Acentra HEALTH

On behalf of

HEALTH FIRST COLORADO

Pediatric Behavioral Therapy (PBT) Review

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Department of Health Care Policy & Financing

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CNSI + Kepro

Acentra HEALTH

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.

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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

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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

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Acentra Health's Services for Providers

- 24-hour/365 days **provider portal** accessed at: atrezzo.acentra.com
- **Provider Communication and Support** email: 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

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Provider Responsibilities

- Providers must request Prior Authorization for services through Acentra'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

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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

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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

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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

- Timely Submission means entering the request before services are rendered and with enough advanced notice for the review to be completed.

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PAR Submission: General Requirements

- PAR submissions will require providers to provide the following:
  - Member ID
  - Name
  - Date Of Birth
  - CPT/HCPCS/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

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Submission Requirements At a Glance

Duration	**PAR limited to 6 months**
Provider Timely Submission Requirement	Prior to rendering services
Retroactive Authorization	Not accepted by Acentra Health
(Member not eligible at time of service)	*Exceptions may be made by HCPF
Servicing Provider / Billing Provider	Organizations with a Tax ID must enroll as provider type 83 – Behavioral Therapy Clinic Eligible Individuals to affiliate with type 83 are: Psychologist with a doctorate degree – type 37 Licensed Behavioral Health Clinician – type 38 Behavioral Therapist – type 84
Requesting Provider	Physician, Physician Assistant, Nurse Practitioner

*When a member's eligibility is determined after the date of service, the member is issued a Load Letter. The Load Letter must be submitted with the supporting clinical documentation for the PAR for a retroactive request to be processed.

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Documentation Requirements

- A legible written and signed ordering practitioner prescription or approved Plan of Care to include:

  - Diagnosis (preferably with ICD-10 code)
  - Reason for therapy
  - The number of requested therapy sessions per week
  - Total duration of therapy

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Documentation Requirements Con't

- Member's treatment history, including current assessment and treatment. Include duration of previous treatment and treating diagnosis if completed by requesting provider.
- Current treatment diagnosis
- Course of treatment, measurable goals and reasonable expectation of completed treatment.
- Documentation supporting medical necessity for the course and duration of treatment being requested
- Assessment or progress notes submitted for documentation must not be more than 60 days prior to submission of PAR request.
- Documentation of Applied Behavioral Analysis (ABA) services must meet Council of Autism Service Providers (CASP) minimum requirements.

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Codes and Descriptions

97153 Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes

97154 Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to face with two or more patients, each 15 minutes

97155 Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes

97158 Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes

97151 Behavior identification assessment, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report. Code can be billed only once every 12 months.

97151 TJ Behavior identification re-assessment, *limited to 2 units per six months*

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Pediatric Behavioral Therapy (PBT) Eligibility

Behavioral therapy is available to all children 20 years of age and under who are currently eligible for Health First Colorado when the service is medically necessary.

The presence of two or more of the following is needed for member eligibility:

- The member has been diagnosed with a condition for which behavioral therapy services are recognized as therapeutically appropriate (evidence-based evidence-based or evidence-informed) including autism spectrum disorder.

- The member's quality of life is impacted due to persistent challenges in social communication, and/or social-emotional reciprocity, across multiple contexts and settings (i.e. in home, school or community activities because behavior or skill deficit interferes with these activities).

- The member presents a safety risk to others. Examples include self-injury, aggression towards other, destruction of property, stereotyped or repetitive behaviors, or elopement.

- Requires evidence-based support in one or more of the following domains: behavior challenges and self regulation, cognition, learning and play, safety, and self-care.

- The client must have a standardized assessment of maladaptive behaviors which demonstrate an inability to function in those activities identified.

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Additional Requirements

- Prescription for services from a qualified healthcare professional (i.e. physician, physician's assistant, nurse practitioner, or psychologist.
- The client is medically stable and without a need for 24-hour monitoring and/or procedures provided in a hospital, or intermediate care facility for person with intellectual disabilities.

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Treatment Plan Documentation Requirements

- A behavioral therapy treatment plan that clearly outlines specific and measurable goals of the treatment plan. The plan must be signed by the BCBA.

- A plan of evaluation for measurable impact on the client's behavior or skills, as demonstrated by 6-month goals and terminal objectives (e.g. discharge criteria)
    - Include charts and graphs of documented objective data

- Multiple Staffing Ratios (2:1+): any client requiring additional staff support regarding severe and destructive behavior must demonstrate all the following within the individualized treatment plan:
    - Services must be administered on-site by the physician or qualified healthcare professional.
    - Additional staff assistance must be provided by appropriately licensed technicians.
    - Client currently exhibits destructive/severe safety issues.
    - Care must be provided in an environment customized to the member's behavior.

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Reauthorization Documentation Requirements

- Meaningful, measurable, functional improvement changes, or documentation of significant interfering events (e.g., serious physical illness, major family disruption, change of residence), if applicable. For changes to be meaningful, they must meet all of the following:
  - Confirmed through data.
  - Documented in quantitative charts and graphs.
  - Durable over time beyond the end of the actual treatment session.

- A signed revised treatment plan with all of the above-mentioned criteria and how behavioral changes have been demonstrated outside the treatment setting including the client's residence and the larger community within which the client resides.

- If barriers are identified causing a delay in progression of goals, document planned interventions to address the barriers.

Exclusion Criteria

- Failure to demonstrate medical necessity
- Unproven and/or investigational treatment modalities utilized for service
- Treatment plan goals which do not align with generally accepted standards of care for that treatment modality
    - The client fails to respond to services, even after encountering different techniques and approaches over two consecutive authorization periods.

Failing to respond to treatment is defined as: no meaningful, measurable, functional improvement changes, or progress has plateaued, and without documentation of significant interfering events (e.g., serious physical illness, major family disruption, change of residence). For changes to be meaningful, they must meet all the following:

- Confirmed through data
- Documented in charts and graphs
- Durable over time beyond the end of the actual treatment session.
- Generalizable outside of the treatment setting to the client's residence and the larger community within which the client resides.

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Exclusion Criteria con't

- Services that are primarily respite or daycare in nature and/or used to reimburse a parent for participating in the treatment program.

- Custodial Care shall be defined as: Any non-medical care that can reasonably and safely be provided by non-licensed caregivers. Such services primarily aim to assist individuals and activities of daily living (ADLs) such as bathing, dressing, eating, and household duties when educational/behavioral modifications are excluded.

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Non-Covered Services

The agency does not cover services in the following settings (this list is not exhaustive):

- Autism or other camps
- Resorts or spas
- Equine or Hippo therapy
- Recreational therapy
- Respite care
- Safety monitoring services
- Vocational rehabilitation
- Life coaching
- Treatment that is unproven or investigational (holding therapy, Higashi, auditory integration therapy, etc.)
- Services rendered by a parent, legal guardian, or legally responsible person

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Tips to Reduce Pends and Denials

- Calculate and request the total units needed for the duration of the request. The system does not calculate this for you.
  - For example, the member needs 20 hours per week for 26 weeks. 20 hours x 4 units per hour x 26 weeks = 2080 total units needed.

- When changes or clarification is requested, make sure to add the changes to the plan of care. Statements “this will be removed” is not a sufficient response.

- Completing the change of provider form in its entirety and with correct end dates to avoid overlap.

- Ensuring the plan of care is signed by the BCBA

- Submitting all required documentation at the time of the request.

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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

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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.

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

3. **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

4. **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.

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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.

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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 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.

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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).**

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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.

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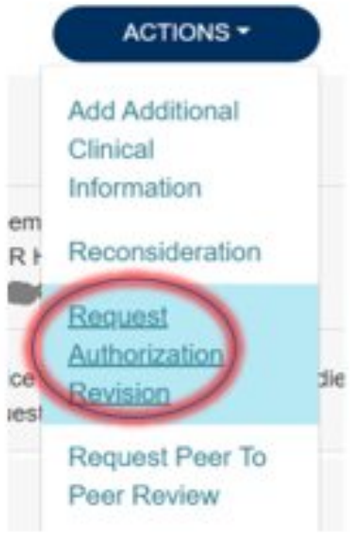
PAR Revision Con't

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 additional documentation to support the request as appropriate



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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.

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Acentra Health Services for Providers - Recap

- 24-hour/365 days provider **Atrezzo Portal** may be accessed at: 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

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Thank you for your time and participation!

- For Escalated concerns please contact: hcpf_um@state.co.us
- Acentra Health Customer Service: (720) 689-6340
- PAR Related Questions: coproviderissue@acentra.com

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