Beginning Billing Workshop
Outpatient Therapies

Health First Colorado
(Colorado’s Medicaid Program)

COLORADO
Department of Health Care
Policy & Financing

Training Objectives

Medical Necessity

Enrollment Requirements

Limitations

Billing

Prior Authorization Requests (PAR)

Medical Necessity

PT/OT/ST must be:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate in terms of type, frequency & duration
- Not primarily for the convenience of the child, parent or legal guardian, physician or other health care provider
- Cost effective

Not covered benefits of fee-for-service PT/OT/ST for any member, regardless of age

- Education
- Personal need
- Comfort therapy
- Experimental
- Investigational
- Hippotherapy

Fee-for-service PT/OT/ST requires

- A medical (physiological) reason to perform services

Physical & Occupational Therapy Enrollment Requirements

- Services must be provided by:
  - State of Colorado licensed physical or occupational therapist who is an approved Health First Colorado provider

- Occupational Therapy Assistants (OTAs) & Physical Therapy Assistants (PTAs) are eligible to provide services:
  - Under supervision of an approved, licensed physical or occupational therapist

- Services provided in the Home Health benefit:
  - Must conform to Home Health policy rules

Physical & Occupational Therapy (PTAs / OTAs) Enrollment Requirements

- PTAs must:
  - Be certified by DORA pursuant to Title 12 Article 41.204
  - Work under supervision of a licensed physical therapist
    - As defined in Colorado Physical Therapy Practice Act (§12-41-203(2) C.R.S.) & accompanying rules as promulgated by State Board of Physical Therapy

- OTAs must:
  - Practice under general supervision of a Colorado registered occupational therapist
  - Must be licensed

Speech-Language Therapy Providers Enrollment Requirements

- Qualified Speech-Language Pathologist or Audiologists
  - Must meet qualifications prescribed by federal regulations for participation at 42 CFR 484.4
  - Must meet all requirements under state law
  - Must be an approved Colorado Medical Assistance Program provider
  - As of July 1, 2013, all Speech-Language Pathologists must be Department of Regulatory Agencies (DORA) certified

Speech-Language Therapy General Policies

- Services must be provided by or under supervision of a certified Speech Pathologist or Audiologist
- Services must be medically necessary
- Habilitative speech therapy services require PAR
- Rehabilitative ST services do not require PAR
  - With exception of members determined to need a speech generating device
  - Should be referred to a Medicaid participating medical supplier for a PAR

Speech Therapy Limitations

- Non-covered benefits
  - Services provided for simple articulation or academic difficulties that are not medical in origin are non-benefit services
- Non-covered benefits for adults (ages 21+)
  - Speech therapy for long-term chronic conditions (Habilitative therapy), unless the member is on the Medicaid Expansion 'Alternative Benefit Plan'
  - Be sure to query the member's eligibility prior to rendering services to see if they qualify for Habilitative therapy, as indicated by the presence of the benefit plan "ABP" (Alternative Benefits Plan)
- Children (ages 20 and under) have both Rehabilitative and Habilitative therapies covered

Speech Therapy Limitations (cont.)

- Maximum of 5 units of service are allowed per date of service
- Services must be medically necessary
- Services must be ordered, prescribed or referred by a licensed Health First Colorado-enrolled physician, physician assistant, nurse practitioner, or individualized family service plan (IFSP)
- For more information on speech therapy services, refer to:

www.Colorado.gov/hcpf/Billing-Manuals

Billing Manuals → CMS 1500 → Speech Therapy

PT/OT Therapy Limitations

- Maximum of 5 units of service for **each therapy type** are allowed per date of service
- Services must be medically necessary
- Services must be ordered, prescribed or referred by a licensed Colorado Medicaid enrolled physician, physician assistant, nurse practitioner, or individualized family service plan (IFSP)
- For more information on therapy services, refer to:

www.Colorado.gov/hcpf/Billing-Manuals

Billing Manuals → CMS 1500 → Physical and Occupational Therapy

Billing

Units of Service

- Consult Current Procedural Terminology (CPT) Manual for definitions for each coded service
    - Some codes represent a treatment session without regard to its length of time (1 unit maximum)
    - Some codes may be billed incrementally as “timed” units
- Providers must follow correct coding guidelines as mandated by HIPAA and NCCI

Billing
Procedure Modifiers

Providers must use the appropriate modifier:

Physical Therapy	PT procedure code	GP
Occupational Therapy	OT procedure code	GO
Rehabilitation Agency / PT Clinic	PT procedure code OT procedure code	GP GO
Speech Therapy	ST procedure code	GN

Note:

- May use additional modifiers as appropriate
- All Habilitative claims must have modifier **96** in addition to the modifiers above; all Rehabilitative claims must have modifier **97**
- Early Intervention providers: in addition to modifiers GP, GO and GN, modifier **TL** must be attached to all claims for Early Intervention PT/OT/ST

Benefit and Billing Information

For more detailed benefit and billing information, refer to:

https://www.Colorado.gov/hcpf/Billing-Manuals

- Billing Manuals → CMS 1500 → Physical and Occupational Therapy
- Billing Manuals → CMS 1500 → Speech Therapy

Prior Authorization (PAR) Facts

- Members need a PAR for greater than 48 units of PT/OT service per rolling 12 month period
- Member may receive PT & OT services during the same time period/service dates
- Separate PAR & necessary documentation required for each request

PAR Facts (cont.)

- PAR effective dates cannot exceed twelve (12) month span
- Approval depends on medical necessity, deemed by authorizing agent
- PAR requests must include legible written & signed M.D./D.O. prescription/order/referral and a signed treatment plan
- Must include all of the following
  - Diagnosis with ICD-10 code
  - Medical necessity for therapy
  - Number of therapy sessions needed per week

PARS are processed by eQHealth®

PAR Facts (cont.)

- If member’s medical condition requires more treatments than listed & authorized on original PAR:
  - New PAR is required
  - PAR must:
    - Include all required information previously noted
    - Must show continued need, ongoing deficits & progress toward treatment goal
  - No retroactive PARs allowed

PAR Facts (cont.)

Habilitative speech therapy

- Requires PAR for adults
- Only adults on the Alternative Benefits Plan have this covered

Provider Services Call Center

1-844-235-2387

Download the Call Center Queue Guide

7 a.m. - 5 p.m. MST Monday, Tuesday, & Thursday
10 a.m. - 5 p.m. MST Wednesday & Friday
The Provider Services Call Center will be utilizing the time between 7 a.m. and 10 a.m. on Wednesdays and Fridays to return calls to providers.

Thank you! Please feel free to ask us any questions you may have.