HEALTH FIRST COLORADO

Outpatient Therapies Review

The Department of Health Care Policy & Financing administers Health First Colorado (Colorado's Medicaid program), Child Health Plan *Plus* (CHP+) and other health care programs for Coloradans who qualify.

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EPSDT

Kepro follows the Early and Periodic Screening, Diagnostic and Treatment (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.

For more information, please review the EPSDT website: https://hcpf.colorado.gov/early-and-periodic-screening-diagnostic-and-treatment-epsdt

About Kepro

In 2021, Kepro was awarded the Colorado Department of Health Care Policy and Financing (HCPF) contract with the state of Colorado for Utilization Management and Physician Administered Drug (PAD) UM review, including outpatient, inpatient, specialty, and EPSDT.

In addition, Kepro will administer or 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

urac ACCREDITED
Health Utilization Management
Expires 12/01/2021

urac ACCREDITED
Case Management
Expires 12/01/2021

urac ACCREDITED
Disease Management
Expires 10/01/2020

urac ACCREDITED
Independent Review Organization: Internal
Expires 09/01/2022

426M
In Savings through Care Management

35 YEARS
Serving Government Sponsored Healthcare Programs

1.8M
UM Reviews a year

Kepro COLORADO Department of Health Care Policy & Financing

Scope of Services

- Audiology
- Diagnostic Imaging
- Durable Medical Equipment
- Inpatient Hospital Review Program (IHRP 2.0)
- 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
- Pediatric Private Duty Nursing
- Personal Care Services
- Physician Administered Drugs

Kepro Services for Providers

- 24-hours/365 days provider portal can be accessed at: https://portal.kepro.com
- Provider Communication and Support email: coproviderissue@kepro.com
- Provider Education and Outreach, as well as system training materials (including slide decks and FAQs) are located at: https://hcpf.colorado.gov/par
- Prior Authorization Review (PAR)
- Retrospective Review (when allowed by CO HCPF)
- PAR Reconsiderations & Peer-To-Peer Reviews
- PAR Revisions
- Access to provider reports and case statuses with Atrezzo Portal
- Provider Manual is posted at: https://hcpf.colorado.gov/par

Provider Responsibilities

- Providers must request prior authorization for services through our direct data entry portal, **Atrezzo,** unless criteria is met and approved for the fax exempt list.
- The Fax Exempt method of requests must be approved by submitting a Fax Exempt Request form and meeting specific criteria, 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; or the provider is visually impaired.
- The form can be located at https://hcpf.colorado.gov/par.
- 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, and
  - submit reconsideration and/or peer-to-peer requests for services denied.
- The system will also give warnings if a PAR is not required.
- Always **VERIFY** the Member's eligibility for Health First Colorado prior to submission by contacting Health First Colorado.

The generation of a Prior Authorization number does not guarantee payment.

PAR (Prior Authorization Request) Submission

- PAR requests submitted within business hours: 8:00AM – 5:00PM (MST) will have the same day submission date.
- Atrezzo portal is accessible 24/7. However, those submitted:
    - **After business hours** will have a receipt date of the **following business day**
    - **Holidays –** will have a receipt date of the **following business day**
    - **Days following State approved closures, i.e., natural disasters;** will have a receipt date of the **following business day**

PAR Submission – General Requirements

PAR submissions will require submitters to provide the following:

- ✓ **Member ID**
- ✓ **Member Name**
- ✓ **Member DOB**
- ✓ **CPT or HCPCS codes for services being requested**
- ✓ **Dates of service(DOS)**
- ✓ **ICD10 code for the diagnosis**
- ✓ **Servicing provider (billing provider) NPI if different than the Requesting provider**
- ✓ **Number of units requested, i.e., visits, number of items, etc.**
- ✓ **Supporting Documentation:** It will be necessary to provide supporting documentation with your submission. Supporting documentation may include valid signed order, office visit notes, laboratory results, imaging results, etc.
    - Requests for Additional Information will be initiated by Kepro if/when there is not substantial supporting documentation to complete a review.

A detailed step by step process for submitting both outpatient and inpatient requests can be found in the provider training manual at https://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.

PAR Requirements

Below is an overview of PAR requirements. A complete list of requirements can be found in the OT/PT billing manual at https://hcpf.colorado.gov/ptot-manual.

PARs are approved for up to a 12-month period (depending on medical necessity determined by the reviewer).

Members may have one active PAR for each type of therapy (Rehabilitative PT, Rehabilitative OT, Habilitative PT, Habilitative OT) with independent time spans.
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Overlapping PAR request dates for same provider types will not be accepted, with the exception of Early Intervention PAR requests which may have overlapping dates of service and multiple provider types.

Legibly written and signed ordering practitioner prescription or approved Plan of Care, to include:

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

PAR Requirements – Part 2

- The member's Physical or Occupational treatment history, including current assessment and treatment, duration of the previous treatment, and treating diagnosis.
- Documentation indicating if the member has received PT or OT under the Home Health Program or inpatient hospital treatment.
- Course of treatment, measurable goals, home exercise program (HEP) with compliance and teaching, and reasonable expectation of completed treatment.
- Documentation supporting medical necessity for the course and duration of treatment being requested.
- Recent assessment or progress notes submitted for documentation, and these must **not be more than 60 days prior to submission** of PAR request.
- Early Intervention PT/OT PARs must additionally indicate that the member has an Individual Family Service Plan (IFSP) and that it is current and approved.
- DME products will need a separate PAR.

PT/OT PAR Guidance

Manual Link	Duration of a PAR
Physical and Occupational Therapy (PT/OT) https://hcpf.colorado.gov/ptot-manual	Limited to 1 year (Submission should NOT exceed 12-month increments)

Submission Requirements at a Glance	Details
Provider Timely Submission Requirement	• No PAR required for units 0-48 per 12-month period. • Providers may submit a PAR without exhausting the 48 units first. • PAR to be submitted prior to unit 49. • Providers' responsibility to track units and know when a PAR is required
Retroactive Authorization (Member not eligible at time of service)	Not accepted by Kepro *Exceptions may be made by HCPF
Servicing Provider (Billing Provider)	Hospital, Physician, Physical Therapist, Occupational Therapist, Rehabilitation Agency, Non-physician Practitioner Group
Requesting Provider	Hospital, Physician, Physical Therapist, Occupational Therapist, Rehabilitation Agency, Non-physician Practitioner Group
Evaluation and orthotic services	No PAR Required

Understanding Therapy Services

Rehabilitative therapies are those meant to assist a member with recovery from an acute injury, illness, or surgical recovery; return to their baseline.
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Habilitative therapies are those meant to help the member retain, learn, or improve skills and functions for daily living. This includes the treatment of long-term chronic conditions and meeting developmental milestones.

Early Intervention PT and OT

https://www.colorado.gov/pacific/hcpf/early-intervention-manual

Early Intervention Services provide developmental supports and services to children birth to four (4) years of age who have either a significant developmental delay or a diagnosed condition that has a high probability of resulting in a developmental delay and are determined to be eligible for the program.

- Early Intervention PT/OT PARs may overlap with Other PT/OT PARs.

- All Early Intervention PT/OT PARs must additionally indicate that the member has an Individual Family Service Plan (IFSP) and that it is current and approved.

- Only one PAR for Early Intervention outpatient PT/OT may be active at a time.

- A maximum of one PAR for Early Intervention outpatient PT/OT and one PAR for non-Early Intervention outpatient PT/OT may be active at any time for children ages 0 –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.

PT/OT Benefit Limitations

A daily limit of five units of physical therapy services and five units of occupational therapy services is allowed, whether it is rehabilitative or habilitative. Some specific daily limits per procedure code apply.

•**Providers are required to consult the American Medical Association's (AMA) Current Procedural Terminology (CPT) manual for each coded service. Some codes represent a treatment session without regard to its length of time (one unit maximum) while other codes may be billed incrementally as "timed" units.**

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

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

Service Units for Outpatient Therapies

Unit/Quantity Calculation

- A unit equals either 1) a timed increment, or 2) one treatment session as described in the specific CPT procedure codes.
- Submit PARs for the number of units for each specific procedure code requested, not for the number of services.

Timed and Untimed Codes

- *Timed Codes:* 1 unit = 15 minutes
- *Untimed Codes:* based on the # of times the procedure is performed.

When reporting service units for the coding system and the procedure is not defined by a specific timeframe, the provider enters **1** in the labeled **Units** field.

- For these types of untimed codes, units are reported based on the number of times the procedure is performed.

Example A: 60 minutes of occupational therapy has a Timed Code (97530); the provider reports 4 units.

Example B: Pathology evaluation uses an Untimed code (92521); entered as 1 unit as only 1 evaluation was completed.

Counting Minutes for Timed Codes

Providers should not bill for services that occur in less than 8 minutes, but they can bill for services provided in the timespan of 8 to 22 minutes as 1 units.

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

Outpatient Therapies - Modifier Requirements

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

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

PAR Outcomes

After submission of a request, you will see one of the following actions occur:

Approval: Met criteria/Code of Colorado Regulations (CCR) applied for the service requested at first level review or was approved at physician level.

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

***Technical Denial*:** Health First Colorado Policy is not met for reasons including, but not limited to, the following:

*** *Untimely Request*
*** *Requested information not received/Lack of Information (LOI)*
*** *Duplicate to another request approved for the same provider*
*** *Service is previously approved with another provider*

Medical Necessity Denial: Physician level reviewer determines that medical necessity has not been met as reviewed under appropriate guidelines. The Physician may fully or partially deny a request.

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) in order to transfer the member's care from the previous provider to the receiving agency. This form is located on the Provider Forms webpage under the Prior Authorization Request (PAR) Forms, drop-down menu, using the instructions located under "How to Complete Change of Provider Form."

PAR Denials

Denials:

If a **Technical Denial** is determined, the provider can request a **Reconsideration**.

If a **Medical Necessity Denial** was determined, it was determined by the Medical Director. Therefore, the next step would be requesting a Reconsideration OR a **Peer-to-Peer.**

Steps to consider after a Denial is determined:

- ***Reconsideration Request:*** the **servicing** provider may submit a request for reconsideration to Kepro within **10 business days** of the initial denial. If the reconsideration does not overturn the denial, 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 by placing 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 vendor's turnaround time (TAT) 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**
- Decrease in the number of unnecessary pends to request additional documentation or information
- Improved care coordination and data sharing between Kepro and the Department's partners, like the Regional Accountable Entities (RAEs) and Case Management Agencies (CMAs)

***For additional information pends: The Provider will have **10 Business Days** to respond, and if there is no response or insufficient response to the request, Kepro will complete the review and **technically deny for Lack of Information (LOI**), if appropriate.*

Turnaround Times – Part 2

Expedited review is where a PAR is expedited because a delay could:

- Jeopardize Life/Health of member
- Jeopardize member's ability to regain maximum function
- And/or subject member to severe pain.

Rapid review is requested because a longer TAT could result in a delay in the Health First Colorado member receiving care or services that would be detrimental to their ongoing, long-term care. A Rapid review may be requested by the Provider in very specific circumstances including:

- A service or benefit that requires a PAR and is needed prior to a HFC member's inpatient hospital discharge.
- A Lack of DME supplies that immediately and adversely impacts a HFC Member's ability to perform activities of daily living.
- Same Day Diagnostic studies required for cancer treatments.
- Genetic or Molecular testing requiring amniocentesis.
- The service is needed as part of a federally-funded clinical trial.

Standard review is one that a majority of cases would fall under when a prior authorization request is needed. These requests will be completed in no more than 10 business days when all information needed for review is submitted.

Definition of Medical Necessity

10 CCR 2505-10; 8.076.1

8. Medical necessity means a Medical Assistance program good or service:

a. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may

include a course of treatment that includes mere observation or no treatment at all;

b. Is provided in accordance with generally accepted professional standards for health care in the United States;

c. Is clinically appropriate in terms of type, frequency, extent, site, and duration;

d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider;

e. Is delivered in the most appropriate setting(s) required by the client's condition;

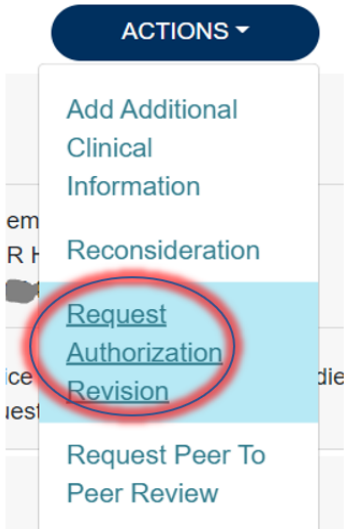
f. Is not experimental or investigational; and

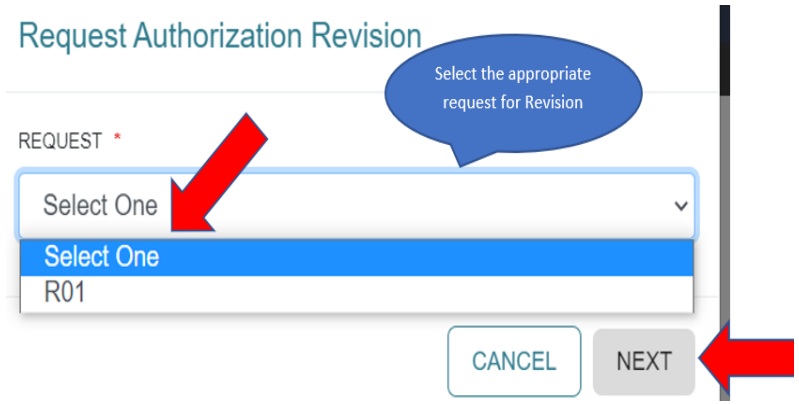
g. Is not more costly than other equally effective treatment options.

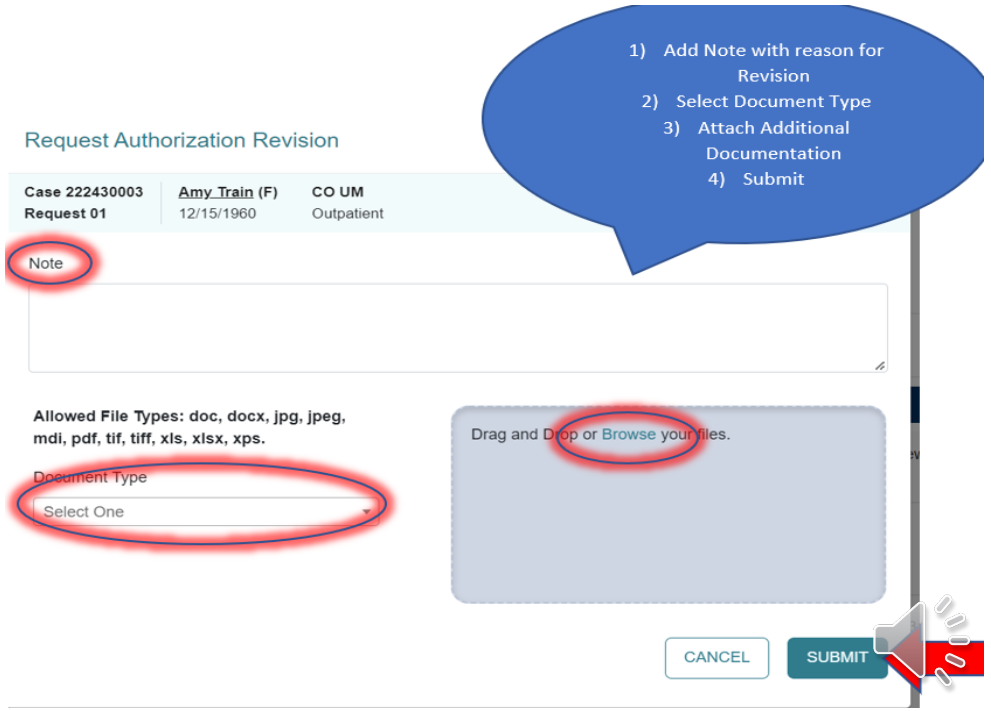
For EPSDT, medical necessity includes a good or service that will or is reasonably expected to, assist the member to achieve or maintain maximum functional capacity in performing one or more Activities of Daily Living, and meets the criteria, Code of Colorado Regulations, Program Rules (10 CCR 2505-10.8.280.4.E.2).

PAR Revision

- If the number of approved units needs to be amended, the provider must submit a request for a PAR revision prior to the PAR end date. Kepro cannot make modifications to an expired PAR or a previously billed-upon PAR.
- To make a revision, simply select “Request Revision” under the “Actions” drop-down, select the Request number, enter a note in the existing approved case of what revisions you are requesting, and upload additional documentation to support the request as appropriate.







Kepro Services for Providers - Recap

- 24-hours/365 days provider **Atrezzo Portal** may be accessed at: https://portal.kepro.com
- **System Training** materials (including slide decks and FAQs) and the **Provider Manual** are located at: https://hcpf.colorado.gov/par
- **Provider Communication and Support** email: coproviderissue@kepro.com

Conclusion

Thank you for your time and participation!

Contact Info

Kepro Call Center: 720-689-6340

PAR-related Questions:
COproviderissue@kepro.com

Training-related Questions:
Coproviderregistration@kepro.com

For escalated concerns please contact:
hcpf_um@state.co.us

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