



*On behalf of*

**HEALTH FIRST COLORADO**

*Outpatient Therapies Review*



# Table of Contents

About Acentra Health

Scope of Services

Acentra Health Services for Providers

Provider Responsibilities

PAR Submission

General Requirements

PAR Requirements

Timely Submission

Occupational and Physical Therapy

PAR Requirements

Documentation Requirements

Continuation of Care Requirements

Understanding Therapy Services

PT/OT Benefit Limitations

Service Units

Timed and Untimed Codes

Modifier Requirements

PAR Determination Process

Turnaround Times

Tips to Reduce Pends and Denials

EPSDT

Medicaid Rule for Medical Necessity

PAR Revision

Change of Provider Form

Recap





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.

# *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

# 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(Q RTP)

# *Acentra Health's Services for Providers*

- 24-hour/365 days provider portal accessed at: [atrezzo.acentra.com](http://atrezzo.acentra.com)
- Provider Communication and Support email: [coproviderissue@acentra.com](mailto: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>

# 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

# *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

# 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

# ***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>

# *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](http://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.

# *Occupational and Physical Therapy PAR Requirements*

PARs are approved for up to a 12-month period

Members may have one active PAR for each type of therapy (Rehabilitative PT, Rehabilitative OT, Habilitative PT, Habilitative OT) with independent time spans.

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.

A complete list of requirements can be found in the OT/PT billing manual <https://hcpf.colorado.gov/ptot-manual>

# Documentation Requirements

## PAR Requests Must Include:

- 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 to include:
  - Diagnosis
  - Type of therapy
  - The number of requested therapy sessions per week
  - Total duration of therapy.
- 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.
- Member's PT/OT treatment history, to include current assessment and treatment, along with the duration of the previous treatment and treating diagnosis

# Documentation Requirements

## Con't

- Documentation indicating if the member has received OT or PT under the Home Health Program or inpatient hospital treatment.
- Course of treatment, measurable goals, home exercise program (HEP) with compliance and teaching, and reasonable expectation of completed treatment
- Recent assessment or progress notes submitted for documentation , and these must not be more than 60 days prior to submission of PAR request.
- Early Intervention PT/OT PARs must additionally indicate that the member has an Individual Family Service Plan (IFSP) and that it is current and approved.
- DME products require a separate PAR.

# *Continuation of Care Requirements*

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

# *Continuation of Care Requirements Con't*

- 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 care that shows either progress, or lack thereof, for review. This must be performed within the last 60 days prior to start date

# ***Understanding Therapy Services***

**Rehabilitative therapies** are those meant to assist a member with recovery from an acute injury, illness, or surgery 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.

## **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 Therapy.

# *PT/OT Benefit Limitations*

A daily limit of five units of physical therapy services and five units of occupational therapy services is allowed, whether it is rehabilitative or habilitative. 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 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.

# *PT/OT Benefit Limitations Con't*

Members may receive up to 48 units of any combination of PT/OT services per rolling 12-month period before a Prior Authorization Request (PAR) is required. Evaluation and orthotic services are not included in this limit. This equates to roughly 12 hours of therapy services (each unit of service being equal to 15 minutes). This unit limit will be automatically enforced by the claims payment system by denying claims that exceed the limit.

- Units of service exceeding the initial 48 units are not covered without an approved PAR.
- The 12-month period begins when therapy is initiated. The unit limit does not roll-over to accumulate more than 48 available units in a 12-month period. Units are continually available until the limit of 48 has been reached in a 12-month period.
- Units decrement from paid units for a specific member, regardless of provider, beginning on the first date of service. A unit equals either 1) a timed increment or 2) one treatment session as described in the specific CPT procedure codes.

# *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.

# *Timed 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 occupational therapy has a Timed Code (97530); the provider reports 4 units.

Example B: Pathology evaluation uses an Untimed code (92521); entered as 1 unit as 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:  $\geq$  8 minutes through 22 minutes**

**2 units:  $\geq$  23 minutes through 37 minutes**

**3 units:  $\geq$  38 minutes through 52 minutes**

**4 units:  $\geq$  53 minutes through 67 minutes**

**5 units:  $\geq$  68 minutes through 82 minutes**

**6 units:  $\geq$  83 minutes through 97 minutes**

**7 units:  $\geq$  98 minutes through 112 minutes**

**8 units:  $\geq$  113 minutes through 127 minutes**



**COLORADO**

Department of Health Care  
Policy & Financing



# **Outpatient Therapy Modifier Requirements**

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

<b>Outpatient Therapy Type</b>	<b>Modifier 1</b>	<b>Modifier 2</b>	<b>Example</b>
Rehabilitative Physical Therapy	GP	97	97110 + GP + 97
Rehabilitative Occupational Therapy	GO	97	97110 + GO + 97
Rehabilitative Speech Therapy	GN	97	92507 + GN + 97
Habilitative Physical Therapy	GP	96	97110 + GP + 96
Habilitative Occupational Therapy	GO	96	97110 + GO + 96
Habilitative Speech Therapy	GN	96	92507 + GN + 96
Early Intervention Physical Therapy	GP	TL	97110 + GP + TL
Early Intervention Occupational Therapy	GO	TL	97110 + GO + TL
Early Intervention Speech Therapy	GN	TL	92507 + GN + TL

# ***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.

# 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.

# 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 HFC 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.

# *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>

# *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).

# *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.

# 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

The image shows a step-by-step process for requesting a PAR revision. It starts with a 'Request Authorization Revision' screen, which has a 'Note' field (circled in red) and a 'File Type' dropdown (also circled in red). A blue speech bubble on the right lists four steps: 1) Add Note with reason for Revision, 2) Select Document Type, 3) Attach Additional Documentation, and 4) Submit. Red arrows point from the 'Note' field and 'File Type' dropdown to the 'Request Authorization Revision' screen. A second red arrow points from the 'Request Authorization Revision' screen to a 'Request Authorization Revision' sub-screen. This sub-screen shows a 'Case' table with 'Case 233430003', 'Request #1', 'Avail. Start (F) 12-15-2020', and 'CO UM Unposted'. It also shows a 'Note' field (circled in red), a 'File Type' dropdown (circled in red), and a 'Drag and Drop or Browse your file' input field. A blue 'SUBMIT' button is at the bottom. A red arrow points from the 'Request Authorization Revision' sub-screen to the 'SUBMIT' button.

# *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.

# *Acentra Health Services for Providers - Recap*

- 24-hour/365 days provider **Atrezzo Portal** may be accessed at: [atrezzo.acentra.com](http://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](mailto:coproviderissue@acentra.com)

*Thank you for your time  
and participation!*

- For Escalated concerns please contact: [hcpf\\_um@state.co.us](mailto:hcpf_um@state.co.us) or [homehealth@state.co.us](mailto:homehealth@state.co.us)
- Acentra Health Customer Service: (720) 689-6340
- PAR Related Questions: [coproviderissue@acentra.com](mailto:coproviderissue@acentra.com)