# Pediatric Behavioral Therapy 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
## 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

| Behavioral **Therapy** | Behavioral **Health** |
| --- | --- |
| Members under the age of 21 | All ages |
| Claims submitted to Gainwell Technologies | Most claims submitted to the Regional Accountable Entities (RAEs) |

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

# Introduction
## Behavioral Therapy vs. Behavioral Health

Health First COLORADO™
Colorado's Medicaid Program

**Pediatric Behavioral Therapy**

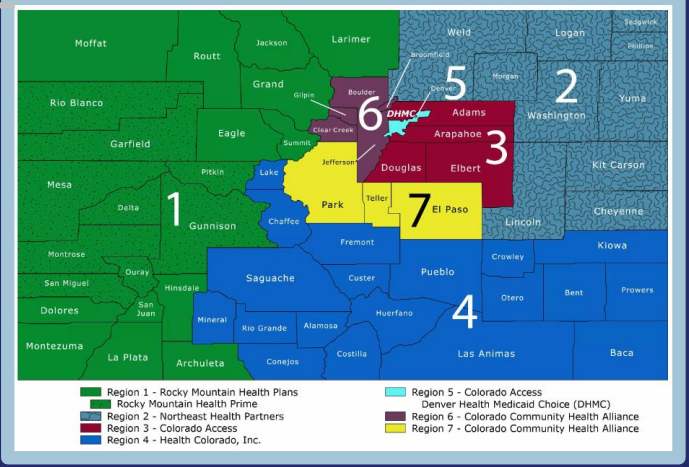
**Behavioral Health Fee-for-Service (FFS) Benefit**

gainwell

Colorado interChange system interacts with the Provider Web Portal

**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)
    - Will need to enroll as type 83 or 84 during revalidation

# Provider Enrollment
## Enrollment Requirements

### Group

- Provider Type 83: Behavioral Therapy Clinic
  - Behavioral Therapy Provider Attestation Form 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

### Individuals (Can affiliate with group)

- Provider Type 84, Specialty 831: Behavioral Therapist
  - Behavioral Therapy Provider Attestation Form
  - 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)

# 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 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<br><br>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<br><br>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. | |

# 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

Acentra HEALTH

# Prior Authorization Requests (PARs)
## ColoradoPAR Program

- All 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

# 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

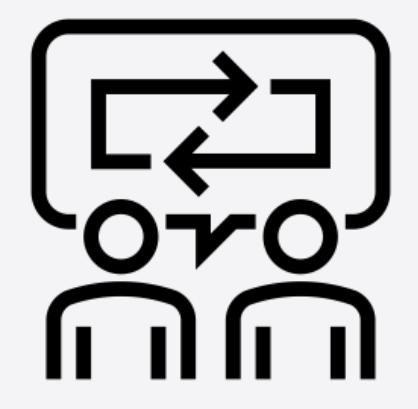
- Final Prior Authorization Request (PAR) determination letters are mailed to members. Letter inquiries should be directed to ColoradoPAR.
- Providers can review requests via the Provider Web Portal
- Services may not be denied because a Prior Authorization Request is denied due to Lack of Information (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 Prior Authorization Requests (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 Prior Authorization Request (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 Prior Authorization Requests (PARs) that have been denied after peer-to-peer review
- If the Prior Authorization Request (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 Prior Authorization Request (PAR) reconsiderations



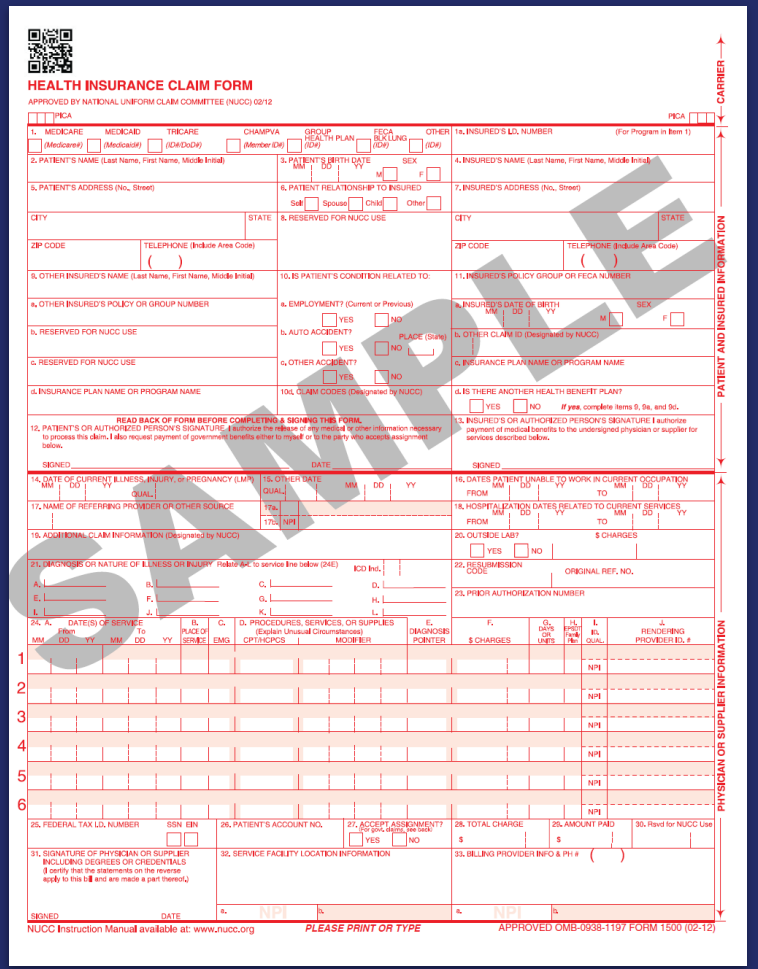
# Billing & Payment

# 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).


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.)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ( )

SIGNED DATE

a. NPI b.

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
## 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

# 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 may suspend 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

**Provider Services Call Center:** 1-844-235-2387

# 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?

***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

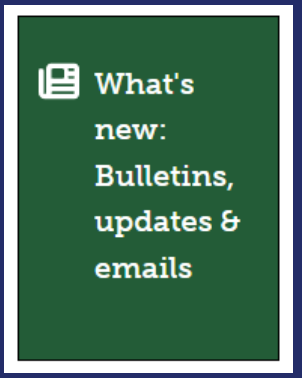
| | | | |
|---|---|---|---|
| Why should you become a provider? | Provider enrollment | Provider services: Forms, rates, & billing manuals | What's new: Bulletins, updates & emails |
| CBMS: CO Benefits Management System | Long-Term Services and Supports | Web portal | |
| Revalidation | Provider contacts: Who to call for help | Provider resources: Quick guides, known issues, EDI, & training | |

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.” Be sure to sign up for 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 drop-down menu “Billing Training – Resources”

# Thank you for the services you provide for Health First Colorado!