



Billing Information for Providers

Produced by

Early Intervention Central Billing Office (EI-CBO)

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1. INTRODUCTION

The purpose of this informational material is to assist the Department of Human Services Early Intervention Payee in billing through the DHS Early Intervention Central Billing Office (EI-CBO), allowing for timely processing and reimbursement.

To ensure all requirements are met before submitting claims to the EI-CBO, the material in this booklet should be read completely by the payee, the billing agent contracted by the payee, or the billing staff employed by the payee.

2. READING AN INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

The Child and Family Connections (CFC) office enters authorizations for Early Intervention (EI) services into the Cornerstone system. Cornerstone is a statewide management information system developed to facilitate the integration of community maternal and child health services provided to Illinois residents by the Illinois Department of Human Services, and to effectively measure health outcomes. Once the CFC enters the information into Cornerstone, it is then available in report format via the Individualized Family Service Plan (IFSP). All members of a child's IFSP team will also be identified on this report.

The IFSP allows the service coordinator to print a single report containing all the information captured in Cornerstone that is pertinent to the IFSP. This report is generated by the service coordinator after developing the IFSP with the team. This is a family-focused document that contains important information regarding the child and the family as well as authorizations for services identified by the team. The IFSP contains demographic information of the family as well as important contact information. The IFSP is given to the family and service providers, as well as to other related parties as necessary. The IFSP is a document to show the current level of the child as compared to their same-age peers. It contains information about the levels of development the child is experiencing. The IFSP also contains valuable information about the needs of the child and family. These needs are expressed as Outcomes which help the team develop the best method of services to meet the Outcomes. Authorized Services are outlined in the IFSP as well.

3. AUTHORIZATION

3.1 Payee Responsibilities

The individual provider must be enrolled with the EI-CBO and the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system as an Early Intervention provider before payment for authorized services can be issued. Enrollment can be initiated by contacting the Provider Connections Credentialing and System Enrollment Office at 800/701-0995 or by accessing their web page at www.wiu.edu/providerconnections.

All Early Intervention services identified on a child's Individualized Family Service Plan (IFSP) are pre-approved. Services provided without a pre-approved authorization are not guaranteed for payment. An

authorization will be generated (Attachment A) by the Child and Family Connections (CFC) office for each service that the provider is entitled to bill for. DO NOT PROVIDE SERVICES PRIOR TO RECEIPT OF THE AUTHORIZATION. THE ONLY EXCEPTION TO THIS RULE IS THE INITIAL IFSP MEETING AS THESE AUTHORIZATIONS ARE GENERATED BASED UPON MEETING ATTENDANCE. Providers must attend the entire IFSP meeting in order to receive an authorization for payment of the IFSP meeting and the evaluation performed prior to the IFSP meeting. Providers should always ask for a copy of the IFSP meeting authorization prior to leaving the meeting. In the event the Service Coordinator cannot print out the authorization (no access to printer), the provider must ask for the authorization number and record it. Service Coordinators are required to have their laptop computer with them at the IFSP meeting. Even if no printer is available, the Service Coordinator can generate the authorization in Cornerstone and provide the authorization number to be recorded and the printed copy can be delivered in a timely manner once they return to their office.

It is the responsibility of the provider to review the authorization immediately upon receipt to verify that all of the information is correct: payee information, frequency, intensity of service to be provided, time frame for which services are to be provided, place of service (onsite/offsite) etc. If there is a discrepancy the provider should contact their local Child and Family Connections office immediately (prior to service provision) to request that the authorization be corrected. There is no guarantee of payment if all policies and procedures are not followed.

Providers must refer to the child's Authorization section of the IFSP to determine the place of service, location, procedure code, frequency and intensity of service to be provided. The local Child and Family Connections office sends the detailed report to the payee verifying that services are authorized.

Requests for assistive technology (AT) devices require developmental review and prior approval before an authorization can be issued with the exception of ear molds and batteries for hearing aids. DHS is responsible for issuing the prior approval. The authorization will not be generated until the Child and Family Connections receives the prior approval from DHS. All services, including AT items, must be delivered to the family prior to billing insurance or the EI-CBO. The vendor must ensure the receipt of the AT item(s) by the family. Vendors are responsible for replacing items not received by the family, at no additional cost to Early Intervention, regardless of the method of delivery.

- Upon receipt, verify that all information on the Service Authorization is correct. If ANY information is not correct, contact the local Child and Family Connections office immediately. Examples to verify include Payee name, place of service (onsite/offsite), begin/end date, and authorized service frequency/intensity.
- Do not provide services without a correct authorization in hand. Services provided that without a correct, pre-approved authorization are not guaranteed for payment.
- Claims will be paid only if the service provided matches the authorization exactly.

- If you believe the child requires increased frequency or length of service, or additional services beyond what you have been authorized to perform, please follow the guidelines in the Provider Handbook entitled “Early Intervention Service Descriptions, Billing Codes and Rates” to complete the “Developmental Justification of Need to Change Frequency, Intensity or Location of Authorized Services” and submit the worksheet to the child’s Service Coordinator at the local Child and Family Connections office immediately to request an IFSP meeting to address your concerns.

If you have questions regarding a service authorization, contact the local Child and Family Connections office that generated the authorization. A current listing of CFC’s can be found on the EI-CBO website, www.eicbo.info , the DHS website, www.dhs.state.il.us/ei or the Provider Connections website at www.wiu.edu/providerconnections.

4. OVERVIEW OF THE EI-CBO BILLING PROCESS

4.1 Billing Rates

Payees are expected to bill the EI-CBO at their usual and customary billing rates with the understanding that the EI-CBO will only reimburse up to the established Early Intervention rates. Payees should refer to the document entitled “Early Intervention Service Descriptions, Billing Codes and Rates” for detailed information on staff qualified to provide EI services, billable activities and rates of reimbursement. Per their signed “Payee Agreement for Authorization to Provide Early Intervention Services”, payees who accept an Early Intervention authorization agree NOT to bill a child’s family for payment above the Early Intervention rates.

4.2 Who Can Bill?

Services are to be provided by a credentialed and enrolled provider. If services are provided by a credentialed associate level EI provider, the associate level provider must work under the supervision of a professional level EI credentialed & enrolled provider who has a pre-approved authorization for the services to be provided. Please see the EI Provider Handbook entitled “Early Intervention Service Descriptions, Billing Codes and Rates”, Attachment 4, Use of Associate Level Providers.

The EI-CBO can reimburse a payee for Early Intervention services that are provided by an equally qualified provider who is Early Intervention credentialed/enrolled with the EI-CBO under the same discipline/credential and is employed by the same payee that the authorization was issued to. This policy ONLY permits substitution of those providers who are enrolled under the same taxpayer identification number.

4.3 Private Insurance Use

When a child enrolled in Early Intervention is covered by a private insurance plan, all credentialed/enrolled providers must bill the private insurance before submitting claims to the EI-CBO

unless a pre-approved exemption or waiver has been issued for the child, the service is one of the “services not billable to insurance” listed below or the family has a self-funded insurance plan and has declined the use of their private insurance plan.

4.4 Services Billable to Insurance

- Assistive Technology (Durable Medical Equipment and Supplies).
- Aural Rehabilitation Services.
- Health Services.
- Nursing Services.
- Nutrition Services.
- Occupational Therapy.
- Physical Therapy.
- Psychological and Other Counseling Services.
- Social Work and Other Counseling Services.
- Speech Therapy Services.
- Vision Services.

4.5 Services Not Billable to Insurance

- Assessment Services.
- Audiological Exam.
- Deaf Mentor.
- Developmental Therapy.
- DT/hearing.
- DT/vision.
- Evaluation Services.
- IFSP Development Services.
- Interpretation.
- Medical Services (for diagnostic /evaluation).
- Parent Liaison.
- Translation.
- Transportation.

4.6 Time to Bill

Claims for authorized services must be received by the EI-CBO no later than ninety (90) days following service delivery or ninety (90) days from the last dated/written correspondence with third party payer. The EI-CBO will not use a fax date or computer print-out date to determine timely filing. In cases where third party payments exceed the Early Intervention rate, the provider’s bill will be considered paid in full. The provider must submit the claim along with the insurance EOB showing the charges were paid in full.

Charges that do not exceed third party recoveries should be submitted to the EI-CBO and will be paid up to the level of the Early Intervention rate. A copy of the insurance carrier's explanation of benefits must accompany the provider's billing to the EI-CBO. In all instances when an insurance carrier has been billed, whether paid in full, paid in part or denied by the carrier, the payee must provide the EI-CBO a copy of the third party (insurance) explanation of benefits and a completed claim with the data elements required by the EI-CBO within 90 days of the of the date recorded on the third party explanation of benefits.

4.7 Remittance from the EI-CBO

The Provider Claim Summary (Attachment G) will explain the action taken on each claim and will be mailed from the EI-CBO. Claims approved for payment will be forwarded to the Illinois State Comptroller's Office for issuance of a check/warrant (Attachment H). Providers can directly access payment information through the State Comptroller's website at www.comptroller.state.il.us. An online vendor's guide to accessing payment information is also available at the website.

The Provider Claim Summary (PCS) and the check/warrant are sent under separate cover and can be matched according to the invoice number shown on the Provider Claim Summary and the invoice number on the state check/warrant. If you have questions regarding information contained within the Provider Claim Summary, contact the EI-CBO Call Center at 800/634-8540. Please do not call the phone number listed on the State Comptroller's check/warrant.

The family will also receive an Explanation of Benefits. Families are requested to review their Explanation of Benefits (EOB) and report dates of service that were paid, but not received. Families who identify a discrepancy between services paid and services provided should contact the EI-CBO Call Center at 800/634-8540 to report the discrepancy for further investigation.

4.8 Physician Authorization

Early Intervention requires a physician script for services. In order for a provider to access private insurance plans or HMO/PPO plans, it may be necessary to obtain a physician authorization. If permission is obtained by verbal orders, written documentation must still be obtained. To document verbal orders, a telephone order form should be completed and sent to the physician for signature, providing a written record of the date the services were authorized. The physician orders should be maintained in the treatment record. The CFC is required to have a copy. The CFC should work with the provider to obtain one and copies must be shared by both parties to ensure compliance.

Physician authorization for treatment can also be obtained by adding a line to the bottom of the evaluation or assessment report and forwarding it to the child's attending physician for signature and dating. Physician reauthorization for continuing intervention can be obtained using the progress summary form or the consultation report.

Providers initiating a third-party billing may not wish to contact physicians by telephone or send IFSP reports without explanation. A copy of any authorization form(s) related to communication with the physician should also be provided to the Central Billing Office.

4.9 Participation/Consent Form

Early Intervention requires consent for all services. The parent signs consent forms for every provider involved in the child's IFSP plan as well as the Insurance Affidavit, Assignment of Release form. The form includes a statement for the authorization to release information to insurance that is necessary for processing a claim and assigns benefits to the provider (as per the plan). When the insurance plan is a self-funded plan, the family may choose to decline insurance billing for one or multiple services.

5. EARLY INTERVENTION DOCUMENTATION REQUIREMENTS

You are required to maintain documentation to support each date of service and each procedure code that you bill to the EI-CBO for a period of at least six years from the child's completion of EI services, and permit access to these records by the local CFC and DHS, or if they are Medicaid reimbursable services the Illinois Department of Healthcare and Family Services (HFS) and the Centers for Medicare/Medicaid Services (CMMS), and the United States Department of Education.

If there are outstanding audit exceptions, records shall be retained until such exceptions are closed out to the satisfaction of DHS. If there is active or pending legal action, records shall be retained until a final written resolution is achieved. The Provider shall also make himself/herself available, as required, for mediation, impartial administrative proceedings or other legal proceedings.

Documentation is a chronological written account kept by you of all dates of services provided to, or on behalf of, a child and family. This includes IFSP development time and the results of all diagnostic tests and procedures administered to a child. All documentation, including the signature of the provider who creates the documentation, must be readable and understandable to families and to persons who will monitor or audit the payee's billing to the EI-CBO. Documentation must include:

1. Physician authorization/order.
2. Documentation of evaluation/assessment should include a record note that identifies the date of service that the evaluation or assessment was completed, time used to complete the evaluation or assessment, time used to write the report based upon the results of the evaluation or assessment, and a copy of the final report that was submitted to the CFC. The date of service is the date that the formal assessment tool was administered. For a six-month review, if it is determined that a formal assessment is not required, providers may summarize their record notes to develop the required six-month report. In this case, documentation would consist of a record note stating that a report was created based upon the summary of record notes and a copy of the final report.

3. Daily documentation of the services provided, including date and length of time of service billed, time in and time out for direct services, or exact time used in minutes for IFSP development. Daily documentation is written and signed by the provider who actually provided the services and consists of a complete overview of the services provided for each procedure code and date of service billed. A check list or pages from an appointment book are not considered documentation or a complete overview of the services provided.
 - A. Documentation overview and provider signature must be readable and understandable to families and to persons who will monitor or audit the Payee's billing to the CBO.
4. Consultations among members of the IFSP team, including the service coordinator and eligible child's physician, can occur via secure email or fax, as long as the time used is documented with a begin/end time or exact time used in minutes. Email sent via the "public internet" is not considered secure. Printed copies of secure emails or faxes must be kept in each child's file as documentation of the consultation.
5. EI does not allow a provider to round up time. It is very important that all record notes include the exact begin/end time or exact time used in minutes for IFSP development time. In addition, all documentation must justify the amount of time actually billed to and paid by the CBO.
6. Progress documentation.
7. Documentation of continued physician authorization.
8. Documentation of discharge from treatment.
9. Supervision notes that document all contact between the supervisor who is responsible for a child's case and the associate level provider who is actually providing the direct service to the child. Calendar pages that identify dates of supervision are not considered supervision notes or documentation.

Calendar pages that identify dates of supervision are not considered supervision notes or documentation.

5.1.1 Transportation providers' documentation must include:

1. A travel log that documents all trips billed, including mileage, departure and destination information.

5.1.2 Interpreters, Interpreters of the Deaf and Translators documentation must include:

1. Daily documentation of services provided, including date of service, discipline for which you have interpreted services and time in/out. Daily documentation should be signed by the provider who

actually completed the services and wrote the documentation. Calendar pages are not considered documentation.

2. Type of interpretation: verbal, sign, or written translation.
3. If written translation, type of document translated (ex: IFSP).
4. Copy of the document to translate and copy of the final document after translation.
5. EI does not pay for translation of non-EI documents.

5.1.3 In addition, providers must also keep the following:

1. Copies of all authorizations under which you have billed for services.
2. A copy of the child's current IFSP.
3. Copies of all claims submitted to insurance and to the EI-CBO.
4. Copies of all Explanations of Benefit received from insurance and the EI-CBO.
5. Any correspondence sent or received on behalf of the child.

PLEASE NOTE: Providers who are not enrolled with the EI-CBO and associate level providers who are not Early Intervention credentialed, are NOT considered eligible Early Intervention providers and should NOT provide services to eligible Early Intervention children unless approved through a Provisional Provider authorization.

In the absence of proper and complete documentation, no payments will be made and payments previously made will be recouped by DHS or HFS.

One case note signed by multiple providers is unacceptable documentation. Each provider that provides a service to a child must maintain documentation to support the actual services provided and each date of service and each procedure code billed to the CBO. This includes providers of group therapy services.

6. HOW TO BILL THE EI-CBO

The EI-CBO will only accept the CMS-1500 form and the UB-04 form from the payee billing for authorized services. Payees and Parents/Guardians who bill the EI-CBO for transportation services must use the DHS Transportation Billing Form. No other forms will be accepted. Claims may be submitted electronically or via paper claims (DHS Transportation Billing Form). Refer to 'How to Bill the EI CBO' section for details.

6.1 Remember

- A maximum of six (6) lines of service are allowed per claim form.
- Only one (1) discipline of service and one (1) provider are allowed per claim form.

Bill using the Early Intervention codes identified on the pre-approved authorization and/or found in the EI Service Descriptions, Billing Codes and Rates booklet.

- Use HCPCS codes for Assistive Technology billing.
- All “miscellaneous” Durable Medical Equipment codes must include the description of the equipment.
- Type the full name of the credentialed/enrolled person who provided the services OR the full name of the credentialed/enrolled supervising provider and the name of the credentialed associate who provided the services.
- Early Intervention does not pay for therapists to provide services to a child/family via the telephone. The exception is for Counselors who are charged with “identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from Early Intervention services.”
- If the provider consults with the family via the phone, it is considered administrative time and is non-billable time. Refer to the Provider Handbook entitled “Early Intervention Service Descriptions, Billing Codes and Rates” found on the DHS, the EI-CBO and the Provider Connections websites for more information regarding billable/non-billable time.
- For billing purposes/claim submission, only use a complete street address plus a nine-digit zip. Do not put a post office box number on your claims.

6.2 CMS-1500 Requirements- (Attachment B)

- Child’s name (last and first) (field 2).
- Child’s complete address (field 5).
- Six (6) digit EI number (field 1a).
- Date of Birth (field 3).
- Name of associate provider, if applicable (last name, first name) (field 19).
- Current ICD-10 treatment diagnosis code (field 21 1-4).
- Date of service (one (1) per line in chronological order) (field 24 A).
- Indicate the two (2) digit place of service (POS) location code (field 24 B) o 03 – Regular Nursery/Day Care (offsite).

- 11- Service Provider Facility (onsite).
- 12- Home (offsite).
- 62- Early Intervention Program (onsite).
- 99- Other Setting (offsite).
- Procedure Codes identified on the authorization (24 D).
- Amount billed (field 24 F).
- Length of session in units (field 24 G).
- Rendering NPI # (field 24J).
- Taxpayer identification number (payee tax ID) (field 25).
- Patient Account number – if applicable (field 26).
- Total Charge (field 28).
- Name of enrolled provider (Last Name, First Name) who performed or supervised services and date (field 31).
- Complete Payee name and billing street address including nine-digit zip (P.O. or Lock Box numbers will not be accepted on claims) (field 33).

6.3 UB-04 Requirements- (Attachment C)

- Complete Payee name and billing address including a nine-digit zip (P.O. or lock Box numbers will not be accepted on claims) (field 1).
- Must include the taxpayer identification number (payee tax ID) (field 5).
- Child's name (last and first) (field 8a).
- Child's complete address (field 9a).
- Date of Birth (field 10).

- Description of service (field 43).

- Bill using the Procedure Codes identified on the authorization for services (field 44).
- Bill using HCPCS codes for Assistive Technology. Durable Medical Equipment codes described as “miscellaneous” must include the description of the equipment. (field 44).

- Bill only one (1) date of service per line in chronological order (field 45).

- Length of session/service units (field 46).

- Amount Billed (field 47).

- Total amount billed (field 47).

- Rendering NPI # (field 56).

- Indicate the two (2) digit place of service (POS) location code (field 57) o 03 – Regular Nursery/Day Care (offsite).
 - 11- Service Provider Facility (onsite).
 - 12- Home (offsite).
 - 62- Early Intervention Program (onsite).
 - 99- Other Setting (offsite).

- Six (6) digit EI number (field 60).

- Current ICD -10 treatment diagnosis code (field 67).

- Name of enrolled provider who performed or supervised services (field 84).

- Name of associate provider, if applicable, under the supervising provider name (field 84).

6.4 DHS Transportation Billing Form Requirements- (Attachment D)

- Child’s name and complete address.

- Child’s (6) six-digit EI number.

- Child’s date of birth.

- Payee name and complete address.

- Payee tax ID number.
- Vehicle License Plate number.
- Bill only one (1) date of service per line in chronological order.
- For taxi and service car mileage code “A0425”, enter the total loaded miles one way. When a round trip is provided two mileage procedure codes and service lines must be completed. The EI-CBO will no longer accept claims for mileage code A0425 that have been billed as a round trip on one service line.
- For private auto mileage “A0090”, enter the total loaded miles one way. When a round trip is provided two mileage procedure code and service lines must be completed.
- Enter the complete departure and destination addresses in the space provided.
- Indicate the alpha code “D” (medical services) or “R” (residence) in the departure and destination code spaces provided.
- Enter the departure and destination times in the space provided.
- For service car, taxi and private auto, bill for loaded mileage only. Loaded mileage means that the child is in the vehicle.
- Enter the charge for each service line.
- Enter the total charges.
- Type or print legibly the full name of the enrolled transportation provider or company on the “Name of Enrolled Provider or Transportation Company” line and date the claim form.
- Providers must read and agree to the billing/authorization information, parental rights and certifications on the back of the billing form.
- IMPACT Enrollment.

Transportation claims may be electronically submitted to the Central Billing Office via QClaims. To learn more about this process please visit www.eicbo.info or call the Help Desk at 1-800-634-8540.

6.5 Interpretation, Interpreters for the Deaf and Translation

- Interpreters must indicate the type of service provided in box 23 of the CMS-1500 whether billed electronically or on paper.
- If billing electronically, multiple disciplines cannot be listed in box 23. All service lines must be for the same discipline. If the provider is interpreting more than one discipline type, each should be billed on a separate form.
- When billing on paper, multiple disciplines can be listed in box 23. A comma should separate each discipline, which will indicate the next line of service.
- If multiple disciplines need to be listed for one line of service indicate this by using a back slash between them (PT/OT = Physical Therapy & Occupational Therapy).
- Claims that do not include the type of service interpreted will be denied.
- Some description examples are as follows:
 - PT = Physical Therapy.
 - OT = Occupational Therapy.
 - ST = Speech Therapy.
 - DT = Developmental Therapy.
 - PS = Psychological Services.
 - SW = Social Work.
 - AU = Audiology.
 - AR = Aural Rehabilitation.
 - PR = Physical Therapy Report.
 - PT = Physical Therapy Evaluation (Same for all disciplines).
 - IM = IFSP Meeting (Same for all disciplines).
- When billing on paper only - If you feel more specific information should be reported to avoid possible denial you may include this at the end of each service line in box 24J.

Please go to www.eicbo.info for more detailed information or call the EI-CBO for technical assistance if needed.

6.6 Initial Evaluation/ Assessment Services

- Evaluation/assessment services for the purpose of determining initial eligibility, participating in the development of an initial comprehensive IFSP, and adding new types of service to existing

IFSP's must be provided by a provider with a credential for Evaluation/Assessment in addition to an Early Intervention Specialist credential in the discipline required by the service being evaluated.

- IFSP meeting attendance is required in order to be paid for initial evaluations used to determine eligibility. The evaluation and IFSP meeting should be billed on the same claim and must be authorized. If no meeting was held and the case is closed the evaluation claim will be paid. If a meeting was held but the provider was unable to attend, a letter from the CFC manager must be attached to the claim for payment approval.
- For children with an active IFSP, regardless of referral date, credentialed evaluators must be used to complete the evaluation to determine the child's need to add a new service to an existing IFSP.
- Payees must bill the EI-CBO for Evaluation/Assessment, IFSP development, audiological exams and Medical Services for diagnostic/evaluation purposes. These services must be provided at no cost to families and are not billable to insurance or directly to families.
 - Interpreters must indicate the type of service provided in box 23 of the CMS-1500 whether billed electronically or on paper.

7. PRIVATE INSURANCE USE

Utilization of private insurance benefits is mandatory unless insurance use has been waived/exempted or the service is required to be provided at public expense and at no cost to the family. When an insurance plan is self-funded, the family may choose to decline insurance billing. Payees are required to accept insurance and/or EI-CBO payment as payment in full for services and agree not to bill the family for further payment. To ensure that the EI-CBO is aware of the appropriate payer, providers must notify the CFC immediately of any changes of insurance coverage that they become aware of for the families they are serving.

Payees should not bill the family directly for any EI services unless the insurance payment was paid to the family versus the provider. EI-CBO pays patient co-pays and deductible charges, up to the maximum allowed per service. An EOB from the insurance company must be attached to all claims billed to EI-CBO regardless of the payment level of the insurance company, even if insurance has paid the claim in full. Technical assistance with issues related to private insurance use is available from the EI-CBO by calling 800/634-8540. Visit the DHS (<https://www.dhs.state.il.us>), the EI-CBO (<https://eicbo.info/>) and EI-Provider Connections (<http://www.wiu.edu/ProviderConnections/>) websites to obtain the latest updates to insurance billing requirements and/or procedures.

8. RESPONSIBILITIES FOR INSURANCE BILLING

8.1 Child and Family Connections Will:

- Assist family in completing Insurance, Affidavit, Assignment and Release form.

- Provide copies of the family's insurance card to the Payee and EI-CBO.
- Request approval of pre-billing waivers and exemptions from the EI-CBO.
- Update EI-CBO and Provider/Payee of changes in insurance policy and benefits.

8.2 Provider/Payee Will:

- Verify insurance benefits with all insurance companies covering the family.
- Verify that insurance coverage has not changed before each service is performed. The provider/payee must be aware of who their payer will be and their requirements for each service provided.
- Bill the insurance company and EI-CBO appropriately for all claims regardless of insurance payment.
- Update CFC and EI-CBO of changes in insurance policy and benefits.
- Follow up with insurance company per EI-CBO instructions.
- Complete Pre-Certification/Authorization (if required) prior to starting services.

8.3 Family Will:

- Assist the CFC and provider/payee in determining insurance benefits and obtaining required documentation, if necessary.
- Provide timely notification of changes in insurance policy/benefits to CFC, EI-CBO, and provider.
- Turn over insurance payments (sent directly to the family) to the provider as appropriate.

8.4 EI-CBO Will:

- Conduct initial basic insurance benefit verification.
- Forward insurance data to CFC.
- Approval/denial of pre-billing waiver and exemption requests.
- Provide technical assistance to provider to help maximize insurance benefits.

9. INSURANCE WAIVERS AND EXEMPTIONS

Child and Family Connections offices, along with the family and the provider/payee, will determine if billing waivers or exemptions are appropriate for children they are serving. Requests for waivers or exemptions are submitted by the CFC to the EI-CBO for approval or denial if the waiver or exemption is not automatically provided during the benefits verification process by the CBO. If approved, direct service payees bill the EI-CBO for all dates of service. If denied, claims must be submitted to the private insurance carrier for payment before billing the EI-CBO. Notice of the approval/denial will be forwarded in writing to the CFC, who will notify the payee and family.

- If the family's insurance plan and/or coverage changes all waivers /exemptions become void and the CFC/Payee must verify coverage and, if necessary, complete the pre-billing waiver or exemption process.
- If the payee changes, all waivers become void and the CFC/Payee must verify coverage and, if necessary, complete the pre-billing waiver or exemption process.

NOTE: Waivers and Exemptions cannot be backdated so services should not be performed until proper documentation of approval is received.

9.1 Pre-Billing Insurance Waivers - Pre-billing waivers will only be issued for the following situations:

- An insurance required provider is not available to receive the referral and begin services.
- No insurance required providers are credentialed in Early Intervention.
- Travel to the insurance required center-based provider would be a hardship to the family.
- Become void if the family's insurance coverage changes or if payee receives payment from the insurance company.
- Are effective for the IFSP period during which they are approved and become void when the IFSP ends or when a change of insurance occurs.

9.2 Insurance Exemptions - Exemptions will only be issued for the following situations:

- Privately Purchased/Non-Group Plan.
- Lifetime Cap (overall policy or service specific).
- Insurance is with the Illinois Comprehensive Health Insurance Program.

- Insurance is connected to a Tax Savings Accounts (such as an HAS, HRA) that automatically withdraws funds based on claims received and processed by health insurance.
- Are effective for the IFSP period during which they are approved and become void when the IFSP ends or when a change of insurance occurs.

9.3 Post-Billing Insurance Waivers - Post-Billing waivers will only be issued for the following situations:

- Will be issued by the EI-CBO based on an approved denial reason listed on the insurance company EOB provided by the payee to the CBO.
 - This means the payee will not need to bill insurance for this service until the beginning of the next insurance benefit year.
 - Expire at the end of the insurance plan's benefit year (NOT IFSP PERIOD). At that time, the payee will be required to bill the insurance company again, according to program requirements.

10. PAYEE SAFETY NET

The Early Intervention program requires an explanation of benefits from the insurance company when a child is covered by private insurance. In some situations, the payee may have trouble in obtaining the required documentation from the insurance company. In these situations, the following process should be followed in order to facilitate a payment decision from the insurance company:

- If no response is received within thirty (30) days from the date of the original claim submission, follow up to inquire about the status of the claim with the insurance company and document the second method of contact.
- Comply with all requests from the insurance company for any additional information and document the submission of the information.
- After sixty (60) days from the date of the original claim submission, if the insurance company still has not responded, the provider should submit a complaint form to the Illinois Department of Financial & Professional Regulation's (IDFPR) Division of Insurance. They can be reached at 877/527-9431 or www.ins.state.il.us.
- IDFPR will investigate the reason for the insurance company's failure to adjudicate the claim and will notify the payee of the outcome in writing.
- If the insurance company agrees to pay after the investigation, the payee submits the claim along with the insurance company EOB to the EI-CBO.

- If the insurance company denies the claim, the payee submits the claim and denial within 90 days from the date identified on the insurance EOB to the EI-CBO.
- EI-CBO will review based upon normal program requirements.

11. CODING REQUIREMENTS

11.1 Procedure Coding

- The procedure codes billable to the EI-CBO are identified on most authorizations for services. Some of these procedure codes include a modifier that must be included on the claim form in order to receive proper reimbursement. The exceptions are for Audiological Exams, Health Consultations, Hearing Aid Checks and Transportation services. Payee's will bill the EI-CBO using one or more of the procedure codes identified in the Provider Handbook entitled "Early Intervention Service Descriptions, Billing Codes and Rates" under the respective service description.
- A complete listing of EI procedure codes for all services can be found in the "Early Intervention Service Descriptions, Billing Codes and Rates" at www.eicbo.info, www.dhs.state.il.us/ei or www.wiu.edu/providerconnections.
- If insurance exists, the procedure codes billed to the insurance company may differ from those used to bill EI-CBO. Providers should refer to the Physicians' Current Procedural Terminology (CPT) book that may be purchased from local medical books stores or from one of the resources included at the end of this section. Additional codes can be found in the HCPCS book. Payees should always bill insurance using the treating-level procedure codes that best describe the services provided to each child/family.

11.2 Diagnosis Coding

- Diagnosis coding discussed in this section does not refer to assigning a medical diagnosis but rather a treating diagnosis. A treating diagnosis tells us "why" you saw the child.
- Diagnosis codes submitted on claim forms (and on other medical documentation) are generally used to determine insurance coverage. Insurance payment is dependent upon meeting insurance company requirements.
- Diagnosis coding is translating the medical terminology used for each service/item given by a provider into a code for billing purposes or other medical purposes after EI eligibility.
- The diagnosis determined for EI eligibility will not necessarily be the same diagnosis used for billing purposes.

- Code to the level of specificity as required in the code manual.
- Knowledge of billing and coding requirements are professional development issues in which each payee must invest time and resources to ensure they can comply with insurance company guidelines.
- Specific questions regarding insurance denials relating to diagnosis coding should be addressed with the insurance company.
- Accurate treating diagnosis and procedure coding directly impacts correct and maximum benefit payment.
- Proper coding involves using the current ICD code set volumes to identify the appropriate codes for items or services provided (as recorded in the patient record) and using those codes correctly on the insurance claim forms.
- Use the current ICD code set codes that describe the diagnosis, symptom, complaint, condition, or problem.
- Use the current ICD code set code that is chiefly responsible for the item or service provided.
- Assign codes to the highest level of specialty. Use the fourth and fifth digits when indicated as necessary in the current ICD code set volumes.
- Code a chronic condition as often as applicable to the patient's treatment.
- Code all documented conditions which coexist at the time of the visit that require or affect care or treatment. (Do not code conditions which no longer exist).

11.2.1 The following services do not require an ICD diagnosis code:

- Evaluation/Assessments, including Audiological Exams and Medical Diagnostic services.
- Family Training and Support which includes Interpretation, Translation, Parent Liaison and Deaf Mentor Services.
- IFSP Development.
- Transportation.

12. CLAIM SUBMISSION TO EI-CBO

Electronic Billing is the preferred process whereby a provider submits claims electronically to the EI-CBO. The benefits of submitting electronically are:

- quicker turnaround (increased cash flow)
- fewer denied claims
- Efficient bookkeeping.

In order to submit electronic claims, the payee must ensure that their software or billing entity is capable of producing a file in the ANSI X12 837P or 837I formats. Claims may be submitted directly to the CBO using the software of the payee's choice or by sending claims through the QClaims billing software provided at no cost to the payee. Information on how to sign up for QClaims is available on the CBO website at www.eicbo.info. For more specific information on the format and field requirements please refer to the EI-CBO Electronic Billing Companion Guide at: www.eicbo.info/providers/CBOCompanionFINAL.pdf.

NOTE: Electronically billed claims are not guaranteed to be received at the CBO the same day they are submitted by the provider. Due to the 90-day filing limit, please allow at least 48 hours for claims to be received at the CBO.

Once you have determined that you have the means to submit claims electronically you must decide if you want to submit directly to the EI-CBO using QClaims or via a clearinghouse each of which have their own advantages such as:

12.1 EI-CBO

- Claims are processed the same day they are received from Q-Claims.
- No per claim fees.
- No setup fees.
- Minimal testing.

12.2 Clearinghouse

- Can submit all claims to one central location to be routed to multiple payers.
- Have the ability to convert non-compliant formats into ANSI X12 files.

- Please ensure your clearinghouse has a Trading Partner Relation with Availity. If you need more information or are ready to begin submitting claims directly please call the EI-CBO Call Center at: 800/634-8540.
- Electronic Remittance Advice (ERA)/ Electronic Data Interchange (EDI) 835 Files are available through Availity.
 - Contact Availity Customer Service at www.availity.com or call 1-800-282-4548.

12.3 Paper Claims Submission

All paper claim forms must be completely typed or electronically printed (including signature). The EI-CBO will not make assumptions and will deny claims that are not typed or electronically printed. The claim forms must also be fully completed with the required data elements. Partially completed forms will be denied (Attachment E) or returned (Attachment F) to the payee unpaid. Ditto marks are not acceptable.

Paper claims must be submitted by U.S. Mail, Federal Express, United Parcel Service (UPS) or other courier service to:

**Early Intervention Central Billing Office
PO Box 19485
Springfield, IL 62794-9485**

12.4 EI-CBO Insurance Billing Unit

Insurance use is mandatory in the Illinois EI system (unless the plan is self-funded, and the family has declined insurance billing) and billing private insurance companies can be very difficult at times. The CBO now offers some relief to the insurance billing requirement. This relief comes in the form of a free insurance billing service to assist the providers in billing private insurance while maximizing payments to providers.

12.4.1 CBO Billing Unit- What We Do

- Register payees by specific provider and child(ren) into the free insurance billing service.
- Code encounters.
- Prepare and submit insurance claims.
- Handle claims follow up.
- Submit any requested information to insurance carriers to assist in accurate claims processing.
- Prepare and submit appeals to insurance carriers.

- Prepare and submit secondary claims for CBO processing.
- Restricted to individual providers and provider groups of seven (7) or fewer.

Once a payee (by individual provider and child(ren)) is registered with the insurance billing service, all that is left for the payee to do, after rendering service, is to submit the required participant encounter forms within 45 days of the date of service. The Insurance Billing Unit will submit claims to the private insurance companies on behalf of the provider. The provider is responsible for obtaining and submitting a copy of the insurance Explanation of Benefits (EOB) to the CBO. Finally, the CBO will complete the claims submission process by billing the EI-CBO based on the insurance EOB provided.

To enroll into the CBO Insurance Billing Unit and for more information please visit our website <https://eicbo.info/providers/insurance-billing-unit/>.

To obtain information on procedure codes, billing rules and other EI guidelines read the Provider Handbook which can be accessed online at http://www.wiu.edu/coehs/provider_connections/documents.php.

Additional information on the CBO can be found on our website www.eicbo.info. You can also contact the Early Intervention CBO Call Center at 1-800-634-8540.

13. SUGGESTED PRACTICE FOR INTERACTING WITH PRIVATE INSURANCE COMPANIES

13.1 Verification of Benefits

- Call the Benefits Verification department of the insurance carrier. The phone number can generally be found on the back of the insurance identification card.
- Identify yourself as a provider and that you want to verify benefit coverage. Give the insurance company representative the name, employer and insurance group # for that employer, if available. The representative will ask you what type of benefits you are calling to verify (OT, PT, ST, Audiological, etc.).
- The representative may first tell you that the verification of benefit is a “quote only” and not a guarantee of payment to you. A final determination regarding reimbursement to you will be made when the actual claim is reviewed by the insurance company. The representative will tell you whether or not the service is covered, and what the rate of reimbursement is. For example, “This policy does have speech therapy benefits, payable at 80% of usual and customary charges, subject to a calendar year deductible of \$250”. That simply means that they will reimburse you for 80%

of your fee, if your fee is considered reasonable for the service provided, and if the deductible for your client has already been met for the current calendar year. (More information about deductibles is provided elsewhere in this manual.)

- If the insurance representative does not volunteer any information to you about policy limitations, be sure to ask if there are any. Here are a few examples of limitations that an insurance company might have for speech therapy benefits:
 - A pre-certification, or pre-authorization is required for office and/or home.
 - A referral must be made by the primary care physician.
 - Services must be medically necessary.
 - Services must be provided by a licensed SLP (Speech Language Pathologist).
 - Limited number of visits per year.
 - Limited number of visits per diagnosis.
 - Maximum amount payable per year.
 - Maximum amount payable per lifetime.
 - Reimbursement is made only for a particular diagnosis or event.
 - Reimbursement is made only to preferred providers for their company.
 - A lower rate of reimbursement may be available for non-preferred providers of their company.
 - Benefits payable by insurance carriers generally have some type of limitations. Be sure to ask for them if they are not volunteered to you!

- If you do not already have the address where your claims should be sent, be sure to ask for it. Many insurance carriers have separate claims-paying facilities, and if your claim is sent to the wrong address, it will add several weeks to the date you are reimbursed.

- Be sure to document every contact and get the name of the person you spoke with and write down the information you receive immediately. If you do not fully understand the quote, ask again, or feel free to call back.

- If there is benefit coverage, notify the family accordingly, so they are aware that their insurance will be billed for the services you provide. (It is possible that OT and PT may be covered, but not ST, or vice versa. Make sure the family understands which services will be billed to insurance, and which services will be billed only to the EI-CBO).

- Initiate services, and once performed, bill the appropriate payer. Be sure to always submit **ALL** claims to EI-CBO to show insurance payments even if insurance payment will be considered payment in full.

14. PRIVATE INSURANCE BILLING FOR PROVIDERS OF EARLY INTERVENTION SERVICES

This section of this booklet has been designed to provide helpful information to alleviate the fears associated with seeking insurance/third-party reimbursement. By reading the text and following the instructions as provided for filing claims, one can be very successful in receiving payment.

Resources for data gathering in regard to the types of insurance/third-party funding available are pointed out. Providers interested in accessing insurance will want to have an understanding of the variety of health-coverage plans available. The description of private insurance, HMOs, self-funded plans, and other government plans in this chapter will be helpful not only for funding purposes, but also as the provider/service coordinator consults with parents.

It outlines documentation requirements of insurance carriers and HMOs for the initiation and continuation of treatment, provides information regarding procedure codes and diagnostic codes and the resources providers will need to use.

A step-by-step approach for completion of the basic CMS-1500 claim form, which is used for private insurance, HMOs, and government plans other than Medicaid.

And finally, we will outline the life cycle of a claim from gathering the data for services rendered to recording the payment. The reimbursement and evaluation process of the billing system is also discussed.

14.1 Health Insurance Carriers and Managed Care Organizations

Currently there are over 2,000 health insurance carriers in the United States and almost 1,000 Health Maintenance Organizations (HMOs). Many of these carriers have several types of plans available to meet the needs of their insured's.

The insurance carrier may also be called an insurer, underwriter or administrative agent, but these terms do not apply to HMOs. The insurance carrier provides coverage as outlined in the contract with the entity purchasing the insurance (company or employer or individual).

It is important for a payee to gather as much information as possible when developing a system to access third-party funding (insurance and HMOs). Understanding the terminology associated with insurance and the way in which the system works will help the provider learn how to work within the insurance billing system and maximize reimbursement.

Consumers may know very little about their health care coverage and its benefits and limitations. They may understand the requirements of deductibles and coinsurance, but many do not know if their plan contains lifetime caps or limits on specific services. As the payee becomes an active participant in the

third-party process, the need for knowledge regarding the differences among insurance plans will become obvious.

Most third-party payers issue an identification card, which provides the plan information necessary for claims processing. Plan changes and open enrollment periods within various plans occur any time of year and are based strictly on the plan or employer. Therefore, it is wise for the payee to request current plan information, including “plan year” during a child’s initial enrollment and to recheck coverage with each plan year. Filing with a plan that no longer insures the child is time-consuming and costly.

Plan specifics can vary significantly by both carrier and employer specifications. Therefore, even children insured by the same carrier may have different plan benefits. The payee’s billing personnel must call the carrier; identify themselves as a provider and request information about any policy limitations regarding the services being rendered. A sample benefit inquiry form is enclosed with this material. Most carriers will provide the necessary information. Obtaining coverage limitations prior to initiation of services saves time and administrative costs. The information provided by the carrier is not a guarantee of reimbursement to the payee.

With the exception of HMO or PPO (Preferred Provider Organization) plans, most standard indemnity carriers do not require prior authorization for therapeutic services but do require standard documentation procedures. It is not unusual for a carrier to request copies of documentation.

The following are standard documentation requirements which are accepted by most insurance carriers when services are provided by licensed, certified practitioners. Each insurance plan is different, and their requirements are established independently so the required documentation may differ. Details regarding documentation requirements by insurance plans are noted at the end of this chapter.

1. Physician authorization/order.
2. Documentation of the evaluation and results (report).
3. Daily documentation of the services provided.
4. Progress documentation.
5. Documentation of continued physician authorization.
6. Documentation of discharge from treatment.

14.1.1 Third- Party Payers

Third-party payers can be categorized as follows: commercial, Blue Cross/Blue Shield (BCBS), HMO or PPO organizations, self-insured plans, CHAMPUS, Illinois Comprehensive Health Insurance Plan (CHP), Division of Specialized Care for Children (DSCC), Medicare, and Medicaid. The following pages will give a brief description of each type of plan.

14.1.2 Private Insurance

Each carrier offers many different plans. A single carrier may sell contracts to individuals and groups and may also act as an administrator for a separate entity. Even some government programs, such as Medicare, are administered by an insurance company. Furthermore, insurance carriers are often used as administrators for insurance benefits by companies who establish “self-insured plans” for their employees’ health care benefits.

Payment for services is made to the beneficiary or assigned payee based on an indemnity table or schedule of benefits for insurance covered services. Assignment of benefits by the insured does not always guarantee direct payment to the payee. Some policies limit direct payment to the insured while others disallow assignment of benefits. In these cases, the payee is responsible for tracking funding and seeking payment from the insured. In Early Intervention, we require the family to complete the Insurance Affidavit, Assignment and Release form to allow Early Intervention payees to submit claims and be reimbursed directly by most insurance plans.

The list of carriers identified at the end of this chapter represents the most frequently named and well-known carriers. The listing does not include all insurance carriers in the United States. Payees should contact the Illinois Insurance Commission for a list of current carrier sources in Illinois.

Insurance can be purchased through group or individual policies. Under group insurance, coverage is provided for a number of people through the use of a single policy. The contractual relationship is between the insurer and the named policyholder (usually the employer). Under an individual policy, the insured individual is the policyholder.

Group insurance coverage generally costs less and provides more comprehensive coverage than individual coverage because the “risk” absorbed by the insurer is less concentrated, and its administrative costs can be spread over a greater number of persons.

Three types of medical care insurance are sold by commercial carriers:

14.1.2.1 Basic Hospital/Medical/Surgical Coverage

Basic hospital/medical/surgical coverage generally refers to services specifically identified as being covered at 100% (that is, first-dollar coverage) of the charges up to specific limits. The plan may specify a deductible, and services may be provided in various settings including a hospital, home or office. Examples of basic coverage could be: a) 180 days per illness per calendar year for hospital inpatient room and ancillary charges, or b) \$250 per calendar year for outpatient diagnostic services.

14.1.2.2 Major Medical Coverage

Major medical coverage is designed to activate once the basic limits are met and to cover items not paid under the basic contract. This type of coverage is usually dependent on deductible and co-insurance provisions which require that the insured incur an out-of-pocket expense each calendar year in

conjunction with the payment of major medical benefits. There is usually a lifetime maximum major medical benefit total.

14.1.2.3 A Comprehensive Medical Plan

A comprehensive medical plan combines the aspects of both the basic and major medical and concepts. It is an increasingly popular mode of coverage from the insurer's and, to a lesser extent, from the insured's perspective. The insurer saves money by reducing the administrative costs in distinguishing between basic and major medical claims and by eliminating the "first-dollar" basic benefit. The insured saves premium expenses in exchange for foregoing the 100% basic coverage. A common example of a comprehensive plan would be a \$200 deductible followed by 80% coverage (or 20% co-insurance) of the next \$4,000 followed by 100% coverage per individual – all on a calendar year basis applicable to covered services. In this example, the insured's liability would be \$1,000 per person with perhaps a \$3,000 family out-of-pocket limit.

General insurance questions can be referred to:

**Illinois Department of Financial & Professional Regulation
320 West Washington, Floor 6
Springfield, Illinois 62767
Consumer Division (Health Section)
(217) 782-4515 or (217) 782-7446**

14.1.2.4 Blue Cross Blue Shield (BCBS)

Nationwide, the most recognizable service type organization involves the Blue Cross/Blue Shield (BCBS) concept. Although originally separate entities, Blue Cross and Blue Shield have merged to provide comprehensive coverage for hospital and non-hospital services. A person becomes a member or subscriber by entering into a contract with the BCBS plan. BCBS functions much as a commercial carrier does, except in its language definitions for contracts and subscribers: BCBS routinely requires providers to meet BCBS standards and enroll in order to become participating providers. The provider requirements for reimbursement by BCBS vary by plan and state.

Historically, there was a clear distinction between the BCBS and "commercial" carriers. The Blue Cross/Blue Shield concept was based on the promise of provision of hospital/medical services as required by the patient. The insured person was described as a subscriber to Blue Cross/Blue Shield plans; the plans established contractual relationships with hospitals and doctors. In the early 1980's, the BCBS concept began to change. The district Blue Cross and Blue Shield plans combined to form Blue Cross/Blue Shield of Illinois. Blue Cross/Blue Shield of Illinois now operates as a commercial carrier.

14.1.2.5 Managed Care Alternatives

Managed care is a concept, which integrates the insurance (financing) aspect with the medical/health care delivery and management function. Managed care is in contrast to the traditional system of medical care

consumption in which the consumer obtains medical care from a variety of providers whose income increases directly with the number and complexity of services rendered. This alternative delivery system is available through the Preferred Provider Organization (PPO) or the Health Maintenance Organization (HMO) model.

14.1.2.6 CHAMPUS/CAMPVA

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is a federal program created for the benefit of dependents of personnel serving in the uniformed services. The federal government maintains CHAMPUS, not as an insurance program, but rather as a service-connected benefit. Hence, the sponsor (the person on active duty) is not covered under the CHAMPUS program; only dependents are covered as are retired personnel and either dependent. Civilian Health and Medical Program of the Veterans Administration (CHAMPVA) follows the CHAMPUS model and serves families of veterans with 100% service-connected disability or the survivors of a veteran who died as a result of a service-connected disability.

It is expected that CHAMPUS/CHAMPVA dependents will not seek civilian medical care except when such care is not available at a nearby military medical-care facility. Prior authorization for medical care in the civilian community is required if the sponsor lives within 40 miles of a military or public health care facility.

Covered CHAMPUS services rendered at nonmilitary facilities are generally the same as those services covered by commercial medical insurance policies. Coverage may have deductibles by individual and/or family and percentage of coverage varies based upon active duty status.

CHAMPUS coverage is secondary to commercial health plans, but primary over other governmental programs such as Medicaid.

Fiscal agents for the CHAMPUS/CHAMPVA programs are chosen on a nationwide competitive basis. The current CHAMPUS fiscal agency for Illinois is Tricare/Humana as of 2018.

14.1.2.7 Illinois Comprehensive Health Insurance Plan

The Illinois General Assembly created a Comprehensive Health Insurance Plan (CHIP) May 1, 1989, to offer a program of health insurance to certain eligible Illinois residents who have been denied major medical coverage by private insurers. The program is designed to provide health insurance (within the constraints imposed by a limited amount of state resources) to eligible residents who can afford but are unable to find major medical insurance coverage in the private market due to a pre-existing health condition or disability. CHIP policies are underwritten by the State of Illinois, by authority of the CHIP Act, amended by Public Act 87-560, effective September 17, 1991, which partially subsidizes the cost of the plan. The plan administrator is Blue Cross/Blue Shield of Illinois.

Information can be obtained by calling or writing to:

**Office of the Board of Directors
Illinois Comprehensive Health Insurance Plan
400 West Monroe Street, Suite 202
Springfield, Illinois 62704-1823
Phone 800/962-8384**

14.2 Types/Categories of Insurance Plan Coverage

14.2.1 HMO Plans

A health maintenance organization (HMO) is a system for organizing, delivering and financing health care. HMOs can have a variety of forms, names and sponsors and can be either for profit or nonprofit. The Health Maintenance Organization and Resource Act (42 U.S.C., 300C) defines a HMO as a “legal entity which provides a prescribed range of services known as basic health services.” Basic health services must be provided to HMO members either directly or indirectly by the staff of the HMO or through medical groups or individual practice associations. There are many different arrangements for providing the services. Routinely, the insured of a HMO does not pay the medical provider on a fee-for-services basis. Instead the premium paid by the patient or the patient’s employer covers all care outlined in the policy, and the patient does not incur deductibles and coinsurance costs. The provider is paid directly by the HMO. There are HMO plans, however, that require the patient to pay a fixed co-pay amount for specified care, such as \$10 per physician visit.

The HMO must control the provision of services to contain costs. It is the controlled utilization of services that is the specialty of the HMO. Consequently, HMO managers are reluctant to pay for services performed by non-HMO staff. A joint agreement between the provider and HMOs should be pursued to best serve the child enrolled in the HMO.

HMOs are popular prepaid health plans because the insured or the employer pays a fixed premium and the patient knows that additional medical costs will not be incurred. HMOs routinely provide or arrange for the provision of the following services: physician and hospital services; laboratory and x-ray procedures; mental health and therapeutic services; prenatal, postnatal and well-baby-care; immunizations and routine health examinations; and prescription drugs with a co-payment. Some HMOs also provide for long-term rehabilitative services, home health services, and eye and dental care. A HMO charges a fixed periodic premium independent of the quantity of services provided a particular enrollee. The implication is the HMO does not gain any substantial revenue by providing more services.

HMOs attempt to offer a competitively priced insurance product by controlling costs through utilization management and by contracting with selected referral providers. HMO enrollee have a legal right to medical care provided by a HMO, in contrast to the traditional sector in which the medical care provider has a right to accept or not accept a particular patient. HMOs accept voluntary enrollment of subscribers for a specified time frame and/or geographic location.

HMOs reimburse providers by two methods:

- **Fee-for-service basis** – Independent providers and group practices contract with the HMO to provide a specific range of services. Under this reimbursement method, the medical provider agrees to supply the services to the HMO’s enrolled participants on a discounted fee-for-service basis. The provider may discount the usual and customary fee charge by as little as 5 percent or as much as 30 percent. The discount varies by contract.
- **Capitation rate** – The HMO determines a fixed rate of payment for the HMO enrollee, based on age and other statistical variables, and pays the HMO enrollees identified primary physician a fixed rate per month. Any additional care or services authorized by the primary physician must be paid for from the capitation rate previously determined. The capitation rate method is primarily used in the group practice model, and the system only remains profitable for the group practice when there are many healthy HMO enrollees to cover the cost of care for the enrollees in need of greater medical care. HMO members agree to see a primary-care physician who is either employed by or contracts with the HMO. The primary physician serves as the “gatekeeper” by providing routine medical care and initiating referrals to medical care specialists who may be employed outside the HMO.

The majority of HMOs require prior authorization (otherwise known as pre-certification) for therapeutic and psychological services. This means that the HMO must grant permission for the provision of services prior to the initiation of intervention. Initial prior authorization is often obtained verbally by telephone, but some HMOs have established written procedures for obtaining such authorization. Various terms such as Prior Authorization or Pre-Certification or Pre-Determination may also be used for these situations.

Basically, HMOs require the same documentation procedures as the insurance industry, plus the additional step of obtaining prior authorization. Thus, it is imperative that the prior authorization mechanism be documented by the provider. The HMO may issue a prior authorization or certification number which must be noted on the claim form when submitting the bill for services. Documentation of the HMO contacts and the type, frequency and duration of services authorized assists when collecting reimbursement. An HMO may even request copies of progress notes when treatment continues for more than 90 days.

The duration of therapeutic intervention a HMO will authorize also varies by HMO policy and plan specifics. Some HMOs will grant a limited number of therapeutic visits and others will authorize a specific time period. Most HMOs do not authorize more than 90 days of services without reauthorization. A provider payee may require practitioners to obtain prior authorization, or it may establish a system whereby documentation is provided to a billing specialist who then secures the HMO’s authorization.

Regardless of who obtains the prior authorization, the term of that prior authorization must be documented. Prior to expiration of the original authorization period, new prior authorization must be obtained.

14.2.2 Preferred Provider Organization (PPO)

Most PPOs adhere closely to the managed-care model (that is, utilization management) and offer economic incentives to enrollees who select low-cost providers. PPOs are often associated with self-insured (funded) plans.

A PPO is similar in operations and benefits to an HMO that functions in an independent practice model. The PPO contracts with selected health care providers to treat enrolled patients for a negotiated fee. PPOs do not usually assume the risk that the HMO does for significant medical illness by the patients enrolled, however. The PPO patient is usually enrolled in the health care plan of a major carrier or a self-insured plan.

PPOs were developed as an alternative to the traditional fee-for-service system that requires the patient to assume deductibles and coinsurance and the HMO system that may contain many restrictions. The PPO allows the patient to reduce the cost of care and expand benefits by obtaining health care services from the preferred providers or to seek health care from non-participating providers at a higher cost.

Each PPO develops its own standards and contracts to meet the needs of the patients and their employer or contracting group.

PPOs maintain a strong utilization review program and monitor participating providers' practice and referral patterns. Similar to a HMO, the PPO may require prior authorization for therapeutic intervention. The provider payee needs to determine the plan specifics when a PPO is identified as a child's health carrier. PPOs generally enforce strong utilization review programs and require patients to seek care through their established provider network. PPOs will allow a practitioner to enroll as a preferred provider and then monitor the type, frequency, duration and outcome of services.

14.2.3 Self-Insured Plans (a.k.a Self-Funded Plans)

Self-insured plans represent a form of health insurance under which the health care benefits are designed and dictated by the employer. Due to the rapidly increasing high cost of health care, this type of health plan is growing because major corporations have found it less costly to provide their own health care plans and dictate the benefits. Families with a self-funded plan may choose to decline private insurance billing for EI services.

Some employers and employee groups have been able to achieve cost savings by assuming all or a portion of the risk of health benefits offered to their employees. Some organizations have also demonstrated the ability to realize savings by processing health claims and paying medical care providers directly. These situations of assumed risk and claims administration are usually referred to as "self-insured" or "self-funded" or "self-administered."

An employer that performs these functions from within its own resources is not "insured" since there is no transfer of risk. The employer retains the potential for loss for all covered medical expenses incurred by the employees and dependents. An employer can transfer some of this risk by purchasing "stop-loss"

coverage from a commercial carrier. For a premium, the commercial carrier will assume the covered medical expenses of an individual who has reached some stated threshold, perhaps \$50,000 in medical expenses in any one policy year. The employer may also pay for commercial coverage, which reimburses the employer for medical expenses paid out in total, perhaps \$1,000,000 for all covered employees.

There are three primary administrative options available to those entities that self-fund. Under an Administrative Services Only (ASO) arrangement, an insurance company provides for the actuarial and benefit design functions, claims processing, data retention and analysis, and stop-loss coverage. A third-party administrator (TPA) can provide all of the services of an ASO except, because it is not an insurance company, stop-loss protection. Self-administration means the employer/health and welfare plan performs the functions that would have been contracted out to a TPA.

Self-insured health plans are not subject to the state laws that regulate the insurance industry. The Employee Retirement Income Security Act (ERISA) prohibits individual states from considering self-insured/funded plans as insurance companies for regulation purposes.

14.3 Insurance Documentation

Most insurance carriers and HMOs outline the minimal documentation they require for funding. Some insurers require physician orders for initiation and continuation of treatment, for example, but do not require standardized and formal daily notes or progress note documentation. They may request working papers and notes regarding the services provided. Payees must be able to produce standardized documentation regarding the services provided, and the progress obtained by the child is more likely to receive reimbursement (see the 'Early Intervention Documentation Requirements' section of this booklet).

The development of standardized procedures should be based upon knowledge of both the Medicaid requirements and the provider requirements and procedures. It is important to incorporate both methods in order to minimize paperwork and avoid allocating extra staff time to the completion of documentation. The integration of the two methods can be done within the IFSP process.

Documentation serves the following purposes:

- It provides a record of the child's condition and the course of treatment from initiation of the IFSP through the time of discharge.
- It serves as an information source for children and their families.
- It facilitates communication among the professionals involved with the child.
- It furnishes data for use in treatment, education, research and funding.
- It provides a method for documenting quality assurance.

There are two major components to documentation: the individual child and the service provided and funding for services provided. Child-related documentation includes evaluation reports, IFSPs, daily notes, consultation reports, progress reports and discharge summaries. Third-party access forms include child identification forms, referral authorization, parental consent forms along with insurance information, physician orders, practitioner credentials/license, service logs and tracking forms.

14.3.1 Third Party Access Forms

- **Physician Authorization:** In order for a provider to access private insurance plans or HMO/PPO plans, it may be necessary to obtain a physician authorization. If permission is obtained by verbal orders, written documentation must still be obtained. To document verbal orders, a telephone order form should be completed and sent to the physician for signature, providing a written record of the date the services were authorized. The physician orders should be maintained in the treatment record. The CFC is required to have a copy. The CFC should work with the provider to obtain one and copies must be shared by both parties to ensure compliance. Physician authorization for treatment can also be obtained by adding a line to the bottom of the evaluation or assessment report and forwarding it to the child's attending physician for signature and dating. Physician reauthorization for continuing intervention can be obtained using the progress summary form or the consultation report. Providers initiating a third-party billing may not wish to contact physicians by telephone or send IFSP reports without explanation. A copy of any authorization form(s) related to communication with the physician should also be provided to the Central Billing Office.
- **Participation/Consent Form:** Parental consent forms should state the payee's authority to access third-party payer sources and should request parental authorization for access of the family's health insurance. The form includes a statement for the authorization to release information to insurance that is necessary for processing a claim and assigns benefits to the provider.

15. COLLECTION AND TRANSMISSION OF TREATMENT DATA

15.1 Health-Related terminology

The health care industry has developed specific language, terminology and definitions that relate to services provided by health care professionals and billed to third-party payers for funding. It is important to understand and use these terms. This chapter provides procedure codes and diagnostic codes that payee's will need to use in order to access third-party reimbursement. Correct and maximum benefit payments are dependent on the accurate coding as to diagnoses and procedure codes.

15.2 Diagnosis and Procedure Coding

Procedural coding systems were developed to standardize the communication of data regarding the treatment of patients by health care providers to third-party payers. Diagnostic coding was developed for medical records and statistical purposes and is used to track diseases; measure incidences of injury, mortality and illness; classify medical procedures; assist in medical research; and evaluate appropriateness of patient care.

Third-party payers use coding systems for statistical purposes and for benefit determination. Most third-party payers use computer programs to determine whether the procedures submitted are necessary for the treatment of the reported diagnosis and whether the services are a fundable benefit of the insurance contract or government program, as well as the total amount of benefits payable for individual services. Procedure and diagnosis coding is a precise process which requires an understanding of medical terminology and clinical procedures. The payee should assign third-party activities to employees or contractors who have knowledge of medical terminology. It is the responsibility of the practitioner to assign diagnosis and procedure codes for services, while the claims specialist reports procedure and diagnosis information to the third-party payer.

The payee should establish a system to generate and transmit this treatment-related information in the most efficient method possible. The goal should be to maximize third-party funding; however, the process should not interfere with the actual provision of services to the child.

15.2.1 Diagnostic Codes

Providers utilize the International Classification of Diseases Codes (most current Revision), Clinical Modification or ICD CM for diagnostic coding. Developed and maintained by the World Health Organization, ICD codes are used to describe illnesses, injuries and accidents for the purpose of medical research and reporting. The ICD code set system numerically classifies diagnosis information by a code number, which payee's need to use submitting claims. The ICD code set includes diseases listed in both a tabular list and an alphabetic index.

Most insurance carriers, HMOs and Medicaid agencies require the use of ICD codes in the billing format. There is adequate space for listing up to 12 codes on the standard CMS-1500 claim form. The primary diagnosis, the condition considered to be the major health problem for which the particular treatment is provided, should be listed first. A secondary diagnosis is a medical condition which has manifested itself at the same time as the primary condition and alters the treatment required or lengthens the expected recovery time of the primary condition. All diagnoses affecting the current treatment of the child should be included.

Benefit payments depend on accurate, precise, and meaningful coding techniques. Failure to provide a current and correct ICD code, use of a code inconsistent with the service or a code which does not substantiate the need for the level of service provided, or use of multiple diagnosis codes that confuse the claims examiner will cause payment problems. Confusion on the part of the payer can be avoided by including the ICD code on each claim and limiting the codes used to those most pertinent and most clearly medically related to the services provided.

For diagnostic codes, please refer to the current ICD code book available from local medical bookstores or use an internet search for resources.

15.2.2 Procedure Codes

For Billing Private Insurance, CHAMPUS, HMOs, PPOs

The procedure code is one the most important items to be entered on the insurance claim form. Since it is necessary for the insurance carrier to understand exactly what service or procedure was provided, this code must reflect that service exactly. The procedure coding scheme is a precise process requiring knowledge of medical terminology and clinical procedures. Since the practitioner is the professional with the best ability to judge the service provided, it should be the practitioner's responsibility to determine the procedure code that best reflects the child's services.

Current Procedural Terminology (current Edition) or CPT, is a systematic listing and coding of procedures and services performed by or under the supervision and/or prescription of a physician. CPT became the procedural coding system in 1985 when the federal Healthcare Financing Administration and the American Medical Association published the Healthcare Common Procedural Coding System (HCPCS), a national-level coding system for reporting health care services to the Medicare and Medicaid Programs. Under CPT guidelines, each procedure or service is identified by a five-digit code. The practitioner should select the procedure code that most accurately identifies the services performed. EI should be billed only with the authorized procedure code. Insurance should be billed with the most appropriate procedure code for the treatment performed. The procedure codes billed to EI and insurance may or may not be the same. It is unnecessary to provide the written description on the filing form when the numeric code is provided. In fact, if both are given and the description provided is different from the procedure referenced by number, it may cause the carrier to reject the claim or to request additional information. For procedure codes, refer to the current Physicians' CPT code book. Books listing the codes may be purchased from a local technical bookstore or use an internet search for resources.

NOTE: Early Intervention Assistive Technology (durable medical equipment) requires coding from the HCPCS code set.

15.3 Insurance Filing Form Preparation

After written permission has been obtained from the child's family, and insurance benefits have been verified, Early Intervention authorized services may be rendered.

The payee will bill the appropriate party. If the child is covered only by a private plan, then the payee will file only to the private plan. If the child is covered by both a private health plan and AllKids, the provider must bill insurance first. The EI-CBO will reimburse payees as the payer of last resort. Private insurance plans are billed first. Payees may bill the EI-CBO first only for families with no private insurance, have AllKids only, in instances where insurance cannot be billed for the services provided, or if the payee has a pre-approved waiver or exemption.

15.3.1 Establishing Rate Scheduled

The payee must determine a “routine and customary” fee for each type of service (procedure) to be filed to the third party. The charges billed across plans should be the same; that is, a fee charged to private insurance should be the same as that charged for the same service to the EI-CBO, IDHS, DSCC, AllKids, etc. Insurance carriers and HMOs routinely reimburse payees on a standardized U&C (usual and customary) fee-per-procedure code, which is calculated based on the standard fees submitted by providers within the same grouping and geographical area. Some carriers fund for the fee submitted by the provider if the fee is lower than the customary fee. Payees may wish to call other local health care providers to obtain data regarding community standards when developing a fee scheduled.

Payees of health care routinely calculate U&C charges based on the costs of providing services. Payees need to consider the following parameters when determining fees for related services:

- Equipment costs and depreciation.
- Consumable supply costs.
- Indirect department costs - costs associated indirectly with services, (such as typing, office supplies, billing forms, scheduling, etc.).
- Personnel costs - direct treatment time and preparation time for practitioner’s administrative costs.
- Profit margin.

In the private sector, a payee’s schedule of charges reflects a relation of its costs to provide the service. A private provider might justify its charges as follows: there are fixed costs to recover and variable costs which are incurred in proportion to the volume of services provided. Costs are classified as direct (for example, a therapist’s salary) or indirect (for example, assigned overhead). A profit factor and an allowance for estimated unreimbursed charges are added to the estimated costs, resulting in gross revenue requirements. The amounts of projected services to be provided are calculated on a weighted average treatment unit basis. Estimated gross revenue is divided by the projected total treatment units to arrive at the amount charged to the patient per unit of service.

Other options are available for determining rates for related services delivered to children with disabilities. The payee could check the local private market, calculate an average of what private providers are charging for the various services, and then deduct a “profit” factor to arrive at a rate for third parties. Otherwise, if the payee contracts with a particular practitioner to render the majority of a particular type of service, it could use the contractual rate as a proxy of the value of services provided by the payee’s employees. For services by practitioners employed by a payee on a full-time basis, the annual contract for salary plus fringe benefits divided into annual hours employed may be used as the basis for determining a unit. A unit equals 15 minutes of service.

Another option to determine usual and customary fees might be to use a fee survey and obtain three fee charges for each service. These figures can be obtained from health care agencies or private practitioners within the local service region. The three figures are used to identify an average fee for each service.

15.3.2 The Insurance Claim Form (CMS-1500)

Treatment date and charge information flows from the payee to the third-party payer via the claim form. The standard claim form, adopted by the American Medical Association and required for use by HIPAA is the Uniform Health Insurance Claim Form, known as the CMS-1500, or Standard Claim Form. Hospitals may use the UB04 Claim form.

Payees must use the accepted standard claim forms. These forms are available from many sources including a medical supplier, medical bookstore, county medical society, office supply stores or the American Medical Association in single form, snap out form and continuous forms for use with computer. Payees may decide to contract with a billing agent who chooses to use a computer-generated format of the CMS-1500 often referred to as a “superbill” or to complete purely “electronic claims.” Electronic claims, eliminating the use of paper, provide the billing data from the place of service directly to the insurer’s computer system and assist the payee/biller in a timely payment schedule.

15.3.4 CMS-1500 Requirements for Completion

The CMS-1500 Claim Form is separated into two parts. The first part (blocks 1-13) contains information about the patient and the insured. The second part (blocks 14-33) contains information regarding the services provided by the practitioner. Please note that not all sections need to be completed.

The following procedures should be used when completing CMS-1500 form. (See copy of the CMS-1500 form in Attachment B which highlights the required fields for EI-CBO billing.)

NOTE: Requirements for insurance company billing may differ. Providers must obtain and comply with the billing requirements from the individual insurance companies they are billing.

15.3.5 UB-04 Requirements for Completion

Although the UB-04 Claim Form is not separated into two parts, the information fields are very similar to that of the CMS-1500. Please also note that not all sections need to be completed

The following procedure should be used when completing the UB-04 form. (See copy of the UB-04 form in Attachment D which highlights the required fields for EI-CBO billing.)

NOTE: Requirements for insurance company billing may differ. Providers must obtain and comply with the billing requirements from the individual insurance companies they are billing.

15.4 The Insurance Reimbursement Process

Once the CMS-1500 or UB04 is generated and checked for accuracy, it should be transmitted to the applicable claims office. Timely filing is mandatory, since third-party payers generally have individual requirements specific to an individual plan. A payee should develop its own directory of those companies and contact persons with which it conducts substantial activity. Under ideal circumstances, the filing office will settle within three to six weeks.

NOTE: Refer to section “OVERVIEW OF THE EI-CBO BILLING PROCESS/Time to Bill” for details on secondary billing to CBO after Insurance Reimbursement is complete.

With an assignment of benefits, obtained as part of the parent consent/participation, the payee should be paid the appropriate insurance proceeds. Most plans will enclose an explanation of benefits (EOB) to explain the calculations involved in the process.

Follow-up with the third-party payer is required when:

- It is necessary to respond to requests for clarification or additional information.
- An unusually long period of time has elapsed after the claim is filed without a response.
- The response is inadequate.

Inquiries from third-party payers may include questions regarding an incomplete or inaccurate form, or requests for additional records to document or support the information submitted.

It is only through experience and persistence that the payee or their insurance representatives can become proficient in the effective follow-up process with their third-party counterparts. It is helpful if the payee or their third-party specialist has knowledge of insurance terminology, claims processing methods across plans, and benefit structures of private and public plans.

A payee or their insurance representative must learn how to deal with all aspects of each problem. Most situations regarding problems of private plans can be resolved over the telephone with the insurance plan’s adjuster.

It is the responsibility of the payee or their insurance representative to audit insurance claim payments to verify that the maximum benefits have been paid. If there is a question concerning payment, contact the plan’s adjuster. Perhaps with additional documentation, an adjustment will be made. If there is a question of benefits payable, request that the claims adjuster send a copy of the plan booklet/document.

15.5 Reporting/Tracking Third-Party Payments

As a control function, a payee should set up an accounting system. This can be used to evaluate satisfaction of end goals, such as effective maximization of third-party payments, and to assist in the satisfaction of means goals, such as efficient completion of insurance claim forms. The child’s financial account stored electronically and in paper form, might include:

1. Current policy details or requirements of third-party plans covering the child.
2. Postings from service logs to reflect summary details of frequency and type(s) of service.
3. Entries to reflect the sequence of claim submissions and the amounts funded by third-party payers.

A properly implemented and maintained “related-service” financial account system can provide the necessary details to respond to individual family inquiries regarding the provider’s access of their insurance plans.

As the explanation of benefits and funding are received, the payee will want to document the activity. The explanation of benefits reports the processing of the claim and the benefits payable or denied or applied to the deductible. It is important to record claims activity (charges billed and results) by service category, date, site, and practitioner. It might also be important to be able to provide the family, a monitor or auditor a statement of an individual child’s activity (charges billed by service category and amount of funding) if questions arise.

In all instances when an insurance carrier has been billed for EI services, whether paid in full, paid in part, or denied by the carrier, the payee must provide the EI-CBO a copy of the third party (insurance) explanation of benefits and a completed claim with the data elements required by the EI-CBO within 90 days of the date recorded on the third party explanation of benefits. This information is used for the purpose of cost analysis and demographic data collection.

16. GLOSSARY OF TERMS USED BY EI-CBO AND INSURANCE CARRIERS

835 File – An electronic transaction that provides claim payment information. These files are used by practices, facilities and billing companies to auto-post claim payment into their systems.

Adjudicate – To determine whether a claim is to be paid or disallowed.

Adjuster – An individual often referred to as a claims representative, who acts for an insurance company in the settlement of a medical claim.

Adjustments – Changes made to correct an error in billing, processing of a claim or as a result of retroactive rate change.

Allowed charges – The specific part of the reported charge that qualifies as a covered benefit, eligible for payment.

Assignment of benefits – An agreement between the insured and provider which authorizes the insurance carrier to pay benefits directly to the provider of services.

Attending physician – The physician in charge of the patient’s medical care.

Beneficiary – T person eligible to receive benefits under a health care plan.

Benefit – An amount payable by an insurance plan or Medicaid for services covered by the plan.

Birthday rule – The rule associated with the process of coordination of benefits in which when both parents have health care coverage, the insurer of the parent whose birthday falls first in a calendar year becomes the primary carrier.

Capitation – A method of payment for health care services in which the provider is paid a fixed fee for each person enrolled in an insurance plan. The monetary allowance for each enrollee is usually based on average costs adjusted for age, sex, and so forth, not on the type or number of services rendered to individual patients.

Carrier – The insurance company, HMO or PPO which writes, underwrites, and/or administers the health insurance policy, HMO or PPO Plan, also referred to as the insurer.

CBO (Central Billing Office) – Office responsible for claim processing among other things under the Early Intervention program.

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) – The federally funded health benefits program designed to provide the military personnel and eligible beneficiaries a supplement to medical care provided in military and public health service facilities, such as for services received in another facility not connected to the military base services.

Centers for Medicare and Medicaid Services (CMS) – Formerly “Healthcare Financing Administration (HCFA)” - federal governmental agency responsible for the administration of the Medicare and Medicaid programs under the auspices of the Department of Health and Human Services.

Child & Family Connections (CFC) office – Early Intervention local office assigned by geographic location of where child resides.

Claim – The written or electronically submitted request for payment of benefits for covered services; standardized claim forms include the HCFA/CMS-1500 and UB-04/CMS-1450.

COBRA – (Consolidated Omnibus Reconciliation Act of 1985) – Federal legislation which mandates to some persons who would otherwise lose group health insurance coverage the right to continue coverage under the group plan for a limited time period. Employees who terminate employment for any reason other than gross misconduct, those whose hours are reduced, and dependents of these employees may continue the group coverage for up to 18 months. Dependents may continue coverage for up to 36 months if they lose coverage for any of the following reasons: death of the employee, divorce from the employee, reaching the maximum age allowed under the policy, or employee eligibility for Medicare. Premium costs for COBRA coverage are borne entirely by the insured and may total up to 102% of the total employer/employee premium contribution under the group plan.

Coinsurance (Co-payment) – A provision of an insurance plan which stipulates the beneficiary’s share of the cost of covered services, usually stated as a percentage of allowed charges.

Comprehensive medical insurance – A policy which provides both basic and major medical health insurance protection. Benefits are usually paid at a set percentage of all covered charges after satisfaction of a periodic deductible.

Congenital anomaly – A medical condition, present at birth, which is significantly different from the norm.

Consent – Voluntary agreement, based on an understanding of the nature of a particular action and the risks involved.

Consultation – Direct intervention with the child, parent or LEA staff about the treatment plan of the child.

Coordination of benefits (COB) – For a patient covered by more than one insurance, the plan provides for carriers to take into account benefits payable by another plan and determine primary and secondary responsibility.

Covered services – Those health care services provided to the patient which are stipulated by an insurance plan as eligible for benefit payments.

Customary charge – A dollar amount representing the lowest charge to a client, including any discount, for a specific service during a specific period of time by an individual provider.

Current Procedural Terminology – Listing of medical terms and identifying codes for reporting medical services and procedures, developed by the American Medical Association. Updated occasionally so ensure the most current version is used when billing.

Deductible – Specific dollars outlined in the insurance plan that must be paid before the benefits of the plan become payable.

Denial – A claim for which payment is disallowed.

DHS or IDHS – Illinois Department of Human Services is the agency overseeing Early Intervention program.

Dependent – Those individuals, other than the insured, who are eligible for coverage under the plan; generally, the insured’s spouse and children.

Diagnosis – The identity of a condition, cause or disease.

Direct service – Professional services provided in a face-to-face contact with the child.

Direct supervision – Supervisor (licensed/certified personnel) physically present on school premises while services are being provided with the possibility of face-to-face contact with the person being supervised.

Disallow – To determine that a billed service(s) is not covered by Medicaid and will not be paid.

Disability income insurance – A type of health insurance that provides periodic payment, in replacement of income, when an insured is disabled due to illness, injury or disease.

DOS – Date of service.

DSCC (Division of Specialized Care for Children) – Illinois agency that provides care coordination for families and children with special health care needs which may lead to disabilities.

Duplicate claim – A claim which has been submitted or paid previously.

Duplicate service – Claims submitted by same payee for same service type on same service date. Second claim will be denied for payment as against EI policy. This includes claims under different authorizations but for same service type if services occurred same day.

Durable medical equipment – Equipment which (1) can withstand repeated use and (2) is used to serve a medical purpose. Example: Orthotics.

Early Intervention (EI) – Lead agency assigned to administer IDEA Part C program.

Electronic claim – Processing and delivery of a claim from one computer to another through a form of magnetic tape or telecommunications.

Electronic Remittance Advice (ERA)- An electronic remittance advice (ERA) is an electronic data interchange (EDI) version of a medical insurance payment explanation. It provides details about providers' claims payment, and if the claims are denied, it would then contain the required explanations.

Eligible – One who is qualified for benefits.

Eligibility file – A file containing individual records for all persons who are eligible for coverage by the plan.

EOB – (Explanation of Benefits) – Written statement from the third-party payer which explains details of benefit calculations.

EPSDT – (Early and Periodic Screening, Diagnosis and Treatment) – A federally mandated program for eligible individuals under the age of 21.

ERISA – (Employee Retirement Income Security Act) – Congressionally enacted pension reform legislation of 1974 that includes stipulations which have evolved to provide insulation for self-funded plans, from individual state's insurance regulations.

Error code – A numeric code indicating the type of error found in processing a Medicaid claim.

Exclusions – Services, conditions, or products which are specifically listed in a policy as not covered.

Fee for service – Payment by a third-party payer to providers of health services of specific amounts for service given.

Fiscal agent – An organization authorized to process claims.

Flexible Spending Account (FSA) - A Flexible Spending Account (also known as a flexible spending arrangement) is a special account that the insured individual puts money into that the insured may use to pay for certain out-of-pocket health care costs. Employers may make contributions to your FSA but are not required to.

Gatekeeper – Refers to the physician(s) in prepaid health care plans who perform initial medical exams or screen prospective care prior to referral to other specialists or allied health professionals within or outside the plan.

HFS (or IHFS) – Illinois Healthcare and Family Services is the agency overseeing Medicaid (AllKids).

Healthcare Administration Common Procedure Coding System (HCPCS) – Includes two levels of standardized procedure codes:

- Level 1 codes are CPT numeric procedure codes.
- Level 2 are national, HCFA, alpha-numeric (A through V) codes for procedures not included in CPT codes.

Health Reimbursement Account (HRA) - Health Reimbursement Arrangements (HRAs) are employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the arrangement. Health Reimbursement Arrangements are sometimes called Health Reimbursement Accounts.

Health Savings Account (HSA) - A type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. By using untaxed dollars in a Health Savings Account (HSA) to pay for deductibles, copayments, coinsurance, and some other expenses, you may be able to lower your overall health care costs. HSA funds generally may not be used to pay premiums.

Health Maintenance Organization (HMO) – An alternative delivery system in which enrollees pay a fixed payment for comprehensive health care services emphasizing preventative and primary care.

Indirect service – Directing the teachers/aides in providing related services in the classroom as non-direct intervention with the child.

Insurance Affidavit, Assignment and Release form – Consent for allowing third party access to private insurance usage including claim submission, correspondence and contact.

Insured - The person who is the primary policy holder in relation to the insurance plan.

Intermediary - Insurance carrier or data processing company which processes Medicare or Medicaid claims on behalf of the government.

International Classification of Diseases, Clinical Modifications – (ICD-CM) - Coding manual developed by the National Center for Health Statistics and others to standardize disease and procedures classification. A listing used by providers in coding diagnosis on claims. Must ensure using most current edition available.

Long-term disability income insurance – A policy that pays benefits to a disabled person for as long as the person is disabled, within policy limitations.

Major medical insurance – Health insurance policy that provides for reimbursement of major illness and injury to insured, usually includes a deductible then provides for expansive benefits.

Maximums – Upper dollar limit a carrier will reimburse for a specific benefit or policy.

Medicaid – A federal government-sponsored medical assistance program that enables eligible recipients to obtain medical benefits outlined within the state Medicaid guidelines.

Medically needy – Individuals whose income and resources equal or exceed those levels for assistance established under a State or Federal plan but are insufficient to meet their costs of health and medical services.

Medical necessity – A service reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a disability or cause physical deformity or malfunction, and if there is no other equally effective course of treatment available or suitable for the recipient requesting the service.

Medical record – Data or information retained in some media form and related to the health status of and treatment rendered to a patient.

Non-covered services – (1) services not medically necessary; (2) services provided for the personal convenience of the patient; or (3) services not covered under the health care plan.

Non-participating Provider (NonPar) – A provider who has not signed a contract with a carrier (HMO or PPO) nor agreed to provide services under the terms of the carrier and/or specific plan.

NPI (National Provider Identifier) – The Early Intervention Program requires the individual rendering provider NPI number be registered with Health and Family Services. This number is also required to be listed on all claim forms submitted to the Central Billing Office.

Overutilization – Any usage of health care programs by providers and/or recipients not in conformance with both State and Federal regulations and laws (include fraud, abuse and defects in level and quality of care).

Participating provider – A medical care provider who has established a contractual relationship with a third-party payer to provide certain services to members of a plan.

Payee (Provider/Payee) – Based on tax identification number used to submit claims for the Early Intervention program. Can be individual person, person “doing business as”, or agency

Payment – Reimbursement to the provider of services for a claim incurred that is a covered benefit.

Peer Review Organization – The utilization and quality control review unit that reviews the validity of diagnostic information: the completeness, adequacy and quality of care provided; the appropriateness of admissions and discharges; and the appropriateness of services provided. Many professional associations have established quality of care and peer review organizations, standards and committees who complete the review process.

Plan of Care – Written statement that details the patient’s condition, functional level, treatment goals and objectives, the physician’s modifications to the plan, and plans for ongoing care, and potential for discharge from treatment.

POS – Place of service.

PreAuthorization – The approval by the third-party payer indicating the proposed treatment will be covered.

Precertification – The process of providing required notice of proposed treatment to the patient’s third-party payer.

PreDetermination – An administrative procedure whereby a provider submits a treatment plan to the carrier before treatment is initiated to determine the cost of the services.

Pre-existing Condition – An injury, disease, or disability that afflicted the insured prior to issuance of the insurance policy, and which frequently excludes the insured from coverage totally or for a specific period of time.

Preferred Provider Organization (PPO) – A PPO is similar to an HMO that uses the open panel plan of preferred providers. Individual health care practitioners become preferred providers and are paid on a negotiated fee-for-service basis by a purchaser group. The patient routinely participates in the health care plan of a commercial carrier, which monitors utilization of service.

Primary carrier – Insurance carrier or HMO/PPO which has first responsibility for payment under coordination of benefits.

Primary diagnosis – The condition considered to be the patient’s major health problem for which treatment is rendered and on which the physician’s claim is based.

Prior authorization – Process of obtaining permission, to provide services, from the carrier who will reimburse the service.

Procedure code – A statistically based code number used to identify medical procedures performed by a provider.

Progress note – A dated, written notation in the child’s record detailing an encounter with the child and the child’s response to the encounter.

Provider – The person, professional, or group practice certified to provide covered health care services to the child.

Provider agreement – A contract between the provider and carrier that states the conditions of participation and reimbursement.

Provider number – A nine-character code assigned to each provider of Medicaid services in Illinois for identification purposes.

Quality assurance program – Activities that measure the kind and degree of excellence of health care delivered. Quality of care is measured against pre-established standards. There are federal and state guidelines that relate to quality assurance programs within HMOs.

Reimbursement – The amount of money remitted to a provider.

Release of Information – The patient’s (or parent or guardian’s) signature on a consent form that allows the release of information necessary to the settlement of the claim.

Screening – The use of quick, simple medical procedures carried out among large groups of people to sort out apparently well persons from those who have a disease or abnormality and identify those in need of more definitive examination or treatment.

Secondary carrier – The insurance carrier that is second in responsibility within the coordination of benefits.

Suspended claim – “In Process Claim” which must be reviewed and resolved.

Third-party payer – A public or private entity that insures against risk of loss or reimburses for expenses incurred in relation to the receipt of medical care services.

UCR - (usual customary reasonable) – A third-party’s method of benefit calculation which takes into account charges billed by all providers within a particular discipline and geographic region.

Unit – A 15 minute increment of therapeutic treatment or diagnostic assessment.

16.1 Early Intervention Partners Contact Information

For problems or questions regarding...

- **Child enrollment and authorizations:** Contact the local Child and Family Connections office.
- **Insurance & billing:** Contact the EI-CBO Call Center at (800)634-8540. Hours of operation are Monday through Friday, 7:30 a.m. to 5:00 p.m. or visit the EI-CBO website at www.eicbo.info.
- **Training:** Contact the Illinois Early Intervention Training Program at (866)509-3867 or visit their website at www.illinoiseittraining.org.
- **Payment information:** Visit the Illinois Office of the Comptroller to check payment status at www.ioc.state.il.us.
- **Monitoring:** Contact the Early Intervention Monitoring Project at (800)507-5057 or visit their website at www.eitam.org.
- **Provider enrollment and/or credentialing:** Contact Provider Connections by telephone at 800/701-0995, or by fax at (309) 298-2305. In addition, further information is available at their website at www.wiu.edu/providerconnections.
- **Latest Early Intervention program information:** Visit the Provider Connections website at <http://www.wiu.edu/ProviderConnections/> or the 'Important Provider Notices' page on the EI-Central Billing Office website at www.eicbo.info.
- **Insurance:** Contact the Illinois Department of Insurance at (877) 527-9431. Further information is available at their website at www.insurance.illinois.gov.

17. ATTACHMENTS

ATTACHMENT A: Sample Authorization

REPORT: HSPR0771	STATE OF ILLINOIS CORNERSTONE	RUNDATE: 04/12/2016
	EARLY INTERVENTION PROGRAM – AUTHORIZED PROVIDER SERVICES	TIME: 10:45 PAGE: 1
CFC SITE: 999999 #30 CFC - SUBURBIA		TELEPHONE: (217) 555-1234
SERVICE COORDINATOR: 999999001 JOHNSON, ALBERT		
A	CHILD EI NUMBER: 123456	PARTICIPANT ID: S111-9901-9901-00
	NAME: SMITH, JOHN	DATE OF BIRTH: 11/25/2013
	CATEGORY: EI EARLY INTERVENTION	
	<hr/>	
B	RESIDENCE	TELEPHONE: (217) 555-1235
	123 HAPPY LANE	
	SPRINGFIELD, IL 62777	
	CONTACT: MARY SMITH	RELATIONSHIP: MOTHER
	AUTHORIZATION START DATE: 02/01/2016	END: 10/31/2016
C	←-----→	
	B AUTHORIZED PAYEE: ABC THERAPY COMPANY	
	123 MAIN STREET SPRINGFIELD, IL 62777-7777	TELEPHONE: (217) 555-0001
D AUTH TYPE: IFSP-DIRECT SERVICE	E SERVICE: SPEECH LANGUAGE THERAPY	
F METHOD: INDIVIDUAL	G PLACE OF SERVICE: 12 / HOME (OFFSITE)	
H PROCEDURE: 92507 / SPEECH THERAPY SERVICES		
I FREQUENCY: 2 PER: WEEK	←-----→ FOR: 60 MINUTE(S)	
K AUTH NUM: 123456-791-001-00	L PRINT DATE: 01/30/2016	M DATE: 02/04/2016
N COMMENTS: JOANIE CUNNINGHAM, SLP		
O PRIVATE INSURANCE: 02/PRIVATE INSURANCE BILL		

- A – Child’s information, including, child’s name, home address, C’Stone identification #, EI #, DOB, contact name, relationship, & contact phone #
- B – Agency the authorization has been assigned to
- C – Date range for when the specified service is authorized to be performed
- D – Type of authorization, see Glossary for definitions
- E – Service type, i.e., OT, PT, SLP, etc.
- F – Method in which the service must be provided, i.e., individual, group, purchase, repair, etc. See Glossary for additional information
- G – Type of location the service will be provided, i.e., offsite, onsite, other, etc.
- H – Authorized procedure code, see Chapters 7-22 for your provider type for additional information
- I – A brief description of the procedure code listed in H
- J – Number of times and intensity the service is to be provided, i.e., number of times per week, month, etc. for number of minutes, miles, etc.
- K – Authorization to use when billing
- L – Date the authorization was printed by the Service Coordinator
- M – Date the authorization was created or last updated
- N – Rendering provider, this includes Associate-Level providers. Correct name must be listed here if the provider is with an agency. If not, the Service Coordinator must be notified to make the necessary corrections.
- O – Insurance requirement, i.e., bill insurance first, insurance billing not required. See CBO billing handbook for additional information

ATTACHMENT B: CMS-1500 Form Example

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA <input type="checkbox"/> PICA <input type="checkbox"/>																																																																																	
1. MEDICARE <input type="checkbox"/> (Medicare) MEDICAID <input type="checkbox"/> (Medicaid) TRICARE <input type="checkbox"/> (ID#DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input checked="" type="checkbox"/> (ID#) OTHER <input type="checkbox"/>				1a. INSURED'S I.D. NUMBER (For Program in Item 1) 155155																																																																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, Child				3. PATIENT'S BIRTH DATE MM DD YY 06 02 19 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>				4. INSURED'S NAME (Last Name, First Name, Middle Initial) Doe, Child																																																																									
5. PATIENT'S ADDRESS (No., Street) 1234 East Street CITY: Anytown STATE: IL ZIP CODE: 60066 TELEPHONE: ()				6. PATIENT RELATIONSHIP TO INSURED Self <input checked="" type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street) 1234 East Street CITY: Anytown STATE: IL ZIP CODE: 60066 TELEPHONE: ()																																																																									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. RESERVED FOR NUCC USE c. RESERVED FOR NUCC USE d. INSURANCE PLAN NAME OR PROGRAM NAME				10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)				11. INSURED'S POLICY GROUP OR FECA NUMBER NONE a. INSURED'S DATE OF BIRTH MM DD YY 06 02 19 SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/> b. OTHER CLAIM ID (Designated by NUCC) c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.																																																																									
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. SIGNED: SIGNATURE ON FILE DATE																																																																																	
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: SIGNATURE ON FILE																																																																																	
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 FROM MM DD YY TO MM DD YY																																																																									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. NPI				18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) Associate Provider Name (if applicable)																																																																																	
20. OUTSIDE LAB? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO \$ CHARGES																																																																																	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind: 0 A. F802 B. C. D. E. F. G. H. I. J. K. L.																																																																																	
22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER Discipline Description (if applicable)																																																																																	
<table border="1"> <thead> <tr> <th>24. A. DATE(S) OF SERVICE</th> <th>B. PLACE OF SERVICE</th> <th>C. EMG</th> <th>D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)</th> <th>E. DIAGNOSIS POINTER</th> <th>F. \$ CHARGES</th> <th>G. DAYS OR UNITS</th> <th>H. RPTOT Freq Plan</th> <th>I. ID. QUAL</th> <th>J. RENDERING PROVIDER ID. #</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>05 12 20 To 05 12 20</td> <td>12</td> <td>97110</td> <td>A</td> <td>100.00</td> <td>4</td> <td></td> <td>NPI</td> <td>36124567 967654321</td> </tr> <tr> <td>2</td> <td>05 19 20 To 05 19 20</td> <td>12</td> <td>97110</td> <td>A</td> <td>100.00</td> <td>4</td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td>3</td> <td>05 26 20 To 05 26 20</td> <td>12</td> <td>97110</td> <td>A</td> <td>100.00</td> <td>4</td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td>4</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td>5</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td>6</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> <td></td> </tr> </tbody> </table>												24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. RPTOT Freq Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #	1	05 12 20 To 05 12 20	12	97110	A	100.00	4		NPI	36124567 967654321	2	05 19 20 To 05 19 20	12	97110	A	100.00	4		NPI		3	05 26 20 To 05 26 20	12	97110	A	100.00	4		NPI		4								NPI		5								NPI		6								NPI	
24. A. DATE(S) OF SERVICE	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. RPTOT Freq Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #																																																																								
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6								NPI																																																																									
25. FEDERAL TAX I.D. NUMBER 361234567				SSN EIN <input type="checkbox"/> <input checked="" type="checkbox"/>		26. PATIENT'S ACCOUNT NO. NONE		27. ACCEPT ASSIGNMENT? (For gov't claims, see back) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 300.00		29. AMOUNT PAID \$ 0.00		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.) ANN THERAPIST SIGNED: DATE: 06052020				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # () ABC THERAPY SOURCE 4321 SOUTH STREET ANYTOWN, IL 60066 a. 123456789 b. 361234567																																																																									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

ATTACHMENT D: Transportation Billing Form Example - Page 1

**DHS EARLY INTERVENTION
TRANSPORTATION BILLING FORM**

Illinois Department of Human Services
EI CENTRAL BILLING OFFICE
P.O. Box 19485
Springfield, IL 62794-9485
CBO: 1-800-634-8540

MUST COMPLETE ENTIRE FORM BEFORE SUBMITTING

Child's Name: Child Doe Payee Name: ABC Transportation Service
 Child's Address: 1234 East Street Payee Address: West Street
 City, State, Zip: Anytown, IL 60066 City, State, Zip: Anytown, IL 60066
 EI #: 155155 Payee Tax ID#: 36-4567890
 Birth Date: 06 / 02 / 2019 Vehicle License Plate #: ABC123
Month Day Year

MUST BILL ONE DATE OF SERVICE PER LINE IN CHRONOLOGICAL ORDER AND ONLY ONE DISCIPLINE OF SERVICE PER BILLING FORM								
Date of Service MM-DD-YY	Procedure Code	POS	Departure Address Dep. Code / Dep. Time		Destination Address Dest. Code / Dest. Time		*Loaded Mileage	Charge
06/05/20	A0120	99	123 East St. Anytown	4321 S. St. Anytown				
			R	10:00 AM	D	10:30 AM		7.26
06/05/20	A0425	99	1234 East St. Anytown	4321 S. St. Anytown			6	4.92
			R	10:00 AM	D	10:30 AM		
06/05/20	T2001	99	1234 East St. Anytown	4321 S. St. Anytown				2.87
			R	10:00 AM	D	10:30 AM		
06/05/20	A0120	99	4321 S. St. Anytown	123 East St. Anytown				7.26
			D	11:35 AM	R	12:05 AM		
06/05/20	A0425	99	4321 S. St. Anytown	123 East St. Anytown			6	4.92
			D	11:35 AM	R	12:05 AM		
06/05/20	T2001	99	4321 S. St. Anytown	123 East St. Anytown				2.87
			D	11:35 AM	R	12:05 AM		
Departure/Destination Code - (use Alpha code in column)							Billed Charges	
D – Medical Services -or- R – Residence							Total Charges	30.01

- This form can be used to bill for **Early Intervention Transportation Services**, only.
- Services must be provided by an enrolled transportation provider or driver employed by the transportation provider.
- Must bill CBO no later than **ninety (90)** days following completion of services.
- Incomplete billing forms will be returned to the provider.
- *Mileage to and from each location where Early Intervention services are provided while child is in the vehicle.

I certify that I provided the services identified above, or a driver employed under my supervision provided the services.

ABC Transportation Service 07/01/2020
 Name of Enrolled Provider or Transportation Company (Print Legibly) Date

Revised 06/13

ATTACHMENT D: Transportation Billing Form Example - Page 2

Please forward ALL billings and explanations of benefits pertaining to this authorization to:
Illinois Department of Human Services
El Central Billing Office
 P.O. Box 19485
 Springfield, IL 62794-9485
 CBO Phone Number: 1-800-634-8540

BILLING/AUTHORIZATION INFORMATION

- Must have authorization in hand prior to providing billing for Early Intervention services in order to ensure payment for service.
- Billings may be submitted to the Central Billing Office by completing the DHS Transportation Billing form.
- The Central Billing Office requires all provider billings related to this authorization be received no later than ninety (90) days following the completion of the services.
- Billings for authorized services must be billed using the National Level II HCPCS Procedure Codes.
- The authorization is limited to the time period, provider, services, supplies or equipment specified on the authorization.
- The Central Billing Office uses a schedule of allowable fee reimbursement for all authorized services.
- By accepting the service authorization, the provider agrees not to seek further payment from the child or the child's family for such authorized services beyond the amounts available from the Central Billing Office.
- By accepting the service authorization, the provider agrees to maintain records which include at a minimum:
 - 1) client information including name, address and IDPA Recipient identification number and
 - 2) copy of transportation invoice, including type of vehicle used, license plate number and name of provider.

PARENTAL RIGHTS

- For Early Intervention parents shall be informed in their native language or normal mode of communication that they have the right to:
- A timely, multidisciplinary evaluation and assessment;
 - Appropriate early intervention services for the child and family if eligibility is determined;
 - Refuse evaluations, assessments and services, and may decline such a service after first accepting it, without jeopardizing other early intervention services;
 - Written prior notice before provider proposes, or refuses, to initiate or change the identification, evaluation or placement of the child, or the provision of services to the child or family;
 - Confidentiality of personally identifiable information;
 - Review and correct records relating to evaluations and assessments, eligibility determinations, development and implementation of Individual Family Service Plans, individual complaints dealing with their child, and any other area under these rules involving records about the child and child's family;
 - Use an advocate in any and all dealings with the early intervention system; and
 - Use administrative and judicial processes to resolve complaints.

STATE OF ILLINOIS CERTIFICATIONS

Affirmative Action/Nondiscrimination: The Provider/Vendor certifies they comply with all Federal and State nondiscriminatory equal opportunity affirmative action orders and regulations. The Provider/Vendor will not engage in discrimination or harassment against any person because of race, color, religion, sex, national origin, ancestry, age, marital status, handicap, unfavorable discharge from the military, or status as a disabled veteran or veteran from the Vietnam era. This certification applies to admission, employment, access to and treatment in the Provider/Vendor programs and activities.

Americans With Disabilities Act (ADA): The Provider/Vendor certifies they are in compliance with Title I through V of the Americans With Disabilities Act signed into law July 26, 1990.

Bribery Clause: The Provider/Vendor certifies that they have not been convicted of bribery or attempting to bribe an officer or employee of the State of Illinois, nor has the Provider/Vendor made an admission of guilt of such conduct, which is a matter of record.

Drug Free Workplace Act: The Provider/Vendor certifies that they are in compliance with Public Act 86-1459 and will not engage in the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance.

Health Care Professionals: The Provider/Vendor certifies they are not involuntarily sanctioned from participating in and/or are not inappropriately being reimbursed under the Title XVII (Medicare) Program, the Title V (Maternal and Child Health) Program or any other section of the Social Security Act. Health care professionals excluded from programs of federal and state agencies shall also be excluded from participation in this program.

Maintaining of Records: The Provider/Vendor agrees to maintain and make available for a minimum of 6 years after completion of the services adequate books, records and supporting documents that support each date of service billed to the DHS/CBO, including daily documentation of services related to the authorization.

Health Insurance Portability and Accountability Act (HIPAA): The provider/vendor certifies that they will comply with HIPAA Standards 45 CFR Parts 160, 162, any and any additional part that may be finalized in the future, where appliance.

The vendor certifies that they have:

- a) not been delinquent in paying a child support order as specified in Section 10-65 of the Illinois Administrative Procedure Act (5 ILCS 100/10-65);
- b) not been in default of an educational loan in accordance with Section 2 of the Education Loan Default Act (5 ILCS 385/2),
- c) not have served or completed a sentence for a conviction of any of the felonies set forth in 225 ILCS 46/25(a) and (b) within the preceding five years (see 30 ILCS 500/50-10); and
- d) not been indicated as a perpetrator of child abuse or neglect in an investigation by Illinois or another state for at least the previous five years.

ATTACHMENT D: Transportation Billing Form Example - Page 3

Instructions to Complete the DHS Early Intervention

Transportation Billing Form

Before completing a DHS Transportation Billing Form to submit claims to the DHS/CBO, please read the following instructions carefully:

- Providers must read and agree to the billing/authorization information, parental rights and certifications on the back of the billing form.
- Billing forms must be typed or electronically printed. The DHS/CBO will not make assumptions and will deny claims that are not legible or are incomplete. Partially completed billing forms will be returned to the provider unpaid.
- Include the child's name (first and last), the child's complete address, the six (6) digit EI number and date of birth on each claim.
- Include the payee name, complete provider address, the Taxpayer Identification Number (Payee Tax ID) and the vehicle license plate number.
- Services must be provided by an enrolled transportation provider or driver employed by the transportation provider.
- Bill one (1) date of service per line in chronological order.
- Bill only six (6) lines of service per billing form.
- Enter the complete departure and destination addresses including city and state, in the space provided.
- Indicate the alpha code D (medical service) or R (residence) in the departure and destination code spaces provided.
- Enter the departure and destination times in the space provided, including the city and state.
- For tax and service car mileage codes A0425, enter the total loaded miles one way. When a round trip is provided, two mileage procedure codes and service lines must be completed. The DHS/CBO will not accept claims for mileage codes that have been billed as a round trip on one service line.
- For private auto mileage (A0090), enter total loaded miles for a round trip on one service line.
- Type or print legibly the full name of the enrolled transportation provider or company on the line that asked for a Name of Enrolled Provider or Transportation Company and date the claim form.
- Bill for loaded mileage only. Loaded mileage means that the child is in the vehicle.

The DHS/CBO will not accept claims that do not include the full departure and destination addresses, the departure and destination codes, the departure and destination times and the license tag number.

ATTACHMENT E: Situation Code Meaning – Page 1

Situation Codes on Provider Claim Summary

Situation Code	Message on PCS	Meaning	What should I do?
1	Child is not eligible on service dates.	This means the child's IFSP dates do not cover the service date(s) being billed or the child is now three years of age. IFSP's and authorizations end the day before the child's third birthday	If the child has not reached the age of 3, contact your CFC to verify IFSP dates. If the service date is the day prior to the child's third birthday or after, the claim is not billable to the CBO.
4	Program benefit is limited to one medical diagnostic evaluation per child, per year.	Only one diagnostic evaluation is approved for a child one time per year.	Verify the date of service the last diagnostic evaluation was billed for.
6	No matching authorization found.	There is no authorization in the CBO system for the services being billed.	The provider should contact the Help Desk if you have a printed copy of the authorization. If not, contact your CFC. Do not bill the CBO until you verify the authorization is in the CBO system.
13	Each line of service must be filled out completely. Ditto marks are not acceptable.	The CBO will not accept claims with ditto marks.	Fill out each line of service completely and resubmit the claim to the CBO.
16	Charges exceed the EI program allowable rate.	The CBO system cuts back any charges billed by the provider that is more than the EI rate or fee.	Verify you billed the CBO for the correct intensity and procedure code. Contact the Help Desk if an error was made by the CBO. If you billed incorrectly, resubmit the claim with the correct information and write "correction" on the claim. If there was no error, the balance should be written off and not billed to the family.
19	Insurance carrier's explanation of benefits was not received.	This means that an EOB is needed for the date(s) of service billed on the claim form. The insurance carrier's EOB is required for payment consideration by the CBO.	Bill the insurance carrier and resubmit the claim to the CBO with the EOB attached. If you have billed the insurance carrier, resubmit the claim with the EOB attached. If a waiver is in place or the insurance coverage has been terminated contact the Help Desk for assistance.
21	Authorized procedure limit has been exceeded. Please check your authorization for frequency/ intensity of service.	This means there are no dollars/services left on the authorization.	Check your authorization for the intensity and frequency that DHS has agreed to pay.
24	Unable to pay the evaluation because the IFSP meeting has not been billed to the CBO or was not billed as authorized. If the meeting was not attended a letter from the CFC is required.	Per DHS policy, the provider must attend the initial IFSP meeting in order to be paid for the evaluation. If the IFSP meeting has not been billed and paid at the CBO the evaluation will not be paid.	Visit the DHS website regarding this policy. If the provider was unable to attend the IFSP meeting, contact the CFC for a letter. Attach the letter to the evolution claim and submit to the CBO for payment.
26	Intensity billed over authorized amount.	The intensity billed on this claim exceeds the authorized amount.	Check your authorization for the intensity DHS has agreed to pay.
27	Charges have been paid previously.	The CBO system automatically denies any charges that have already been paid.	Review the PCS and check your files for payment. If payment cannot be located, contact the Help Desk who can provide the claim number and date of the PCS the claims data displays on.
28	The amounts billed to insurance and the CBO don't match.	This means that provider has billed one amount to the insurance company and a different amount to the CBO.	Review the claims billed to the insurance and the CBO. Resubmit the claim to the CBO with the same billed amount billed to insurance carrier.
30	Child has secondary insurance, which must be billed and requires EOB's from both insurance companies be submitted to the CBO.	This means the provider must bill the primary and secondary insurance before billing the CBO.	The provider must bill the secondary insurance and resubmit the claim to the CBO with EOB's from both insurance carriers attached.

ATTACHMENT E: Situation Code Meaning – Page 2

31	CBO records indicate this child's insurance has changed. Resubmit the claim with an EOB from the current insurance carrier.	This means the family has a new insurance carrier.	The provider should contact the family or CFC to obtain the latest insurance information.
33	This service was previously paid by insurance and therefore, the denial submitted is not payable.	This means the CBO has an insurance EOB on file from the insurance carrier showing they previously made payment on another dates of service.	Check the denial reason on the insurance EOB. The provider or biller should contact the insurance carrier for more information regarding the recent service denial. The provider may need to resubmit the claim to the insurance depending on the denial reason.
34	This service is not billable to insurance per DHS policy. Refund the insurance payment and re-bill CBO with claim and proof of refund.	The service billed is not billable to insurance therefore should not be billed to insurance per DHS rule and policy.	The provider should refund the insurance company then resubmit the claim to the CBO along with the proof of the refund to the insurance attached to the claim.
35	The CBO cannot process payment on this claim until an explanation of the denial code is submitted.	This means there is no denial reason explanation listed on the insurance EOB. The CBO cannot pay without a denial reason.	The provider should resubmit the claim and the entire EOB, including the denial reason, to the CBO for consideration of payment.
39	The denial reason on the EOB is insufficient or not payable by the CBO.	This means the CBO cannot pay the claim based on the denial reason give on the EOB.	The provider should review the denial reason on the EOB. The insurance may be asking for more information from the provider, which means the claim may need to be resubmitted to the insurance again before submitting to the CBO.
40	The claim cannot be paid because the associate level provider was not credentialed on the date of service billed.	This means the latest information received by the CBO from Provider Connections indicates the associate level provider was not credentialed on the date of service.	You will need to contact Provider Connections to verify.
41	The procedure code/modifier combination submitted is not a valid service under the Early Intervention program. Please correct these codes and resubmit them for payment.	This means the CBO does not recognize the procedure code billed.	You should refer to the DHS website for the procedure code list. Correct the code on your claim and resubmit.
42	The type of service/discipline interpreted or translated is missing. Ex: PT,OT ,ST,SR written in box 23 of CMS -1500 claim form.	This means the CBO needs to know what type of discipline was interpreted because many providers interpret for more than one service type in a day. This may cause claims to deny as a duplicate.	The provider should write the type of service they interpreted for in box 23 of the CMS-1500 form. See the 'Billing Information for Providers' booklet at www.eicbo.info for more information.
45	There is a DHS insurance exemption in place for this service date. Refund the insurance and re-bill the CBO with proof of refund.	When there is an exemption in place the provider cannot bill the insurance for services.	The provider should refund insurance their payment and re-submit the claim to the CBO with the proof of refund.
46	The CBO is in receipt of an insurance EOB that is not an original copy. Resubmit the claim with an original copy of the EOB attached.	This means the original EOB appears to have been adjusted by hand or altered in some way from its original form.	The provider should obtain a corrected EOB from the primary insurance or provide the CBO with an original unaltered copy along with the claim.
47	The insurance carrier's EOB received in not legible.	This means the CBO cannot clearly read the EOB.	The provider should provide the CBO with a legible copy of the EOB along with the claim.
48	Claim exceeds the 90 day filing limit.	The CBO requires all provider billings related to a child's authorization be received no later than 90 days following the completion of the	If the claim was delayed due to primary insurance, you should resubmit the claim along with an informational letter to the attention of the Claim Processing Supervisor for review.

ATTACHMENT E: Situation Code Meaning – Page 3

		services or from the last communication from the insurance company.	
49	The ICD-10 treatment diagnosis is missing or invalid.	The CBO requires an ICD-10 treatment diagnosis on the claim form.	The provider should correct the claim and resubmit the claim to the CBO.
53	Private insurance declined. Refund	Parent declined use of private insurance. Please refund insurance and resubmit to CBO with proof or refund.	The provider should refund the insurance company and resubmit proof of the refund to the CBO. Proof of refund includes, a copy of the processed check issued to the insurance carrier and a copy of the adjusted EOB from the insurance carrier. See 'How to Send Resubmitted or Corrected Claims to the Central Billing Office' at www.eicbo.info for additional information.
54	Private insurance declined. Resubmit	Parent declined use of private insurance. Resubmit to insurance as billed in error then resubmit correction to CBO.	The provider should notify the insurance carrier that the claim was billed in error. Resubmit the adjusted insurance EOB along with a claim form to the CBO. See 'How to Send Resubmitted or Corrected Claims to the Central Billing Office' at www.eicbo.info for additional information.
99	Freeform message.	This is freeform message entered by an EI Claims Processor. This information is only pertinent to a certain claim or provider.	Read the message carefully. Contact the Call Center for further explanation of message.

ATTACHMENT F: Returned (Mail Back) Claim Form

RETURNED CLAIM FORM

Early Intervention Central Billing Office
 P.O. Box 19485
 Springfield, IL 62794-9485
 1-800-634-8540

The attached bill is being returned because it does not include complete information as required by EI-CBO. Please provide additional details in the areas as marked below and resubmit the original claim with the corrections made, along with this CBO dated request sheet to the above address. Please re-review the entire claim for completeness before resubmission

Missing / Incomplete / Incorrect Information

- Date(s) of service
- Child's 6-digit EI number
- Child's date of birth
- Child's address
- Length of session
- Provider name
- Provider address
- FEIN / Social Security #
- Place of service code
- ICD-10 Code
- Local HCPC / Procedure code
- Fee(s) charged for service

- Enrolled Provider supervising Associate

Other Reason(s) for return

- Child not enrolled in EI system
- Description of equipment is required
- Provider/Physician not known at this location
- Provider/Physician not enrolled in EI system
- Documents received without claim form. Use CMS 1500 or UB04 form
- Only 6 lines of service per claim (in chronological order)
- Illegible claim / provider name

- Insurance EOB missing required data for processing
- Associate level provider not EI credentialed
- Both providers on claim are EI credentialed. Identify provider who actually did services.
- Discrepancy with EI #/ Child's name
- Services cannot be paid before they are rendered
- EI-CBO Provider Claim Summary or Denial Letter needed with corrected claims
- Other – See CBO Comments

CBO Comments _____

Provider Comments _____

Date Returned to Provider _____ **Processor Initials** _____

11/19/18 PZM

ATTACHMENT G: Sample Provider Claim Summary

PROVIDER CLAIM SUMMARY

IMPORTANT: This document contains information intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law.

If you are not the intended recipient (or an employee or agent responsible for delivering this to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (toll-free 1-800-634-8540) to arrange the



EARLY INTERVENTION
CENTRAL BILLING OFFICE
P.O. BOX 19485
SPRINGFIELD, IL 62794-9485
1-800-634-8540

JANE MARIE DOE
123 EAST STREET
ANYTOWNUSA, IL 60055

Date: 04/08/2020

The following is to notify you of the action taken on your claim(s). Checks are sent under separate cover by the state Comptroller's Office. Please reference the Invoice Number below with the Invoice Number shown on the state check.

Page: 1 of 9

361234566

Provider Service Information	Service Dates	Units/Miles	Billed	Not Allowed	Remarks	Benefit Allowed
Invoice: 92999998	Provider: 99999999	Jane Marie Doe				
		Ref: 123456789			Claim: 20XXX-XX-XXX	
Child Doe						
Occ Therapy Ind Off	02/19/2020	4 units	175.00	100.28	16	74.72
Occ Therapy Ind Off	02/26/2020	4 units	175.00	100.28	16	74.72
			350.00	200.56		149.44
16	Charges exceed the EI program allowable rate.					
		Ref: 123456789			Claim: 20XXX-XX-XXX	
Child Doe						
Occ Therapy Ind Off	02/21/2020	4 units	175.00	100.28	16	74.72
			175.00	100.28		74.72
					** Paid by insurance:	-66.07
					Payable:	8.65
16	Charges exceed the EI program allowable rate.					
		Ref: 123456789			Claim: 20XXX-XX-XXX	
Child Doe						
Occ Therapy Ind Off	03/02/2020	4 units	175.00	100.28	16	74.72
			175.00	100.28		74.72
					** Paid by insurance:	-66.07
					Payable:	8.65
16	Charges exceed the EI program allowable rate.					
		Ref: 123456789			Claim: 20XXX-XX-XXX	
Child Doe						
Occ Therapy Ind Off	03/05/2020	4 units	175.00	100.28	16	74.72
			175.00	100.28		74.72
16	Charges exceed the EI program allowable rate.					

ATTACHMENT H: Sample Comptroller Check

AF4302454

DANIEL W. HYNES
COMPTROLLER - STATE OF ILLINOIS



DOE JANE MARIE
1234 EAST STREET
ANYTOWNUSA, IL 62005

Agency * HUMAN SERVICES
Warrant Number AF4302454
Warrant Amount \$616.35
Warrant Date 06-01-2005
Voucher Number PV444590333364

Vendor Number ***** B

Payment Description: Part C Early Intervention Medical Services to Provider
Not Subject to Contractual Withholdings
Service Dates: 04/08/05-04/26/05
Department of Human Services 1300

Invoice Number	Inv. Date	Customer ID	Billing Account Number	Net Amount
90333364	052505			616.35

Payment of interest may be available if the State fails to comply with the Illinois Prompt Payment Act. (30 ILCS 540/1)
* For questions, contact: HUMAN SERVICES 800-843-6154/800-447-6404(TTY)

AF4302454
REFER TO THIS NUMBER

DRAWN BY DANIEL W. HYNES
ON THE TREASURER OF THE STATE OF ILLINOIS

COMPTROLLER 20-2180

PAY THIS AMOUNT: **Six Hundred Sixteen*****35/100** **\$*****616.35**

VOID AFTER TWELVE MONTHS

DATE ISSUED 06-01-2005

TO THE ORDER OF JANE MARIE DOE
1234 EAST STREET
ANYTOWNUSA, IL 60055

AF4302454

COUNTERSIGNED AND REGISTERED: *Judy Baar Topinka*
Judy Baar Topinka, Treasurer, State of Illinois

GRANTED, DRAWN, AND RECORDED: *Daniel W. Hynes*
Daniel W. Hynes, Comptroller, State of Illinois