method of requests must be approved by submitting a Fax Exempt Request form and meeting specific criteria, 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.
- The form can be located at https://hcpf.colorado.gov/par.
- 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, and
  - submit reconsideration and/or peer-to-peer requests for services denied.
- The system will give warnings if a PAR is not required.
- Always **VERIFY** the Member's 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 (Prior Authorization Request) Submission

- PAR requests submitted within business hours: 8:00AM – 5:00PM (MT) will have the same day submission date.
- Atrezzo portal is accessible 24/7. However, those submitted:
  - **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**

PAR Submission – General Requirements

PAR submissions will require submitters to provide the following:

- ✓ **Member ID**
- ✓ **Member Name**
- ✓ **Member DOB**
- ✓ **CPT or HCPCS codes for services being requested**
- ✓ **Dates of service(DOS)**
- ✓ **ICD10 code for the diagnosis**
- ✓ **Servicing provider (billing provider) NPI if different than the Requesting provider**
- ✓ **Number of units requested, i.e., visits, number of items, etc.**
- ✓ **Supporting Documentation:** It will be necessary to provide supporting documentation with your submission. Supporting documentation may include valid signed order, office visit notes, laboratory results, imaging results, etc.
    - Requests for Additional Information will be initiated by Kepro if/when there is not substantial supporting documentation to complete a review.

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

PAR Requirements

Below is an overview of PAR requirements. A complete list of requirements can be found in the Speech Therapy billing manual at https://hcpf.colorado.gov/speech-therapy-manual

Independent speech therapists and outpatient hospital-based therapy clinics providing outpatient speech therapy must submit and have approved PARs for medically necessary services prior to rendering the services.

Prior Authorization Requests are approved for up to a 365-day period (depending on medical necessity determined by the authorizing agency).

- Retroactive PAR requests will be accepted for children ages 0-4 who are under the direction of the Early Intervention program. Retro-authorization requests will be approved for a window of 30 calendar days from the date on which the provider submits the PAR, even if this does not encompass the start-date of the IFSP. Dates requested on the PAR must be within the dates on the IFSP.
- Eligible members may receive Habilitative speech therapy in addition to Rehabilitative speech therapy so long as the therapies are not duplicative and rendered on the same date of service.
- Overlapping PAR request dates for same provider types will not be accepted, except for Early Intervention PAR requests which may have overlapping dates of service and multiple provider types.
- If member has an overlapping PAR with a different provider, a completed Change of Provider form will be required. This form can be located at https://hcpf.colorado.gov/par#forms . This form must be submitted, and an authorization number generated on the new request, PRIOR to any billing.

Submit PARs for the number of units for each specific procedure code requested, not for the number of services. Modifiers must be included on both the PAR and claim submission. When submitting a PAR for either rehabilitative or habilitative services, the procedure codes must include GN + 96/97 modifiers (e.g. 92507+GN+97).

PAR Requirements Continued

PAR Requests Must Include:

- Legibly written and signed ordering practitioner prescription or approved Plan of Care, to include:
  - **diagnosis**
  - **reason for therapy**
  - **the number of requested therapy sessions per week**
  - **total duration of therapy.**
- Member's speech therapy treatment history, to include current assessment and treatment, along with the duration of the previous treatment and treating diagnosis
- Documentation indicating if the member has received ST under the Home Health Program or inpatient hospital treatment
- Current treatment diagnosis
- Course of treatment, measurable goals, and reasonable expectation of completed treatment
- Documentation supporting medical necessity for the course and duration of treatment being requested

Speech Therapy

Speech Therapy has no yearly quantitative limit to services. However, there is a daily quantitative limit of five units.

The manual link for the Speech Therapy billing manual is https://hcpf.colorado.gov/speech-therapy-manual.

Submissions at a Glance	Details
Provider Timely submission	Prior to rendering services
Retroactive Authorization (Member not eligible at time of service)	Not accepted by Kepro *Exceptions may be made by HCPF
PAR Duration	**Change in Policy to allow up to 365 days**
Servicing Provider (Billing Provider)	Providers enrolled as clinics, non-physician practitioner groups, rehab agencies, hospitals, or as individual speech therapists or audiologists.
Requesting Provider (Ordering Provider)	Hospital, Physician, physician assistant, or Nurse Practitioner, Audiologist, Speech Therapist, Rehabilitation Agency, Non-Physician Practitioner Group

Understanding Speech Therapy Services

Enrolled members ages 20 and under and adult clients in limited circumstances qualify for medically necessary Speech Therapy services.

https://hcpf.colorado.gov/speech-therapy-manual

These include but are not limited to:

- Evaluation
- Individual and group therapeutic treatment
- Alternative and augmentative communication device evaluation
- Assistive technology assessment
- Cognitive skill development

Rehabilitative therapies are those meant to assist a member with recovery from an acute injury, illness, or surgical recovery; return to their baseline.

Habilitative therapies are those meant to help the member retain, learn, or improve skills and functions for daily living. This includes the treatment of long-term chronic conditions and meeting developmental milestones. Both children and adults have rehabilitative speech therapies covered, but only some adults have Habilitative speech therapies covered. All children have Habilitative speech therapies covered.

Early Intervention
https://www.colorado.gov/pacific/hcpf/early-intervention-manual
Early Intervention Services provide developmental supports and services to children birth to four (4) years of age who have either a significant developmental delay or a diagnosed condition that has a high probability of resulting in a developmental delay and are determined to be eligible for the program. An approved IFSP may serve as an 'order for services', in lieu of a physician order for Speech Therapy.

ST Benefit Limitations

- Eligible members may not receive both Rehabilitative and Habilitative speech therapy services on the same date of service.
- Speech Therapy is limited to five (5) units of service per date of service. Some specific daily limits per procedure code apply. Please see below:
  - **While a maximum of five units of service is allowed per date of service, providers are required to consult the American Medical Association's (AMA) Current Procedural Terminology (CPT) manual for each coded service. Some codes represent a treatment session without regard to its length of time (one unit maximum) while other codes may be billed incrementally as "timed" units.**
- Members determined to need a speech generating device (HCPCS codes E2500, E2502, E2504, E2510, E2211, E2512, and E2599) should be referred to a Health First Colorado participating medical supplier to be prior authorized.

This information can be found in the ST Billing Manual for reference.

Documentation Requirements

Providers need to submit the following documentation on new admissions:

- Evaluation/Re-evaluation
- An order/referral/plan of care that is signed by either an MD, DO, NP or PA with either a physical signature or a CMS compliant electronic signature
- An order/referral/plan of care that includes the diagnosis, type of therapy, frequency and duration specification and covers the PAR dates requested
- A plan of care that is within 90 calendar days prior to the requested start date and includes the diagnosis, type of therapy, therapeutic interventions, frequency and duration specifications and cover the PAR dates requested.

Providers need to submit the following documentation for continuation of care reviews:

- Evaluation/Re-evaluation
- An order/referral/plan of care that is signed by either an MD, DO, NP or PA with either a physical signature or a CMS compliant electronic signature
- An order/referral/plan of care that includes the diagnosis, type of therapy, frequency and duration specification and covers the PAR dates requested
- A plan of care that is within 90 calendar days prior to the requested start date and includes the diagnosis, type of therapy, therapeutic interventions, frequency and duration specifications and cover the PAR dates requested.
- A recent complete therapy re-evaluation or updated progress notes on the current plan of that shows either progress, or lack thereof, for review. This must be performed within the last 60 days prior to start date.

For more information, please refer to the July Provider Bulletin **https://hcpf.colorado.gov/bulletins** and the Speech Therapy Billing Manual **https://hcpf.colorado.gov/speech-therapy-manual .**

ST: Two or more services performed

Example 1:

Doctor/clinic performs two separate services, both under 8 mins. Combine the two service minutes together. If the total time equals the time range of 8 to 22 mins, bill for the service performed with the most minutes as 1 unit.

- Document the total number of timed minutes in the Visits/Encounter table.
- To bill for multiple timed services over 8 mins, combine the total time together.

Example 2:

- 24 minutes of neuromuscular reeducation, code 97112
- 23 minutes of therapeutic exercise, code 97110
- Total treatment time = 47 minutes or (3 units)

Example 3:

- 7 minutes of neuromuscular reeducation (97112)
- 7 minutes therapeutic exercise (97110)
- 7 minutes manual therapy (97140)
- Total timed minutes = 21 minutes (1 unit)

Determining What Time Counts towards a 15-minute Timed Codes Unit

Only count time where services/treatment are being performed for/with the patient. Toileting, rest, waiting to use equipment, or for treatment to begin, etc., are not considered treatment time.

Service Units for Outpatient Therapies

Unit/Quantity Calculation

A unit equals either 1) a timed increment, or 2) one treatment session as described in the specific CPT procedure codes.

Submit PARs for the number of units for each specific procedure code requested, not for the number of services.

Time and Untimed Codes

Timed Codes: 1 unit = 15 minutes

Untimed Codes: based on the # of times the procedure is performed.

When reporting service units for the coding system and the procedure is not defined by a specific timeframe, the provider enters **1** in the labeled **Units** field. For these types of untimed codes, units are reported based on the number of times the procedure is performed.

Example A: 60 minutes of speech therapy has a Timed Code (97130), the provider reports 4 units.

Example B: Pathology evaluation used as an Untimed code: 92521 entered as 1; only 1 evaluation was completed**.**

Counting Minutes for Timed Codes

Providers should not bill for services that occur in less than 8 minutes, but they can bill for services provided in the timespan of 8 to 22 minutes as 1 unit.

Units	Number of Minutes
1 unit:	≥ 8 minutes through 22 minutes
2 units:	≥ 23 minutes through 37 minutes
3 units:	≥ 38 minutes through 52 minutes
4 units:	≥ 53 minutes through 67 minutes
5 units:	≥ 68 minutes through 82 minutes
6 units:	≥ 83 minutes through 97 minutes
7 units:	≥ 98 minutes through 112 minutes
8 units:	≥ 113 minutes through 127 minutes

Outpatient Therapies- Modifier Requirements

Modifier codes must be included for all ST requests. The same modifiers used on the PAR must be used on the claim, in the same order.

Outpatient Therapy Type	Modifier 1	Modifier 2	Example
Rehabilitative Speech Therapy	GN	97	92507 + GN + 97
Habilitative Speech Therapy	GN	96	92507 + GN + 96
Early Intervention Speech Therapy	GN	TL	92507 + GN + TL

PAR Outcomes

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

Approval: Met criteria/CCR applied for the service requested at first level review or was approved at physician level.

Request for additional information: Information for determination is not included and vendor requests this to be submitted to complete the review.

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/Lack of Information (LOI)*

**Duplicate to another request approved for the same provider*

**Service is previously approved with another provider*

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.

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) in order to transfer the member's care from the previous provider to the receiving agency. This form is located on the Provider Forms webpage under the Prior Authorization Request (PAR) Forms, drop-down menu, using the instructions located under "How to Complete Change of Provider Form."

PAR Denials

Denials:

If a **Technical Denial** is determined, the provider can request a **Reconsideration**.

If a **Medical Necessity Denial** was determined, it was determined by the Medical Director. Therefore, the next step would be requesting a **Peer to Peer**.

Steps to consider after a Denial is determined:

- ***Reconsideration Request:*** the **servicing** provider may request a reconsideration to Kepro 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 by placing 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 vendor's turnaround time (TAT) 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**
- Decrease in the number of unnecessary pends to request additional documentation or information
- Improved care coordination and data sharing between Kepro and the Department's partners, like the Regional Accountable Entities (RAEs) and Case Management Agencies (CMAs)

***For additional information pends: The Provider will have **10 Business Days** to respond, and if there is no response or insufficient response to the request, Kepro will complete the review and **technically deny for Lack of Information (LOI**), if appropriate.*

Turnaround Times – Part 2

Expedited review is a PAR that is expedited because a delay could:

- Jeopardize life/health of member
- Jeopardize ability to regain maximum function
- And/or subject to severe pain

Rapid review is a PAR that is requested because a longer TAT could result in a delay in the Health First Colorado (HFC) 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
- A lack of DME supplies that immediately and adversely impacts a HFC Member's ability to perform activities of daily living (ADL)
- Same Day Diagnostic studies required for cancer treatments
- Genetic or Molecular testing requiring amniocentesis

Standard review is one that most cases would fall under as a prior authorization request is needed but not in a rapid or expedited time frame. These requests will be completed in no more than 10 business days.

Definition of Medical Necessity

10 CCR 2505-10; 8.076.1

8. 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;

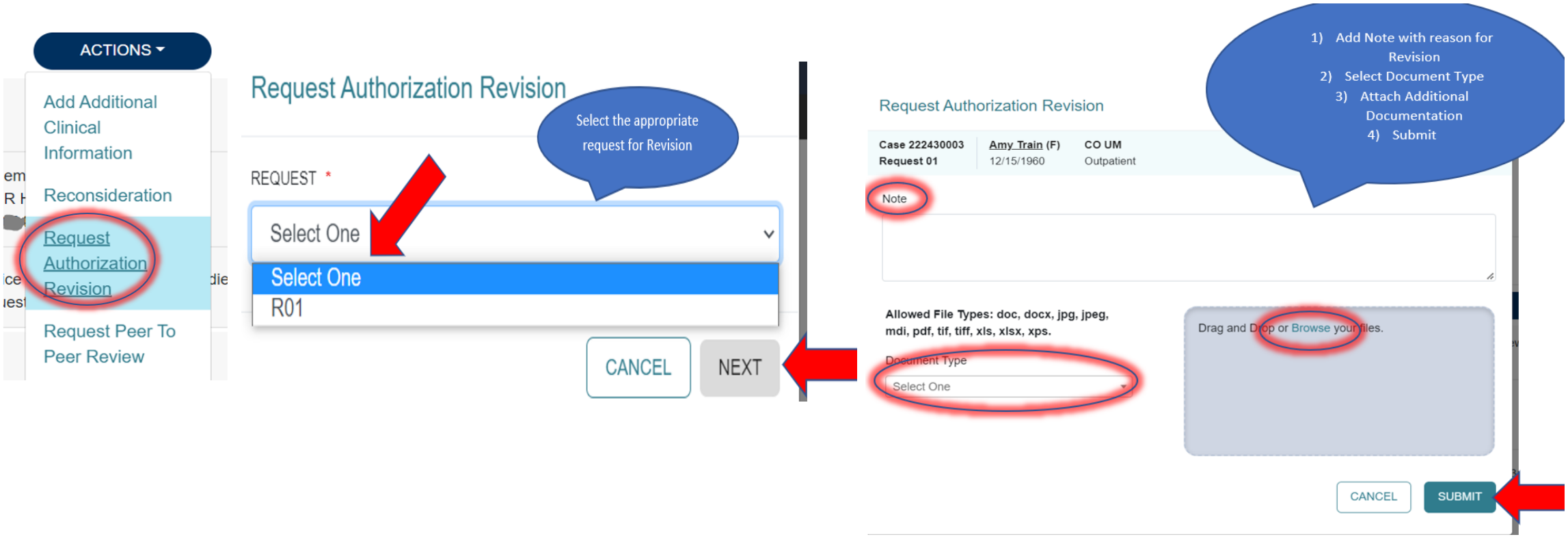
f. Is not experimental or investigational; and

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).

PAR Revision

- 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. Kepro cannot make modifications to an expired PAR or a previously billed-upon PAR.
- To make a revision, simply select “Request Revision” under the “Actions” drop-down, select the Request number, enter a note in the existing approved case of what revisions you are requesting, and upload additional documentation to support the request as appropriate.



Kepro Services for Providers - Recap

- 24-hours/365 days provider **Atrezzo Portal** may be accessed at: https://portal.kepro.com
- **System Training** materials (including slide decks and FAQs) and the **Provider Manual** are located at: https://hcpf.colorado.gov/par
- **Provider Communication and Support** email: coproviderissue@kepro.com

Conclusion

Thank you for your time and participation!

Contact Info

Kepro Call Center: 720-689-6340

PAR-related Questions: COproviderissue@kepro.com

Training-related Questions: Coproviderregistration@kepro.com

For escalated concerns please contact: hcpf_um@state.co.us

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