Pediatric Behavioral Therapy Specialty Training

Health First Colorado

(Colorado’s Medicaid Program)

COLORADO

Department of Health Care Policy & Financing

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.

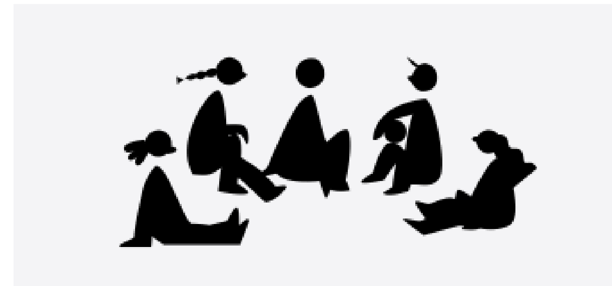
Agenda

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

Introduction

Introduction
Pediatric Behavioral Therapy

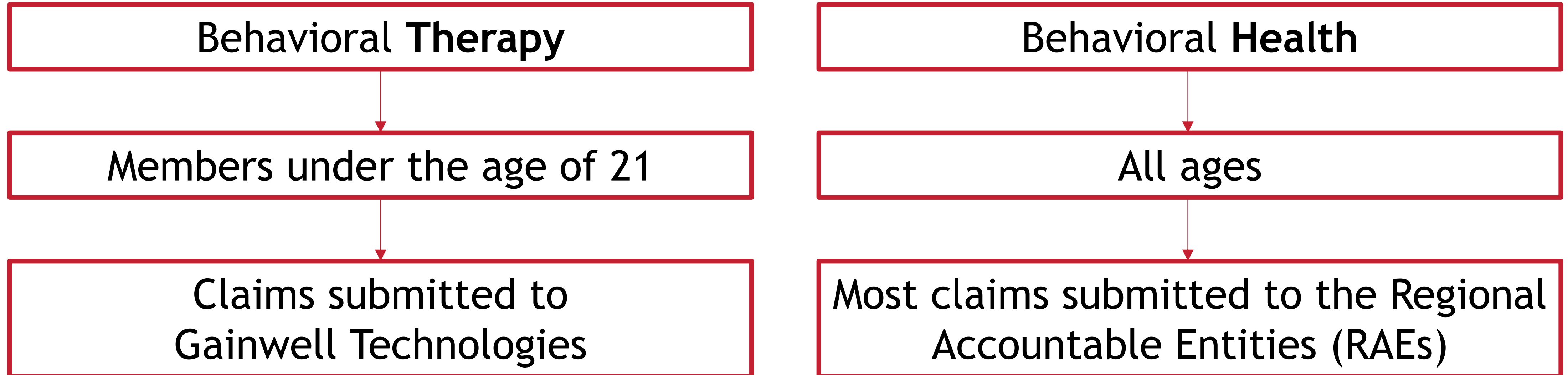
- Pediatric Behavioral Therapy includes services for children/youth under age 21 who have Autism Spectrum Disorder (ASD) and/or other diagnosis as justified by medical necessity
- Behavioral therapy services include treatments that help change maladaptive behaviors
  - These services must be found to be medically necessary to be covered
- Behavioral therapy services are billed as fee-for-service claims to the Fiscal Agent, Gainwell Technologies



Introduction
Behavioral Therapy vs. Behavioral Health

- Behavioral health includes comprehensive mental health and substance use disorder services for all ages
  - Behavioral health includes (but is not limited to) provider types:
    - 5 (Physician)
    - 25 (Non-Physician Group Practitioner)
    - 35 (Community Mental Health Center)
    - 37 (Licensed Psychologist)
    - 38 (Licensed Behavioral Health Clinician)
    - 39 (Physician Assistant)
    - 41 (Nurse Practitioner)
    - 64 (Substance Use Disorder Clinic)
    - 68 (Qualified Residential Treatment Program)

Introduction
Behavioral Therapy vs. Behavioral Health



Many services for members with autism (other than Pediatric Behavioral Therapy) are submitted to the RAEs

Introduction

Behavioral Therapy vs. Behavioral Health

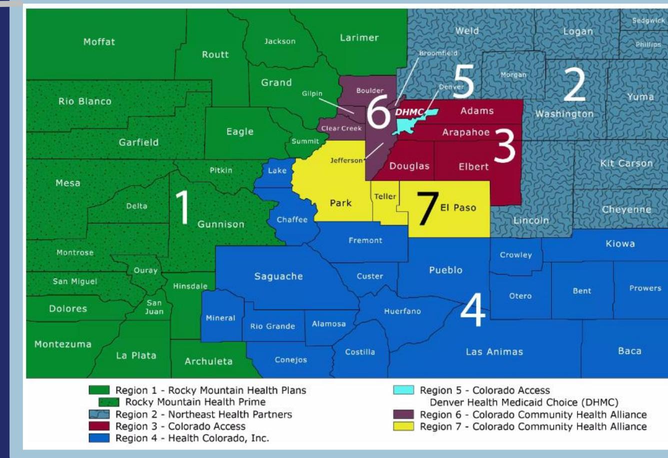
Pediatric Behavioral Therapy

Colorado interChange system interacts with the Provider Web Portal

Behavioral Health Fee-for-Service (FFS) Benefit

Medicaid Behavioral Health Benefit (BHO+B)

Regional Accountable Entities (RAEs)



Provider Enrollment

Provider Enrollment

Approved Provider Types

- Approved provider types for Pediatric Behavioral Therapy include:
  - 83 (Behavioral Therapy Clinic)
  - 84 (Behavioral Therapist), must be affiliated to 83
  - 37 (Licensed Psychologist)
  - 38 (Licensed Behavioral Health Clinician)

  - Prior to the development of provider types 83 and 84, some providers enrolled as types 24 (Non-Physician Practitioner Individual) and 25 (Non-Physician Practitioner Group)
    - Providers who enrolled prior to 2019 must re-enroll under provider types 83 and 84 during the revalidation process
    - All newly enrolled behavioral therapists (84) must affiliate to provider type 83, so if a clinic is still enrolled as a provider type 25, it will need to revalidate as an 83 before the behavioral therapist can affiliate with it

Provider Enrollment
Enrollment Requirements

<u>Group</u>

- Provider Type 83: Behavioral Therapy Clinic
  - <u>Behavioral Therapy Provider Attestation Form</u> for all individual behavioral therapists (84) affiliated with the clinic
    - Not needed for Licensed Psychologists and Licensed Behavioral Health Clinicians
  - Evidence of license, credential, training and/or experience as indicated in the attestation form

<u>Individuals</u> (Can affiliate with group)

- Provider Type 84, Specialty 831: Behavioral Therapist
  - <u>Behavioral Therapy Provider Attestation Form</u>
  - Evidence of license, credential, training or experience (e.g., Board-Certified Behavior Analyst accreditation)

Provider Enrollment
Enrollment Requirements

Individuals (Can affiliate with group)

- Provider Type 37, Specialty 520: Licensed Psychologist
  - Division of Regulatory Agencies (DORA) License
  - Degree: PhD, PsyD or EdD
- Provider Type 38, Specialty 521: Licensed Behavioral Health Clinician
  - Division of Regulatory Agencies (DORA) License
  - ACD/LAC (Licensed Addiction Counselor), CSW (Clinical Social Worker), LPC (Licensed Professional Counselor) or MFT (Marriage and Family Therapist)

COLORADO
Department of Health Care Policy & Financing

Benefit Overview

Benefit Overview
Member Eligibility

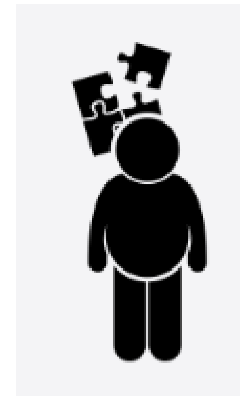
- Pediatric Behavioral Therapists are encouraged to confirm specific coverage types when verifying eligibility. Providers must verify that a member has Health First Colorado benefits before providing any Medicaid services.
  - When viewing eligibility in the Provider Web Portal, Medicaid coverage is listed as "**Medicaid State Plan**" and "**TXIX**" (Title XIX)
    - Medicaid Behavioral Health Benefits (BHO+B) through the Regional Accountable Entities (RAEs) do not cover Pediatric Behavioral Therapy
    - Child Health Plan *Plus* (CHP+) does not cover Pediatric Behavioral Therapy (Common Procedural Terminology [CPT]) codes 97151, 97153, 97154, 97155, 97158

Benefit Details

	Coverage	Description	Effective Date	End Date
+	TXIX	Medicaid State Plan - HH	11/01/2023	11/28/2023

Benefit Overview
Covered Services

- Behavior identification assessment and re-assessment
- Behavioral treatment plan must be person-centered and based on individualized, measurable goals and objectives over a specific timeline
  - For specific member being treated
  - Must identify the medically necessary services to be provided
- Child Health Plan *Plus* (CHP+) does not cover ABA therapy. However, CHP+ will do assessments and diagnosis.



Benefit Overview
Ordering, Prescribing, Referring (OPR) Providers

- All services must have a written order, prescription or referral by any of the following:
  - Physician (M.D. or D.O.)
  - Physician Assistant
  - Nurse Practitioner
- Can include an approved Individualized Family Service Plan (IFSP) for Early Intervention Speech Therapy (Senate bill 07-004 states the IFSP "shall qualify as meeting the standard for medically necessary services“)

Benefit Overview
Co-Treatment

- Pediatric Behavioral Therapists who co-treat with Outpatient Therapies (Occupational, Physical and Speech 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
Pediatric Behavioral Therapist	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/IFSP documentation that co-treatment will be used

Prior Authorization Requests (PARs)

Prior Authorization Requests (PARs)

ColoradoPAR Program

- All Pediatric Behavioral Therapy services must be pre-approved by the ColoradoPAR Program -Acentra Health (formerly Kepro)

- 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.	

COLORADO
Department of Health Care Policy & Financing

Prior Authorization Requests (PARs)
ColoradoPAR Program

- Prior Authorization Requests (PARs) need to be submitted for number of units and not number of services
- Modifiers must be included on both the PAR and claim submission

Prior Authorization Requests (PARs)
ColoradoPAR Program

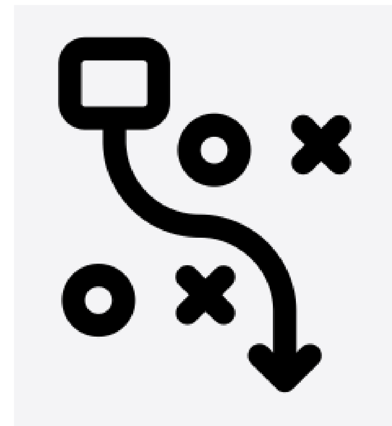
- All Prior Authorization Requests (PARs) for members ages 20 and under are reviewed according to Early Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines
- Do not render or bill for services until the PAR has been processed

Prior Authorization Requests (PARs)
Original Requests

- Prior Authorization Requests (PARs) must include:
  - a letter of medical necessity (e.g., prescription, approved Plan of Care) signed by a Medical Doctor (MD), Nurse Practitioner (NP), Physician Assistant (PA) or Psychologist with a doctorate degree and including:
    - 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
  - a standardized assessment of maladaptive behaviors (completed within 12 months of beginning therapy)

Prior Authorization Requests (PARs)
Original Requests

- Prior Authorization Requests (PARs) also must include:
  - a behavioral therapy treatment plan that includes specific and measurable goals and reasonable expectations, number of treatment and supervision hours and level of caregiver training and support
  - any treatment history, including assessment or progress notes which must not be more than sixty (60) days prior to submission of PAR request
  - billing provider name and address



COLORADO
Department of Health Care Policy & Financing

Prior Authorization Requests (PARs)
Original Requests

- Prior Authorization Requests (PARs) must also include answers to the following questions. Answers will not affect approval:
  - Is a signed order for Pediatric Behavioral Therapy evaluation attached to this PAR?
  - Is a signed treatment plan for the requested services attached to the PAR?
- ColoradoPAR approves or denies, by individual line item, each requested service listed

Prior Authorization Requests (PARs)
Original Requests

- 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
- Services may not be denied because a Prior Authorization Request is denied due to Lack of Information (LOI) on the request

Prior Authorization Requests (PARs)

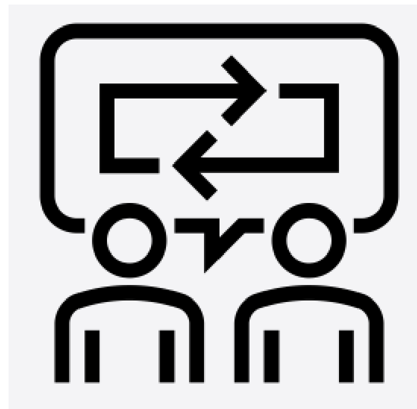
Subsequent Requests

- Prior Authorization Requests (PARs) are approved for up to a 6-month period
- In order to have subsequent PARs approved, documentation showing data in charts and graphs must be attached. Data should show thorough assessment of the treatment plan and how therapy is benefitting the member.
- Overlapping PAR dates will not be accepted

Prior Authorization Requests (PARs)

Denials

- Prior Authorization Requests (PARs) that are denied are able to 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



Billing & Payment

Billing

Claims Submission

Pediatric Behavioral Therapy services must be billed using the CMS 1500 professional claims form or the 837 Professional (837P) transaction, which requires using rendering and billing National Provider Identifiers (NPIs)

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

- Only Pediatric Behavioral Therapy claims are submitted as fee for service to the Fiscal Agent. Other services for members with autism are submitted to the Regional Accountable Entities (RAEs).

Billing
Codes & Modifiers

- 97153
- 97154
- 97155
- 97158
- 97151
- 97151 with modifier TJ

- 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
Places of Service

Place of Service (POS)	Code Description
02	Telemedicine (Refer to the Telemedicine Billing Manual)
11	Office
12	Home
99	Other - Community Based

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

COLORADO
Department of Health Care Policy & Financing

Billing

Common Denial Reasons

Member Not Eligible for Title XIX

Check to make sure that:

- correct Member ID is listed on the claim
- member was eligible for Health First Colorado benefits on the date of service

Coverage needs to be listed as “Medicaid State Plan” or “TXIX” on the Provider Web Portal

If member’s eligibility has changed to Child Health Plan *Plus* (CHP+), they are no longer eligible for Pediatric Behavioral Therapy benefits

Billing

Common Denial Reasons

Prior Authorization (PAR) Not on File

(Member does not have commercial insurance as primary payer)

Check to make sure that:

- a Prior Authorization Request (PAR) is on file for the member for the date of service
- the Member ID on the claim matches what is listed on the PAR
- units on the claim match what is listed on the PAR
- all billing dates on the claim match what is listed on the PAR
- modifiers listed on the claim match what is on the PAR

Billing
Common Denial Reasons

Prior Authorization (PAR) Not on File
(Member has commercial insurance as primary payer)

Check to make sure that:
- the paid amount from the commercial insurance has been entered on the claim
- if the commercial insurance paid zero and applied all charges to the deductible, the third-party liability Explanation of Benefits (EOB) is attached to the claim

If a third-party liability pays at zero due to applying all charges being applied to the deductible, providers must attach the EOB so the claim can be manually reviewed and paid
- *This is the only reason for attaching a primary payer's EOB*

Billing

Common Denial Reasons

Rendering Provider ID is Not on File *or*
Provider Not Authorized to Perform or Provide Service Requested

All claims require a rendering individual National Provider Identifier (NPI) in addition to the billing provider ID. This individual provider is the person who renders the service to the member (e.g., technician, qualified healthcare professional).

Be Aware! Even if the billing provider has revalidated, claims will deny if an individual provider has not revalidated as a Health First Colorado provider

Check to make sure that:

- An individual National Provider Identifier (NPI) is listed on the claim in the “rendering provider” field

Resources

Resources

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

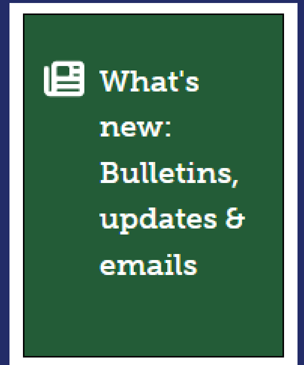
The **General Provider Information Manual** is an overview of the program, including billing and policy information

The **Pediatric Behavioral Therapy Billing Manual** provides specific guidance for the benefit

Provider Contacts web page

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." Be sure to sign up for Provider Types 00, 83 and 84.



- 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.

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

Where can I…?

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

Revalidation

Provider contacts: Who to call for help

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

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

COVID-19 Provider Information | Resources for HCBS Providers

SAVE System | ColoradoPAR | DDDWeb | Value Based Payments

COLORADO
Department of Health Care Policy & Financing

Thank you!