Hello and welcome to the provider benefit specific training for speech therapy providers.

Today we will discuss EPSDT, Acentra Health and our scope of services, Acentra Health services for providers, provider responsibilities, the PAR request submission, general requirements, submission requirements, timely submission, speech therapy PAR requirements, understanding speech therapy, documentation requirements, service units for speech therapy, common pends and denials, tips to reduce pends and denials, PAR determination process turnaround times, Medicaid rule for medical necessity, PAR revision, the change of provider form and then have a brief recap.

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 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.

In 2021 Kepro was awarded the Department of Health Care Policy and Financing contract for utilization management and Physician Administered Drug review.

With over 6 decades of combined experience, CNSI and Kepro have come together to become Acentra Health.

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 and our mission is to continually innovate solutions that deliver maximum value and impact to those that we serve.

In addition to UM review, Acentra health will administer or provide support in a client overutilization program, annual HCPCS code review, a quality program, reporting, review

criteria selection, customer service line, appeals, peer to peer and reconsiderations, as well as fraud and false claims reporting.

Our scope of services include audiology, diagnostic imaging, durable medical equipment, the inpatient Hospital Review program, medical services, molecular and genetic testing, out of state inpatient services, outpatient physical, occupational and speech therapy, pediatric behavioral therapy, private duty nursing, personal care services, and physician administered drugs.

Our provider portal Atrezzo is available 24 hours a day, 365 days a year, and can be accessed at portal.kepro.com. For provider communication and support email Coproviderissue@acentra.com . For provider education and outreach as well as system training materials and the provider manual please visit the Colorado PAR website at hcpf.colorado.gov/PAR.

Providers must request prior authorization for services through Acentra's Portal Atrezzo. A fax exempt request form may be completed 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 parts per month and would prefer to submit a PAR via fax or the provider is visually impaired.

Utilization of the Atrezzo portal allows the provider to request the prior authorization for services, to upload clinical information to aid in the review of the prior authorization request, and to submit reconsiderations and/or peer to peer requests for services denied.

The system will give a warning if a PAR is not required.

You should always verify the members eligibility for Health First Colorado prior to submission.

As always, the generation of a prior authorization number does not guarantee payment.

Requests submitted within the business hours of 8:00 AM to 5:00 PM Mountain time will have the same day submission date. While the Atrezzo portal is accessible 24 hours a day, seven days a week, PAR requests submitted after business hours, on holidays or on days following state approved closures will have a receipt date of the following business day.

PAR submissions will require providers to provide the Members ID, name and date of birth.

The CPT or HCPCS codes to be requested, the dates of service, the ICD 10 code for the diagnosis, and the servicing provider, or the billing provider's national provider identifier if it is different than the requesting providers.

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.

PAR requests must include a legibly written and signed ordering practitioner prescription or approved plan of care that includes the diagnosis, the reason for therapy, the number of requested therapy sessions per week and the total duration of therapy.

The Members speech therapy treatment history, to include current assessment and treatment, along with the duration of the previous treatment and treating diagnosis.

Documentation indicating if the Member has received speech therapy under the Home Health program or inpatient hospital treatment.
The current treatment diagnosis.

The course of treatment, measurable goals and reasonable expectation of completed treatment.

Documentation supporting medical necessity for the course and duration of the treatment being requested, and 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.

There is no PAR required for 12 sessions per 12-month period.

However, providers may submit a PAR without exhausting those 12 sessions first. You should submit a PAR prior to session 13. It is the provider’s responsibility to track units and know when a PAR is required. Please note that the 12 sessions follow the Member and are not for each provider.

Retroactive authorizations are not accepted by Acentra Health. However, exceptions may be made by HCPF.

The PAR duration is limited to 365 days.

Enrolled members ages 20 and under and adult clients in limited circumstances qualify for medically necessary speech therapy services.

These include, but are not limited to, an evaluation, individual and group therapeutic treatment, alternative and augmentative communication device evaluation, assistive technology assessment and cognitive skill development.

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 covered.

Early Intervention Services provide developmental supports and services to children birth through four 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 speech therapy.

Eligible members may not receive both rehabilitative and habilitative speech therapy services on the same date of service.

Speech therapy is limited to 5 units of service per date of service.

Some specific daily limits per procedure code apply.

While a maximum of five units of service is allowed per date of service, providers are required to consult the American Medical Associations Current Procedural Terminology manual for each coded service. Some codes represent a treatment session without regard to its length of time, which would be a one unit maximum, while other codes may be billed incrementally as timed units.

Members determined to need a speech generating device should be referred to a Health First Colorado participating medical supplier to be prior authorized.

Providers will need to submit the following documentation on new admissions: an evaluation or reevaluation. An order/referral/plan of care that is signed by either the physician, the nurse practitioner or the physician assistant 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, as well as a plan of care that is within 90 calendar days prior to the requested start date and includes the diagnosis, the type of therapy, therapeutic interventions, frequency and duration specifications and covers the PAR dates requested.

In addition, a recent complete therapy reevaluation 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 the requested start date for continuation of care reviews.

A unit equals either a timed increment or one treatment session as described in the specific CPT procedure codes.

You should submit PARs for the number of units for each specific procedure code requested, not for the number of services.

For time codes, one unit equals 15 minutes.

For untimed codes, this is based on the number 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 would enter one in the labeled units field.

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

For example, for 60 minutes of speech therapy, if using a timed code, you would report 4 units.

Another example is a pathology evaluation would use an untimed code and you would enter one as only one evaluation was completed.

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 one unit.

Modifier codes must be included for all speech therapy requests.

The same modifiers used on the PAR must be used on the claim and in the same order.

The GN modifier should be used on all speech therapy requests.

In addition, you should add the 97 modifier for rehabilitative speech therapy request, the 96 modifier for Habilitative speech therapy request, and the TTL modifier for early intervention speech therapy request.

The following items are frequently missing in the documentation that lead to pends and or denials: a complete therapy reevaluation or progress note on the current plan of care showing progress or lack thereof from within the last 60 days prior to the requested start date.

Documentation noting if a home exercise plan has been or will be provided to the Member and the level of compliance with the Home Exercise Plan.

A physician signed referral or plan of care that includes the frequency and duration specifications and covers the PAR dates being requested.

Frequently documentation is signed by the clinical fellow and not the speech language pathologist.

The evaluation with all testing and assessment results.

Please note providers have 10 business days to respond to the request for additional information.

Below are some tips to help reduce pends and denials.

Be sure to upload all required documentation at the time of submission.

On the evaluation be sure to include the following:

The referral information. The reason for the referral and the referral source.

The 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, any available test results, any previous therapies or interventions for the presenting diagnosis and functional changes (or lack thereof) as a result of previous therapies and interventions.

The assessment. This should include a summary of the members, impairments, functional limitations and disabilities based on a synthesis of all data and findings gathered from the evaluation procedures. Pertinent factors which influence the treatment diagnosis and prognosis must be highlighted in the inter relationship between the diagnosis and disability for which the referral was made must be discussed.

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 and 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/Reevaluation. This is to be measured from the period within 60 days prior to the 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, maximum assist if the Member needs assistance working on a goal.

The home Exercise plan compliance. If exercises are being given to work on at home, are they working on them?

Please note these tips are not all inclusive and are only to be used to aid in the documentation.

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

An approval.

This means it met criteria for the service requested at first level review or was approved at physician level.

A request for additional information.

This means that information for determination was not included in the vendor requests this to be submitted in order to complete the review.

A technical denial. Health First Colorado policy is not met for reasons including but not limited to the following:

An untimely request.

The requested information was not received or lack of information.

The request is duplicate to another request already approved for the same provider or the service is previously approved with another provider.

You could also receive a medical necessity denial.
This means that the physician level reviewer determines that medical necessity had not been met, and it has been reviewed under appropriate guidelines.

The physician may fully or partially deny a request.

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.

For a reconsideration request, the servicing provider may request the 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 review.

For the peer-to-peer request, an ordering provider may request the peer-to-peer review within 10 business days from the date of the medical necessity adverse determination.

To do so, you would 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 review.

The turnaround time for completion of a PAR review ensures a thorough and quality review of all PARS by reviewing all necessary and required documentation when it is received, it decreases the number of unnecessary pends to request additional documentation or information, and it improves care coordination and data sharing between Acentra Health and the department's partners, such as the regional accountable entities and case management agencies.

For additional information, pends the provider will have 10 business days to respond. If there is no response, or if there is an insufficient response to the request, Acentra will complete the review and technically deny for lack of information if appropriate.

A PAR that is expedited is because a delay could jeopardize the life or health of a member, it could jeopardize the ability of the member to regain maximum function, and/or it could subject the member to severe pain.

These requests will be completed in no more than four business hours.

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 the Health First Colorado member’s inpatient hospital discharge.

These requests will be completed in no more than one business day.

The majority of cases would fall under the standard review category as a prior authorization request is needed.

These requests will be completed and no more than 10 business days.

Medical necessity means a medical assistance program good or service 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.

It is provided in accordance with generally accepted professional standards for health care in the United States.

It is clinically appropriate in terms of type, frequency, extent, site and duration.

It is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker or provider.

It is delivered in the most appropriate setting required by the client's condition.

It is not experimental or investigational and it 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.

If the number of approved units needs to be amended or reallocated, the provider must submit a request for a revision prior to the PAR end date.

Acentra Health cannot make modifications on an expired or a previously billed PAR.

To make a revision, simply select request revision under the actions drop down, then select the request number and enter a note in the existing approved case of what revisions you are requesting.

Then upload any additional documentation to support the request as appropriate.

When a member receiving services changes providers during an active PAR certification,

the receiving provider will need to complete a change of provider form to transfer the Members care from the previous provider to the receiving agency.

This form is located on the provider forms webpage under the prior authorization request form drop down menu along with instructions on how to complete the change of provider form.

The provider portal Atrezzo is available 24 hours a day, 365 days a year, and can be accessed at portal.kepro.com.

For system training materials and the provider manual please visit hcpf.colorado.gov/par.

For up-to-date information, please register for the provider bulletins by visiting hcpf.colorado.gov/provider-news.

For any escalated concerns, please contact hcpf_um@state.co.us

For Acentra Health customer service, please call 720-689-6340.

For any PAR related questions, email coproviderissue@acentra.com.

This concludes our presentation. Thank you for your time and participation.