Acentra HEALTH

On behalf of

HEALTH FIRST COLORADO

Speech Therapy Review

COLORADO
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
- Psychiatric Residential Treatment Facility (PRTF) and Qualified Residential Treatment Program(QRTP)

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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 Health'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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PAR Submission: General Requirements

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

https://hcpf.colorado.gov/par

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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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Documentation Requirements

PAR Requests Must Include:

- An order/referral/plan of care that is signed by either an MD, DO, NP or PA with either a physical signature or a CMS compliant electronic signature to include:
  - Diagnosis
  - Reason for therapy
  - The number of requested therapy sessions per week
  - Total duration of therapy.
- A plan of care that is within 90 calendar days prior to the requested start date and includes the diagnosis, type of therapy, therapeutic interventions, frequency and duration specifications and cover the PAR dates requested.

- Member's ST treatment history, to include current assessment and treatment, along with the duration of the previous treatment and treating diagnosis

Documentation Requirements Con't

•Documentation indicating if the member has received ST under the Home Health Program or inpatient hospital treatment.

•Evaluation/Re-evaluation

•Course of treatment, measurable goals, and reasonable expectation of completed treatment

•If a member is seeing another provider, then that provider's plan of care will need to be submitted with the PAR request for coordination of care.

•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 PARs must additionally indicate that the member has an Individual Family Service Plan (IFSP) and that it is current and approved.

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Continuation of Care Requirements

Providers need to submit the following documentation for continuation of care reviews:

- Evaluation/Re-evaluation
- An order/referral/plan of care that is signed by either an MD, DO, NP or PA with either a physical signature or a CMS compliant electronic signature
- An order/referral/plan of care that includes the diagnosis, type of therapy, frequency and duration specification and covers the PAR dates requested

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Continuation of Care Requirements Con't

- A plan of care that is within 90 calendar days prior to the requested start date and includes the diagnosis, type of therapy, therapeutic interventions, frequency and duration specifications and cover the PAR dates requested.

- A recent complete therapy re-evaluation or updated progress notes on the current plan of care that shows either progress, or lack thereof, for review. This must be performed within the last 60 days prior to start date

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Understanding Therapy Services

Rehabilitative therapies are those meant to assist a member with recovery from an acute injury, illness, or surgery return to their baseline.

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. Both children and adults have rehabilitative speech therapies covered, but only some adults have Habilitative speech therapies covere

Early Intervention:

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. An approved IFSP may serve as an order for services, in lieu of a physician order for Therapy.

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ST Benefit Limitations

• Eligible members may not receive both Rehabilitative and Habilitative speech therapy services on the same date of service.

• Speech Therapy is limited to five (5) units of service per date of service. Some specific daily limits per procedure code apply. Please see below:

• While a maximum of five units of service is allowed per date of service, 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 determined to need a speech generating device (HCPCS codes E2500, E2502, E2504, E2510, E2211, E2512, and E2599) should be referred to a Health First Colorado participating medical supplier to be prior authorized.

ST Benefit Limitations Con't

Members may receive up to 12 visits of ST services per rolling 12-month period before a Prior Authorization Request (PAR) is required.

• Units of service exceeding the initial 12 visits 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 12 visits in a 12-month period. Units are continually available until the limit 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.

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Service Units for Speech Therapy

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.

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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 speech therapy has a Timed Code (97130); 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 unit.

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

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Speech Therapy Modifier Requirements

Modifier codes must be included for all ST 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 Speech Therapy	GN	97	92507 + GN + 97
Habilitative Speech Therapy	GN	96	92507 + GN + 96
Early Intervention Speech Therapy	GN	TL	92507 + GN + TL

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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.

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

3. **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 HFC 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.

Tips to Reduce Pends and Denials

- Upload all required documentation at the time of submission.
- On the evaluation be sure to include the following:
  - Referral information. Reason for referral and referral source.
  - History. This should include the diagnosis pertinent to the reason for the referral including date of onset. Cognitive, emotional and or physical loss necessitating referral and date of onset and the current functional limitation or disability as a result of the loss, any preexisting loss or disabilities, available test results, any previous therapies/interventions for the presenting diagnosis and functional changes (or lack thereof) as a result of previous therapies/interventions.
  - Assessment. This should include a summary of the members impairments, functional limitations, and disabilities based on a synthesis of all data/findings gathered from the evaluation procedures. Pertinent factors which influence the treatment diagnosis and prognosis must be highlighted and the inter-relationship between the diagnosis and disability for which the referral was made must be discussed

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Tips to Reduce Pends and Denials Con't

Plan of Care. A detailed plan of care must be included in the documentation of the initial evaluation. This must include specific long-term and short-term treatment goals for the entire episode of care which are functionally based and objectively measured, proposed interventions/treatments that are to be provided during the episode of care, the proposed frequency and duration of services to be provided and an estimated duration of the episode of care.

• Progress/Re-evaluation. This is to be measured from the period within 60 days prior to requested start date and needs to show the functional status of the member. This is where the member is functionally on the goal. Not a percentage or progressing and should include minimal/moderate/max assist if the member needs assistance working on a goal.

• Home Exercise Plan (HEP) Compliance. If exercises are being given to work on at home, are they working on them?

*** These tips are not all inclusive and are only to be used to aid in documentation.

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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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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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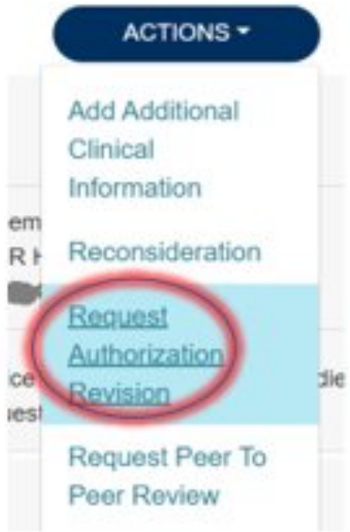
PAR Revision Con't

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 the required PAR form for adults and any 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 or homehealth@state.co.us
- Acentra Health Customer Service: (720) 689-6340
- PAR Related Questions: coproviderissue@acentra.com

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