Therapy (Physical, Occupational, Speech) Specialty Training

Health First Colorado

(Colorado's Medicaid Program)

Navigating This Presentation

- Underlined words or phrases often will link viewers to more information, such as web pages. If you are viewing this presentation in normal mode (not slideshow mode), you may need to press the Ctrl key while you click on the link in order to open it.
- Use color-coded table of contents slides to navigate to specific areas of interest in the presentation.
  - Use back arrows provided in the bottom right corner of some slides to return to table of contents slides.

Agenda

- Introduction
- Provider Enrollment
- Benefit Overview
- Prior Authorization Requests (PARs)
- Billing & Payment
- Resources

Introduction

Introduction
Outpatient Therapies

- The term “outpatient" refers to any therapy that is not performed in an inpatient hospital or by a home health agency
- Therapists providing services in a school setting must follow school district policy
- Outpatient therapy services are billed as fee-for-service claims to Health First Colorado’s Fiscal Agent (Gainwell Technologies)

Introduction
Rehabilitation

- Rehabilitative therapies assist members with:
  - recovery from acute injury, illness or surgery
  - regaining or relearning skills and functions for daily living

- Rehabilitative therapies are a benefit when provided in nursing facilities

Introduction
Habilitation

- Habilitative therapies assist members with:
  - meeting developmental milestones
  - treating long-term chronic conditions
  - retaining, learning or improving skills and functions for daily living

- Not a benefit when provided in nursing facilities
- Not categorized as an Inpatient or Home Health benefit ("Acute" and "Long-term" therapies are Home Health benefits)
- Not to be confused with Habilitation services found within Home and Community-Based Services (HCBS) waivers programs

Introduction
Overview

Outpatient therapies must be:	• Accompanied by a medical (physiological) reason to perform services • In accordance with generally accepted standards of medical practice • Clinically appropriate in terms of type, frequency and duration • Not primarily for the convenience of the child, parent or legal guardian, physician or other health care provider • Cost effective
Services not covered for any member, regardless of age:	• Comfort • Educational • Experimental • Investigational • Personal need

Provider Enrollment

Provider Enrollment
Approved Provider Types

- Approved provider types for therapies include:
  - Physical therapist
  - Occupational therapist
  - Speech-language pathologist
  - Physician (MD or DO)
  - Physician assistant
  - Advanced practice nurse

- All provider types must be licensed by the Colorado Department of Regulatory Agencies (DORA)

Provider Enrollment
Supervision of Other Providers

- The following providers are eligible to provide services, but they must work under supervision of an enrolled therapist
    - Physical and occupational therapy assistants certified by the Colorado Department of Regulatory Agencies (DORA)
    - Speech-language pathology assistants
    - Clinical fellows
- Cannot enroll with Health First Colorado
- Supervising therapist's National Provider Identifier (NPI) must be used as the rendering provider on the claim form
- Documentation must indicate that the assistant performed the services

Provider Enrollment
Supervision of Other Providers

- **Physical therapists** may supervise up to four (4) individuals at one time who are not physical therapists, including certified nurse aides, to assist in the therapist's clinical practice
  - Authority extends to the limits stated in the Physical Therapists Practice Act per section C.R.S. § 12-41-113(1)

Provider Enrollment
Group Enrollment

- Provider Type 48, Specialty 397: Practitioner
  - Affiliated physical, occupational or speech therapist in the group
- Provider Type 48, Specialty 470: Comprehensive Outpatient Rehabilitation Facility
  - Affiliated Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) in the group

- Enrollment Type
  - Group

- Must enroll with group's Federal Employer Identification Number (FEIN)
- Group must be enrolled prior to enrollment of individual practitioners

Provider Enrollment
Group Enrollment

- Provider Type 25, Specialty 441: Non-Physician Practitioner - Group
  - Affiliated behavioral health clinician, psychologist, nurse practitioner, nurse midwife, Certified Registered Nurse Anesthetist (CRNA), physical therapist, occupational therapist, speech therapist or audiologist in the group

- Enrollment Type
  - Group

- Must enroll with group's Federal Employer Identification Number (FEIN)
- Group must be enrolled prior to enrollment of individual practitioners

Provider Enrollment
Group Enrollment

- Provider Type 15, Specialty 220: Outpatient Therapies Pediatric Behavioral Therapy Clinic
  - Affiliated behavioral therapist, physical therapist, occupational therapist or speech therapist in the group

- Enrollment Type
  - Group

- Must enroll with group's Federal Employer Identification Number (FEIN)
- Group must be enrolled prior to enrollment of individual practitioners
- Behavioral Therapy Provider Attestation Form must be included for the individual pediatric behavioral therapists affiliated with the group

Provider Enrollment
Individual Enrollment

- Provider Type 17, Specialty 451: Physical Therapist
- Provider Type 27, Specialty 452: Speech Therapist
- Provider Type 28, Specialty 450: Occupational Therapist

- Enrollment Types
  - Billing Individual
  - Individual Within a Group
  - Ordering, Prescribing and Referring (OPR) *(Speech Therapists only)*

- Must enroll with individual's Social Security Number (SSN)
- May affiliate with one or more groups (after group is enrolled with Health First Colorado)

Benefit Overview

Benefit Overview
Member Eligibility

- **Physical and Occupational Therapies**
  - Rehabilitative and habilitative physical and occupational therapy services are covered for all age groups

- **Speech Therapy**
  - Rehabilitative speech therapy services are covered for all age groups
  - Habilitative speech therapy services are covered for all children ages 20 and under and adults on the Alternative Benefit Plan (ABP)
    - If an adult member only has "TXIX - Medicaid State Plan“ listed in the coverage details box when checking eligibility in the Provider Web Portal, they are not eligible for habilitative speech therapy services
    - Providers should look for "ABP - Alternative Benefit Plan" listed in the coverage details box when checking adult member eligibility in the Provider Web Portal

Benefit Overview
Medical Necessity

- Therapy services must be medically necessary to qualify for Health First Colorado reimbursement, which means the 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
  - Is clinically appropriate in terms of type, frequency, extent, site and duration
  - Is not primarily for the economic benefit of the provider or primarily for the convenience of the member, caretaker or provider
  - Is delivered in the most appropriate setting(s) required by the member's condition
  - Is not experimental or investigational
  - Is not more costly than other equally effective treatment options

Benefit Overview
Ordering, Prescribing, Referring (OPR) Providers

- All services must have a written order, prescription or referral by any of the following Health First Colorado-enrolled providers:
  - Physician (MD or DO)
  - Physician Assistant
  - Nurse Practitioner
  - An approved Individualized Family Service Plan (IFSP) for Early Intervention Physical Therapy/Occupational Therapy or Speech Therapy

- Services must be started within 28 days of the date ordered

Benefit Overview
Documentation Requirements

- Rendering providers must document all evaluations, re-evaluations, services provided, member progress, attendance records and discharge plans
- All documentation must be kept in the member's records along with a copy of the Ordering, Prescribing and Referring (OPR) provider’s order
- Documentation must support both the medical necessity of services and the need for the level of skill provided
- Rendering providers must copy the member's primary care provider, OPR provider and medical home on all relevant records

Benefit Overview
Documentation Requirements

- All documentation must include:
  - Member's name and date of birth
  - Date and type of service provided
  - Description of each service provided during the encounter, including procedure codes and time spent on each (including start and stop times)
  - Total duration of the encounter
  - Name(s) and title(s) of the person(s) providing each service and the name and title of the therapist supervising or directing the services

Benefit Overview
Documentation: Episode of Care

- Health First Colorado requires the following types of documentation as a record of services provided within an episode of care: initial evaluation, re-evaluation, visit/encounter notes and a discharge summary

- An **episode of care** is defined as the period of time from the first date of service to the last date of service a member is under the care of a provider:
  - In one therapy discipline
  - In one setting
  - For the current condition(s) being treated
  - For a specific plan of care

Benefit Overview
Documentation: Initial Evaluation

- Written documentation of the **initial evaluation** must include:
  - Referral source and reason for referral
  - Member's health history pertinent to the reason for referral, including diagnoses
  - Summary of impairments, functional limitations and disabilities
  - Detailed plan of care certified by a physician, physician assistant or nurse practitioner that includes:
    - Specific functionally-based and objectively-measured treatment goals for the entire episode of care
    - Proposed interventions and treatments to be provided
    - Proposed duration and frequency of services to be provided
    - Dated signature of physician, physician assistant or nurse practitioner or some other document that indicates approval of the plan of care

Benefit Overview
Care Plan Regular Review

- A care plan cannot cover more than a 90-day period, or the time frame documented in an approved Individualized Family Service Plan (IFSP)
- Under state law, a therapist's plan of care must be reviewed, revised if necessary and signed as medically necessary by the member’s physician, physician assistant or nurse practitioner once every 90 days

Benefit Overview
Documentation: Re-Evaluation

- A **re-evaluation** must occur when there is an unanticipated change in the member's status, failure to respond to interventions or any new problems or goals that require significant modification of the treatment plan
- Re-evaluation documentation must include the following:
  - Reason for re-evaluation
  - Member's health and functional status reflecting changes
  - Findings from any repeated or new examination elements
  - Changes to plan of care

Benefit Overview
Documentation: Encounter Notes

- **Encounter notes** document the implementation of the plan of care established by the therapist at the initial evaluation and must include:
  - Member's name and date of birth
  - Date and type of service(s)
  - Description of each service provided, including procedure codes
  - Short- or long-term goals being addressed during the visit
  - Total timed code treatment minutes and total treatment time in minutes (not including time for services that are not billable, such as rest periods)
  - Number of units billed
  - Name(s) and title(s) of the person(s) providing each service, including assistants and the therapist supervising or directing the service(s)

Benefit Overview
Documentation: Encounter Notes

- Encounter notes should also include:
  - Subjective element that includes the reason for the visit, the member or caregiver's report of the member's current status relative to treatment goals and any changes in member's status since the previous visit
  - Objective element that includes the provider’s findings, including abnormal and pertinent normal findings from any procedures or tests performed
  - Assessment element that includes the provider’s assessment of the member's response to interventions, specific progress made toward treatment goals and any factors affecting the intervention or progression of goals
  - Plan element that states the plan for the next visit(s)

Benefit Overview
Documentation: Discharge Summary

- At the conclusion of therapy services, a **discharge summary** must be included in the documentation of the final visit in an episode of care, including:
  - Highlights of the member's progress or lack of progress towards treatment goals
  - Summary of the outcome of services provided during the episode of care

Benefit Overview
Limitations: Physical Therapy and Occupational Therapy

- A daily limit of five (5) units of **physical therapy** and five (5) units of **occupational therapy** is allowed, regardless of whether it is rehabilitative or habilitative services
  - Some specific daily limits per procedure code apply

Benefit Overview
Limitations: Physical Therapy and Occupational Therapy

- Members may receive up to 48 units (approximately 12 hours) of any combination of **physical therapy and occupational therapy** services per a rolling 12-month period before a Prior Authorization Request (PAR) is required
  - The 12-month rolling period begins on member's first date of service, not with the start of a calendar year
  - Unused units do not roll over into the next 12-month period
  - Units begin decrementing from paid units for a specific member on the first date of service regardless of provider
  - A unit equals either 1) a timed increment, or 2) one treatment session as described in the specific Current Procedural Terminology (CPT) codes
  - Evaluation and orthotic services are not included in the 48-unit limit

Benefit Overview
Covered Services: Speech Therapy

Assessment: Speech therapy service may include testing and clinical observation, as appropriate for chronological or developmental age, for one or more of the following areas, and must yield a written evaluation report

- Expressive language
- Receptive language
- Cognition
- Augmentative and alternative communication
- Voice disorder
- Resonance patterns
- Articulation/phonological development
- Pragmatic language
- Fluency
- Feeding and swallowing
- Hearing status based on pass/fail criteria
- Motor speech
- Aural rehabilitation (defined by provider's scope of practice)
- Speech therapy for the diagnosis of Gender Affirming Care

Benefit Overview
Covered Services: Speech Therapy

Treatment: Speech therapy service may include one or more of the following, as appropriate:

- Articulation/phonological therapy
- Language therapy including expressive, receptive and pragmatic language
- Augmentative and alternative communication therapy
  - Adults with chronic conditions may qualify for augmentative and alternative communication services when justified and supported by medical necessity to allow the individual to achieve or maintain maximum functional communication for performance of activities of daily living
- Auditory processing/discrimination therapy
- Fluency therapy
- Voice therapy
- Oral motor therapy
- Swallowing therapy
- Speech reading
- Cognitive treatment
- Necessary supplies and equipment
- Aural rehabilitation (defined by provider's scope of practice)

Benefit Overview
Limitations: Speech Therapy

- Members may not receive both rehabilitative and habilitative **speech therapy** services on the same date of service
- Members determined to need a speech-generating device should be referred to a Health First Colorado-enrolled Durable Medical Equipment (DME) supplier to be prior authorized

Benefit Overview
Limitations: Speech Therapy

- Members may receive up to 12 sessions of **speech therapy** services per a rolling 12-month period before a Prior Authorization Request (PAR) is required
  - One (1) date of service is equivalent to one session, regardless of the number of units billed on that date of service
  - The 12-month rolling period begins on the member's first date of service, not with the start of a calendar year
  - Unused units do not roll over into the next 12-month period
  - Units begin decrementing from paid units for a specific member on the first date of service regardless of provider

Benefit Overview
Verifying Remaining Service Units

- Providers can verify remaining service units on the Provider Web Portal by clicking on “Eligibility” and then “Eligibility Verification”
- Providers should check the “Limit Details” after searching for the specific member

If Unit limits are exhausted, then please check the billing manual to find whether additional Units can be prior authorized.

Limit Details

As of 06/20/2024		Allowed Limit	Used Limit
Individual	5500 PT & OT SVC LIMITS	48	28

Benefit Overview
Verifying Remaining Service Units

- Units are calculated regardless of whether they were paid with a Prior Authorization Request (PAR)
- Once a PAR is utilized, a full 365 days must elapse before a member has another 48 units of physical and occupational therapy or 12 units of speech therapy available without requiring a PAR
- Providers may request revision of an existing PAR or may submit a new PAR if additional therapy is needed

Benefit Overview
Co-Treatment

- Therapists are only allowed to bill for the time interacting with the member and not the total time in the room
  - Each provider may only bill for the time they directly treat the member during the co-treatment session

Benefit Overview
Co-Treatment Matrix

Home Health Therapist	Pediatric Behavioral Therapist	Outpatient Therapist (Occupational, Physical, and Speech therapists)	Home Health CNA	Personal Care Provider
Allowable only with joint goals in PAR and with approval	Allowable with clear reason for safety or medical necessity in PAR and with approval only	Providers will only bill for the time interacting with the member, and not the total time in the room. Must have clear, joint goals in PAR and with approval	Must provide and document the need for a multi-modality visit, and services must be documented in the care plan - services must be auditable PBT goals and interventions must be documented in the plan of care with a description of how they are performed with CNA tasks	Must provide and document the need for the multi-modality visit, and services documented in the care plan - services must be auditable PBT goals and interventions must be documented in the plan of care with a description of how they are performed with PC tasks

- Prior to treatment:
  - Valid clinical rationale for providing co-treatment must be present
  - Each provider must have an approved plan of care or Individualized Family Service Plan (IFSP) for Early Intervention which includes co-treatment
  - Each provider must have an approved prior authorization which includes the plan of care or IFSP documentation that co-treatment will be used

Benefit Overview
Services NOT Covered

- Duplicate therapy (same services performed by therapists of different disciplines on the same dates of service)
- Services provided by unsupervised therapy assistants
- Services specified in a plan of care that is not reviewed and revised as medically necessary by the member's physician, physician assistant, nurse practitioner or approved Individualized Family Service Plan (IFSP) for Early Intervention Physical Therapy/Occupational Therapy or Speech Therapy
- Services that are experimental, investigational or provided as part of a clinical trial and have been determined not to be medically necessary
- Services not documented in the member's health care record

Benefit Overview
Services NOT Covered

- Services not part of the member's plan of care
- Services for conditions of chronic pain that do not interfere with the member's functional status and that can be treated by routine nursing measures
- Therapeutic service that is denied Medicare payment because of the provider's failure to comply with Medicare requirements
- Supplies that can be obtained from a medical supplier
- Vocational or educational services, except as provided under Individualized Education Plan (IEP)-related or waiver services
- Educational, personal need and comfort therapies
- Art and craft activities for the purposes of recreation

Benefit Overview
Services NOT Covered

- Psychosocial services
- Record keeping documentation and travel time (e.g., transport and waiting time of a member to and from therapy sessions)
- Time spent for preparation, report writing, processing of claims or documentation regarding billing or service provision

Benefit Overview
Services NOT Covered: Speech Therapy

- **Speech therapy** services not covered for any age:
  - Treatment for dysfunction that is self-correcting (e.g., natural dysfluency or developmental articulation errors)
  - Services provided for simple articulation or academic difficulties that are not medical in origin are non-benefit services
  - Treatment of speech and language delays not associated with an acquired or chronic medical condition, neurological disorder, acute illness, injury or congenital defect, unless they are covered by an Individualized Family Service Plan (IFSP)

Benefit Overview
Services NOT Covered: Speech Therapy

- **Speech therapy** services not covered for adults (ages 21 and above):
  - Speech therapy for long-term chronic conditions (habilitative therapy), unless the member is on the Alternative Benefit Plan
  - Maintenance programs when goals of a treatment plan have been achieved, and no further progress is expected

Prior Authorization Requests (PARs)

Prior Authorization Requests (PARs)
Physical and Occupational Therapy

- A Prior Authorization Request (PAR) is needed for **greater than 48 units** of most **physical and occupational therapy** services per a rolling 12-month period
- Members may receive physical and occupational therapy services during the same time period
- Separate PAR and necessary documentation are required for each request
- Retroactive PARs are not allowed

- A maximum of one PAR for Early Intervention outpatient physical and occupational therapy and one PAR for non-Early Intervention outpatient therapy may be active at any time for children ages 0 through 4
  - Overlapping Early Intervention and non-Early Intervention outpatient PT/OT PARs will only be accepted if the treatment plans associated with each meet different goals and use different treatments

Prior Authorization Requests (PARs)
Speech Therapy

- A Prior Authorization Request (PAR) is needed for services **greater than 12 units** of **speech therapy** per a rolling 12-month period

- Retroactive PARs will be accepted for children ages 0 through 4 who are under the direction of the Early Intervention program

  - Retroactive authorizations 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 Individualized Family Service Plan (IFSP)

  - Dates requested on the PAR must be within the dates on the IFSP

Prior Authorization Requests (PARs)

- Prior Authorization Requests (PARs) must include:
  - A letter of medical necessity (e.g., prescription, approved plan of care) signed by a physician (MD or DO), Physician Assistant (PA) or Nurse Practitioner and include:
    - Diagnosis (preferably with International Classification of Diseases [ICD]-10 code)
    - Reason for therapy
    - Number of requested therapy sessions per week
    - Expected total duration of therapy
  - Member's treatment history, including assessment and progress notes no greater than 60 days from the date of request
  - Name, address and National Provider Identifier (NPI) of rendering provider if individual therapist
  - Name, address and NPI of billing provider

Prior Authorization Requests (PARs)

- Refusal, failure or negligence by the provider to submit a Prior Authorization Request (PAR) for **services beyond the first 48 units of physical and occupational therapy or first 12 units of speech therapy** does not mean that those additional services are non-covered
- Technical/lack of information (LOI) denial does not mean those services are not covered and members may not be billed for services denied for LOI
- Services partially approved are still considered covered services and members may not be billed for the denied portion of the request
- Services totally denied for not meeting medical necessity criteria are considered non-covered services

Prior Authorization Requests (PARs)
Assistive Technology

- HB14-1211 requires that all members seeking complex rehabilitation technology must have an initial Assistive Technology Assessment prior to receiving complex rehabilitation technology and then follow-up assessments as needed (Current Procedural Terminology code 97755)
- Only licensed speech, physical and occupational therapists may render this specialty evaluation and Prior Authorization Requests (PARs) must follow these guidelines:
  - Include a current prescription or referral for an Assistive Technology Assessment from the member's primary care physician
  - May indicate up to one (1) year duration
  - May indicate initial new assessment or follow-up assessment visits

Prior Authorization Requests (PARs)
Assistive Technology

- Prior Authorization Requests (PARs) for code 97755 should be submitted independently from other services
- Only one (1) active Prior Authorization Request (PAR) is allowed per member, per time period, for assistive technology; overlapping PAR requests will be denied
- Initial physical, occupational and speech therapy evaluation services (e.g., 97161 and 92521) are not required prior to submitting PAR
- Code 97755 is limited per member to 20 units (5 hours of assessment) per day and 60 units per State Fiscal Year (July 1-June 30)
- Code 97755 is separate from **physical and occupational therapy** and is not part of the benefit limitations

Prior Authorization Requests (PARs)
Assistive Technology

- If a member requires further assessment by a different provider not indicated on the original and still active Prior Authorization Request (PAR), the original PAR must be closed by the original requesting provider
- Once closed, a new PAR can be submitted
- Members may request a “change of provider” on their PAR by contacting the utilization management vendor directly

Prior Authorization Requests (PARs)
Early and Periodic Screening, Diagnostic and Treatment

- All Prior Authorization Requests (PARs) for members ages 20 and under are reviewed according to Early Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines

Prior Authorization Requests (PARs)
ColoradoPAR Program

- All therapy Prior Authorization Requests (PARs) and revisions must be processed by the ColoradoPAR Program
  - Acentra Health is the Utilization Management (UM) vendor
  - Refer to the Colorado Utilization Manual (UM) Provider Manual

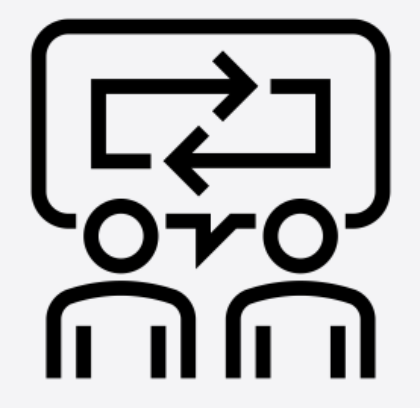
- When submitting a PAR:
  - Request number of units, not number of services
  - Include appropriate modifiers
  - Answer clinical questions on the portal
  - Attach relevant clinical documentation

Prior Authorization Requests (PARs)
ColoradoPAR Program

- Final Prior Authorization Request (PAR) determination letters are mailed to members
  - Letter inquiries should be directed to ColoradoPAR
- Providers can review requests via the Provider Web Portal
- Do not render or bill for services until the PAR has been approved

Prior Authorization Requests (PARs)
Denials

- Prior Authorization Requests (PARs) that are denied may go through a peer-to-peer review with the provider who originally requested the PAR
- Providers can request reconsideration (second opinion) of PARs that have been denied after peer-to-peer review
- If the PAR is denied for medical necessity, the reconsideration will be performed by a different physician, including an appropriate specialist
- Members can also submit appeals for PAR reconsiderations



Prior Authorization Requests (PARs)
Primary Payers

- Prior authorization is not needed when a primary payer, such as commercial insurance, pays

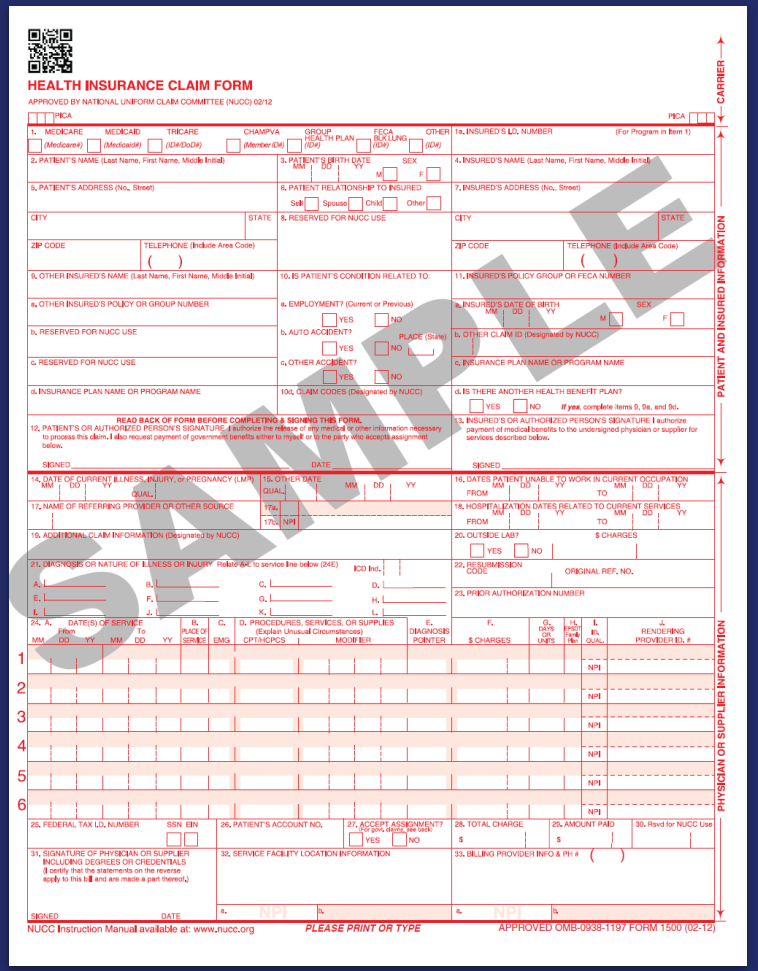
When is a PAR Required?	When is a PAR *Not Required*? *
The primary insurance did not pay on the claim.	TPL or Medicare paid on the claim for the services billed.
The TPL PAR is partially denied by the primary payer.	TPL covers ***all*** the services requested.
The member does not have Medicare or TPL.	

Billing & Payment

Billing
Claims Submission

Therapy services are usually billed using the CMS 1500 professional claims form or the 837 Professional (837P) transaction, which requires using Rendering; Billing; and Ordering, Prescribing and Referring (OPR) National Provider Identifiers (NPIs)

Claims should be submitted to the Fiscal Agent (Gainwell Technologies)


HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED DATE SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Billing
Exceptions to Professional Claim Submission

- Therapy services provided at an outpatient hospital are reported on the institutional claim (UB-04) and are reimbursed as part of the hospital's Enhanced Ambulatory Patient Groups (EAPG) payment
- Therapy services provided at Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) are billed as part of the encounter rate for the center

Billing
Procedure Codes

- Refer to the appropriate billing manual for a list of covered procedure codes
  - Some codes represent a treatment session without regard to its length of time (1 unit maximum)
  - Some codes may be billed incrementally as timed units
- Providers must follow correct coding guidelines as mandated by the Health Insurance Portability and Accountability Act (HIPAA) and the National Correct Coding Initiative (NCCI)
- Current Procedural Terminology (CPT) codes describe medical procedures and professional services
  - CPT is a numeric coding system maintained and copyrighted by the American Medical Association
  - Code books are available from a variety of bookstores

Billing
Untimed and Timed Codes

- **Untimed Codes**
  - Providers enter "1" in the claim field labeled “units” when reporting units for codes where the procedure is not defined by a specific timeframe
  - Untimed code units are reported based on the number of times the procedure is performed
- **Timed Codes**
  - Providers enter the appropriate number of 15-minute units of service in the claim field labeled “units” when reporting units for codes specifying direct (one-on-one) time spent in contact with member
  - *Example: A member received a total of 60 minutes of occupational therapy (e.g., 97530) on a given date of service. The provider reports 4 units of code 97530.*

Billing
Reporting Timed Codes

- Providers should report codes only for time spent in the delivery of the modality requiring constant attendance and therapy services (e.g., intra-service care which begins when the provider is directly working with the patient)
- Pre- and post-delivery services should not be counted (e.g., rest periods, bathroom breaks, getting member to treatment table or mat)

Billing
Counting Minutes for Timed Codes

- Providers should not bill for services performed for less than eight (8) minutes when only one (1) service is rendered in a day
- Providers should bill a single 15-minute unit for treatment greater than or equal to eight (8) minutes through and including 22 minutes for any single timed code in the same day
- Providers should bill a single 15-minute unit if any 15-minute timed service is performed for seven (7) minutes or less than 7 minutes on the same day as another 15-minute timed service is also performed for 7 minutes or less since the total time of the two is eight (8) minutes or greater than 8 minutes
  - Bill the one (1) unit for the service performed for the most minutes
  - The same logic is applied when three or more different services are provided for 7 minutes or less than 7 minutes

Billing
Counting Minutes for Timed Codes

- Provides should bill two (2) units if the duration of a single modality or procedure in a day is greater than or equal to 23 minutes through and including 37 minutes and so on:
  - 3 units if duration is 38 minutes through 52 minutes
  - 4 units if duration is 53 minutes through 67 minutes
  - 5 units if duration if 68 minutes through 82 minutes
  - 6 units if duration is 83 minutes through 97 minutes
  - 7 units if duration is 98 minutes through 112 minutes
  - 8 units if duration is 113 minutes through 127 minutes

- The pattern remains the same for treatment times in excess of 2 hours
- Specific examples are provided in the Physical and Occupational Therapy Billing Manual

Billing
Counting Minutes for Timed Codes

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

Billing
National Correct Coding Initiative (NCCI): Speech Therapy

- National Correct Coding Initiative (NCCI) Procedure-To-Procedure (PTP) and Medically Unlikely Edits (MUE) edits apply to certain combinations of **speech therapy** procedure codes
  - Providers should not report CPT codes 97110, 97112, 97150, 97530, 97127 or G0515 as unbundled services included in services coded as 92507, 92508 or 92526
  - One (1) provider should not report CPT codes 92507 and 92508 on the same date of service as CPT codes 97127, 97533 or G0515
  - One (1) provider should not report CPT code G0283 with CPT code 92526

Billing
Procedure Modifiers

Physical Therapy	PT procedure code	GP
Occupational Therapy	OT procedure code	GO
Rehabilitation Agency / Physical Therapy Clinic	PT procedure code OT procedure code	GP GO
Speech Therapy	ST procedure code	GN

- Providers may use additional modifiers as appropriate
  - All habilitative claims must have modifier 96 in addition to the above modifiers
  - All rehabilitative claims must have modifier 97 in addition to the above modifiers
  - Early intervention providers must attach modifier TL to all claims in addition to the above modifiers

Billing
Places of Service: Physical Therapy and Occupational Therapy

Place of Service (POS) code	Description
02	Telemedicine - Not provided in patient's home (only applicable to certain procedure codes). Refer to the Telemedicine Billing Manual.
03	School
10	Telehealth - Provided in patient's home. Refer to the Telemedicine Billing Manual.
11	Office
12	Home
13	Assisted Living Facility
62	Comprehensive Outpatient Rehabilitation Facility
99	Other - community location

- Telemedicine is available only for specific procedure codes found in the Telemedicine Billing Manual

Billing
Places of Service: Speech Therapy

Place of Service (POS)	Code Description
02	Telemedicine- not provided in patient's home. Refer to the Telemedicine Billing Manual.
03	School - (non-public) services provided in or during public school must be billed by the school district only
10	Telehealth- provided in patient's home. Refer to the Telemedicine Billing Manual.
11	Office
12	Home
13	Assisted Living Facility
99	Other - (Community Based Organization)

- Telemedicine is available only for specific procedure codes found in the Telemedicine Billing Manual
- Early intervention providers may report any place of service code that aligns with the treatment ordered by the member's Individualized Family Service Plan (IFSP)

Billing
Ordering, Prescribing and Referring (OPR)

- A Health First Colorado-enrolled Ordering, Prescribing and Referring (OPR) provider's National Provider Identification (NPI) number must be included on the claim form (CMS 1500 field 17b)
  - Physician (MD or DO)
  - Physician Assistant
  - Nurse Practitioner

- Claims without a valid OPR NPI which are paid will be subject to recovery
  - "Valid" means the NPI is registered to a provider that legitimately orders, prescribes or refers the therapy service being rendered

- Medical documentation must be kept on file to substantiate the order, prescription or referral for therapy services

Billing
Ordering, Prescribing and Referring (OPR)

- The Early Intervention Service Broker may list their National Provider Identifier (NPI) as the rendering and referring NPI for early intervention services ordered through an Individualized Family Service Plan (IFSP)
  - Must include modifier TL on the procedure line to denote service ordered by an approved IFSP and delivered with the time span noted in the IFSP

Resources

Resources

For Our Providers web pages: https://hcpf.colorado.gov/our-providers

The **General Provider Information Manual** is an overview of the program, including billing and policy information

The **Physical and Occupational Therapy Billing Manual** provides specific guidance for the physical therapy and occupational therapy benefits

The **Speech Therapy Billing Manual** provides specific guidance for the speech therapy benefit

Fee Schedule web page

Provider Contacts web page

hcpf.colorado.gov/our-providers

Where can I find…?

For Our Providers

- Enrollment forms
- Revalidation dates spreadsheet
- National Provider Identifier (NPI) information
- Provider types

- Fee schedules
- General Provider Information manual
- Billing manuals & appendices
- Forms
  - Prior Authorization Requests (PARs)
  - Load letters
  - Request to use paper claim form

- Newsletters
- What's New?

Why should you become a provider?

Provider enrollment

Provider services: Forms, rates, & billing manuals

What's new: Bulletins, updates & emails

CBMS: CO Benefits Management System

Long-Term Services and Supports

Web portal

Revalidation

Provider contacts: Who to call for help

Provider resources: Quick guides, known issues, EDI, & training

Where can I…?

- Check member eligibility
- Submit claims
- Review Prior Authorization Requests (PARs)
- Receive Remittance Advices (RAs)
- Complete provider maintenance requests

- Quick Guides for Web Portal
- Known issues
- EDI Support
- Training registration
- Information about
  - Accountable Care Collaborative & RAEs
  - Co-Pays
  - EVV

COLORADO
Department of Health Care Policy & Financing

COVID-19 Provider Information | Resources for HCBS Providers | SAVE System | ColoradoPAR | DDDWeb | Value Based Payments

Reminders

- Remember to sign up for Department of Health Care Policy & Financing communications by visiting the website and clicking “For Our Providers” and then “What’s new: Bulletins, updates & emails.”

- Interested in more training? Sign up or view training materials by visiting the website and clicking “Provider Resources” and then “Provider Training.” Presentations are listed under the calendar in the “Billing Training – Resources” section.

Thank you!