COLORADO
Department of Health Care Policy & Financing

POLICY MEMO

Title: Pediatric Behavioral Therapy Policy Clarification	**Topic:** Benefits
Audience: Enrolled Providers	**Sub-Topic:** Administrative Policy
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Legal Authority: Federal Medicaid law, 42 U.S.C. § 1396d(a) and 42 U.S.C.§ 1396d(r), 10 CCR 2505-10 § 8.280.4.E	
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Purpose and Audience:

The purpose of this memo is to inform and remind Pediatric Behavioral Therapy (PBT) providers about billing, documentation, and payment policies and requirements for the therapies.

Information:

The following information provides reminders for PBT providers about Health First Colorado (Colorado's Medicaid program) requirements for billing, coding, documentation and utilization management. Providers must ensure their billing, coding and utilization requests comply with these requirements.

Utilization Management Update:

Health First Colorado covers medically necessary PBT services in a school setting. Health First Colorado will no longer be covering 40 hours of service in a clinic setting when the child has access to school hours, unless the school district demonstrates that the child cannot be served in a classroom setting. EPSDT requests will still be considered if they are medically necessary, but information from the school (such as an IEP or another document) will need to be submitted showing the total number of hours of PBT that will be provided in school.

Coding Reminders:

This is a reminder that code 97151 is a flat rate, and one (1) unit is to be billed once every 365 days. Code 97151TJ is set at two (2) units that can be billed once every 365 days.

Enrollment Changes:

Please note that all providers are required to change enroll to provider type 83/84 from provider type 24/25 by September 1, 2025. Any provider who has already changed their provider enrollment should be sure to close out their 24/25 enrollments no later than August 31, 2025, or they will be closed via our system.

Please be sure you have changed your billing systems to reflect this provider type change, so you have no delays in Health First Colorado payments.

If you have any questions or need additional guidance on how to complete the tasks, including Prior Authorization Requests, Electronic Visit Verification and claims assistance when you update the provider type, please contact Martina Schmidt (Region 5) via the Provider Field Representative portal, please include in your request you have questions regarding the PT 84/83 Project.

Documentation:

Each provider is required to maintain legible, complete, and accurate records necessary to establish that conditions of payment have been met for Health First Colorado covered goods and services. These records also must contain a complete description of the basis for the type, frequency, extent, duration, and delivery of goods and/or services provided to Medical Assistance Program members.

Each entry in a medical record must be signed and dated by the individual providing the service or good. Stamped signatures are not acceptable. Printed or displayed electronic records must note that signatures and dates have been applied electronically (10 CCR 2505-10 § 8.130.2.G).

Providers are required to ensure that all required signatures are obtained before any claims are submitted for payment (*see* 2023 Provider Participation Agreement, Section 4.3 - General Electronic Data Interchange and System Security).

Consistent with PBT regulatory bodies, provider session notes are required to contain detailed descriptions of therapy sessions. Session notes should include basic patient information, a narrative summary of the treatment provided, and a detailed summary of behavior targets, intervention types, and other relevant data. The notes providers take during therapy sessions also provide required substantiation in billing claims for payment by Health First Colorado and communicating the rationale for ongoing services, if any. In sum, session notes serve as a comprehensive record of billed sessions, evidence of the necessity of therapy, documentation of response to treatment, coordination of care, and notation of other important events.

The use of templates or Electronic Health Records does not guarantee that there will be no findings in audits. Templates were designed to align with standard medical documentation practices and in accordance with American Medical Association Current Procedural Terminology (CPT) code requirements. However, the templates must be used correctly. Staff training, monitoring, and internal auditing are necessary to ensure that adequate documentation practices are occurring. Providers must comply with the requirements set forth for their certification or licensure, as well as the requirements for the contents of session notes.

Co-Treatment:

Co-treatment sessions between two outpatient therapists (pediatric behavioral therapists, physical therapists, occupational therapists, and/or speech-language pathologists) are a covered service under the following conditions:

- A valid clinical rationale for providing co-treatment must be present; and
- Each provider must have an approved plan of care which includes co-treatment.

Co-treatment notes must describe the additional services, identify the co-treatment providers, and provide a clear justification for co-treatment services. Note that time while members are napping is not covered or billable time. Time while the other modality is treating is also not billable. Payments for claims submitted related to nap time or another provider's treatment time will be subject to recoupment.

Credentials:

The provider must submit claims only for those benefits provided by health care personnel who meet the professional qualifications established by the State (2023 Provider Participation).

Adaptive behavior treatment with protocol modification (97155) is administered by a physician or other qualified health care professional face-to-face with a single patient. A Board-Certified Behavior Analyst (BCBA), or equivalent, is the minimum qualification required to administer services under CPT code 97155.

Autism Services Provider means any person who provides direct services to a person with autism spectrum disorder; is licensed, certified, or registered by the applicable State licensing board or by a nationally recognized organization; and meets the following: (F) Is nationally registered as a "registered behavior technician" by the behavior analyst certification board or by a similar nationally recognized organization and provides direct services to a person with an autism spectrum disorder under the supervision of an autism services provider (*see* C.R.S. § 10-16-104 (1.4)(a)).

Adaptive behavior treatment by protocol (97153) is administered by a technician under the direction of a physician or other qualified health care professional, utilizing a treatment protocol designed in advance by the physician or other qualified health care professional. A Registered Behavior Technician (RBT) is the minimum qualification required to administer ABA services to a child diagnosed with autism under CPT code 97153.

Electronic Visit Verification:

Providers of the following services reimbursed by Health First Colorado as fee-for-service must utilize Electronic Visit Verification (EVV) – PBT under Early, Periodic Screening, Diagnosis and Treatment Services, when provided in the home or community as defined in Section 8.280 (10 CCR 2505-10 Adaptive behavior treatment by protocol, § 8.001.2.A.9).

Providers using the State EVV Solution must collect, for each visit, the following data:

i. The Colorado Medicaid ID of the client receiving the service;

ii. Information to identify the individual providing the service;

iii. The time the visit began and ended;

iv. The EVV-required service that was performed;

v. The date the visit occurred; and

vi. The location of the visit (see 10 CCR 2505-10 § 8.001.3.A.1.b).

Action To Be Taken:

Providers should ensure their business practices meet these requirements. Recently the Office of the Inspector General (OIG) audited members' PBT treatment in Colorado, including provider documentation. As a reminder, if there are findings that your documentation and subsequent claims do not meet the national certification requirements and all applicable American Medical Association (AMA) requirements, are subject to compliance monitoring and review for fraud, waste, and abuse in accordance with 10 CCR 2505-10, § 8.076.

Definition(s):

None

Attachment(s):

None

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