Hello and welcome to Kepro's provider benefit specific training for speech therapy providers.

Today we will review EPSDT Kepro and Kepro's scope of services, Kepro's services for providers, provider responsibilities, PAR submission, general requirements, the PAR process, PAR guidance and requirements, service units for speech therapy, response times, Medicaid rule for medical necessity, PAR revisions, and then have a brief recap.

KEPRO follows the early and periodic screening, diagnostic and treatment 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.

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

In addition, Kepro will administer or participate in a client overutilization program, annual healthcare common procedure coding system (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 claims reporting.

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

Kepro's provider portal Atrezzo, can be accessed 24 hours a day, 365 days a year 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 can all be found at HCPF.colorado.gov/par

Providers must request prior authorization for services through our direct data entry portal Atrezzo, unless criteria has been 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.

This form can be located at hcpf.colorado.gov/PAR

Using the Atrezzo portal does allow the provider to request the prior authorization for services. It allows them to upload clinical information to aid and review of the PAR request, and it allows them to submit reconsideration and or peer to peer requests for services that have been denied.

The system will give a warning 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.

As always, 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, those requests that are 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 the members ID, name, date of birth, the CPT or HCPCS codes for services being requested, the dates of service, the ICD 10 code for the diagnosis, the servicing providers NPI if this is different than the requesting provider, the number of units requested and any supporting documentation.

Supporting documentation may include valid signed order office, visit notes, laboratory results or imaging results.

Requests for additional information will be initiated by Kepro if or 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 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.

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

Prior authorization requests are approved for up to a 365-day period.

Retroactive PAR requests will be accepted for children ages zero to four 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 the 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 a member has an overlapping PAR with a different provider, a completed change of provider form will be required.

This form can be located at hcpf.colorado.gov/PAR#forms.

This form must be submitted in an authorization number generated on the new request prior to any billing.

For a complete list of requirements, please visit the speech therapy billing manual at hcpf.colorado.gov/speech-therapy-manual.

PARs should be submitted 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 plus 96 or 97 modifiers.

PAR requests must include legibly written and signed ordering practitioner prescription or approved plan of care, which includes the diagnosis, the reason for therapy, the number of requested therapy sessions per week and the total duration of therapy.

You must also submit the Member's speech therapy treatment history, to include the current assessment and treatment, along with the duration of the previous treatment, and treating diagnosis. Documentation indicating if the Member has received speech therapy under the Home Health program or inpatient hospital treatment, current treatment, diagnosis, course of treatment, measurable goals and reasonable expectation of completed treatment and documentation supporting medical necessity for the course and duration of the treatment being requested.

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 hcpf.colorado.gov/speech-therapy-manual

For timely submission, this should be submitted prior to rendering services.

Retroactive authorization is not accepted by KEPRO, but exceptions may be made by HCPF

The PAR duration can be up to 365 days.

The servicing provider is the billing provider, this is who will get paid.

The requesting provider can be either the hospital, the physician, the physician assistant, nurse practitioner, audiologist, speech therapist, rehab agency, or non-physician practitioner group.

Enrolled members ages 20 and under, and adult clients in limited circumstances, qualify for medically necessary speech therapy services.

These include, but are not limited to, the 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 services provide developmental supports and services to children birth to four 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.

Eligible members may not receive both rehabilitative and habilitative speech therapy services on the same date of service.

Speech therapy is limited to 5 units of service per date of service.

Some specific daily limits per procedure code apply, while a maximum of five units of service is allowed per date of service, providers are required to consult the American Medical associations current procedural terminology manual for each coded service.

Some codes represent a treatment session without regard to its length of time, while other codes may be billed incrementally as timed units.

Members determined to need a speech generating device should be referred to a Health First Colorado participating medical supplier to be prior authorized.

This information can be found in the speech therapy billing manual for reference.

For new admissions, providers need to submit the evaluation or reevaluation, 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.

In addition to the above, PAR requests for continuation of care reviews should also include a recent complete therapy reevaluation or updated progress notes on the current plan that shows either progress or lack thereof for review. This must be performed within the last 60 days prior to the start date.

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

When the doctor or clinic performs 2 separate services, both under 8 minutes, you would combine the two service minutes together. If the total time equals the time range of 8 to 22 minutes bill for the service performed with the most minutes as one unit.

You would document the total number of timed minutes in the visits encounter table. To bill for multiple timed services over 8 minutes, combine the total time together.

24 minutes of neuromuscular reeducation code 97112 and 23 minutes of therapeutic exercise code 97110 has a combined total treatment time of 47 minutes, or three units.

Another example is 7 minutes of neuromuscular reeducation 97112, 7 minutes of therapeutic exercise 97110 and 7 minutes manual therapy 97140 has total time minutes of 21. This would be 1 unit.

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

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

You should submit PARs for the number of units for each specific procedure code requested, not for the number of services.

Time codes are one unit equals 15 minutes.

Untimed codes are based on the number of times the procedure is performed.

When reporting service units for the coding system, and the procedure is not defined by a specific time frame, the provider enters one in the labeled units field.

For these types of untimed codes, units are reported based on the number of times the procedure is performed.

For example, 60 minutes of speech therapy has a timed code 97130, The provider reports 4 units.

A pathology evaluation used as an untimed code 92521 is entered as one, only one evaluation was completed.

Below is a table showing the number of units per minutes of service. Providers should not bill for services that occur in less than 8 minutes, but they can bill for services provided in the time span of 8 to 22 minutes as one unit.

Modifier codes must be included for all speech therapy requests.

The same modifiers used on the PAR must be used on the claim and in the same order.
All speech therapies should use the GN modifier. Rehabilitative speech therapy should also include the 97 modifier, for habilitative speech therapy the 96 modifier, and for early intervention speech therapy the TL modifier.

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

An approval. This means the request met criteria at first level review or was approved at physician level.

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

A technical denial can be issued for reasons such as an untimely request, the requested information was not received, the request is a duplicate to another request approved for the same provider, or the request has been previously approved with another provider.

A medical necessity denial means that the 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 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 forms drop down menu, using the instructions located under How to complete the change of provider form.

If a technical denial is determined, the provider can request a reconsideration within 10 business days of this denial.

If a medical necessity denial was determined, it was determined by the medical director.

The next step would be to either request a peer-to-peer review or a reconsideration.

For the reconsideration, you must request this within 10 business days of the initial denial.If the reconsideration is not overturned, the next option would be to request the peer to peer review.

This is only available for medical necessity denials.

For the peer-to-peer request, this must also be requested 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. Peer-to-peer will be arranged on one of the provided dates and times for the conversation to be conducted.
You may also call Kepro customer service at 720-689-6340 to request the peer to peer.

Turnaround time for 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.

A decrease in the number of unnecessary pends to request additional documentation or information and improved care coordination and data sharing between KEPRO and the department's partners like the regional accountable entities and case management agencies.

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 if appropriate.

An expedited review is a PAR that is expedited because a delay could jeopardize the life or health of a member, It could jeopardize the members ability to regain maximum function and/or it could subject the member to severe pain.

A rapid review is 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 for speech therapy.

This would be a service or benefit that requires a PAR and is needed prior to a Health First Colorado members inpatient hospital discharge.

A standard review is the 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 and no more than 10 business days.

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 health care 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 client's 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 in 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. 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, then 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's provider portal Atrezzo, can be accessed 24 hours a day, 365 days a year 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 questions or concerns, you can call Kepro customer service at 720-689-6340 or email coproviderissue@kepro.com.

For training related questions, please email coproviderregistration@kepro.com.

For any other escalated concerns, please contact hcpf_um@state.co.us.

This concludes our presentation.

Thank you for your time and participation.