

**Early Intervention
Central Billing Office
(EI-CBO)**



**BILLING INFORMATION
FOR PROVIDERS**

July 2002

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INTRODUCTION

The purpose of this informational material is to assist the Department of Human Services Early Intervention Provider 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 independent provider, the billing agent contracted by the independent provider, or the billing staff for a provider agency.



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 multidisciplinary 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. The report is generated by the service coordinator after developing the IFSP. This is a family-focused document that contains important information regarding the child and the family. The IFSP is given to the family and service providers, as well as to other related parties as necessary.

Tips

The following tips are provided to avoid delays in the processing of your claims:

- 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.
- Claims will be paid only if the service provided matches the procedure code and location on the service authorization.
- If you believe the child requires increased frequency or length of service, or additional services beyond what you have been authorized to perform, please contact 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 web site, <http://www.eicbo.info> and the DHS web site, <http://www.dhs.state.il.us/ei>.



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AUTHORIZATIONS

The individual provider must be enrolled with the EI-CBO 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 <http://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.**

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.

Providers must refer to the child's 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 provider verifying that services are authorized.

Requests for assistive technology devices require medical review and prior approval before an authorization can be issued with the exception of ear molds 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.



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OVERVIEW OF THE EI-CBO BILLING PROCESS

Billing Rates

Providers are expected to bill the EI-CBO at their usual billing rates with the understanding that the EI-CBO will always reimburse up to the established Early Intervention rates. Providers 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. Providers who accept an Early Intervention authorization agree NOT to bill a child’s family for payment above the Early Intervention rates.

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 they must work under the supervision of a professional level EI credentialed provider who has a pre-approved authorization for the services to be provided.

The EI-CBO can reimburse an agency 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 and is employed by the same agency the authorization was issued to. This policy ONLY permits substitution of those providers who are enrolled under the same agency’s tax payer identification number.

Private Insurance Use

When a child enrolled in Early Intervention is covered by a private insurance plan, all credentialed providers must bill the insurance before submitting claims to the EI-CBO unless an exemption or waiver has been approved for the child.

Services Billable to Insurance

- Assistive Technology (Durable Medical Equipment and Supplies)
- Aural Rehabilitation Services
- Developmental Therapy
 - DT/hearing
 - DT/vision
- 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

Services Not Billable to Insurance

- Audiological Exam
- Medical Services (for diagnostic /evaluation)
- Family Training and Support
- Parent Liaison
- Interpretation
- Transportation
- Evaluation Services
- Assessment Services
- IFSP Development Services

Time to Bill

Claims for authorized services rendered on or after service dates of July 1, 2005 must be submitted to the EI-CBO no later than ninety (90) days following service delivery. 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.

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 web site at <http://www.comptroller.state.il.us>. An online vendor's guide to accessing payment information is also available at the web site.

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.



BILLING 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 Public Aid 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 must be readable and understandable to families and to persons who will monitor or audit your billing to the EI-CBO. Documentation must include:

1. Physician authorization/order
2. Documentation of evaluation/assessment results (reports)
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 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.
4. Progress documentation
5. Documentation of continued physician authorization
6. Documentation of discharge from treatment
7. 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.

Transportation providers' documentation should include:

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

Interpreter's documentation should 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 you as the provider who wrote the 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

In addition, providers should 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 Explanation's 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 authorization.

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

HOW TO BILL THE EI-CBO

The EI-CBO will only accept the HCFA/CMS-1500 form and the UB-92 (HCFA-1450) form from providers billing for evaluations, assessments and direct services. Providers and Parents and/or Guardians who bill the EI-CBO for transportation services must use the DHS Transportation Billing Form. No other forms will be accepted.

All claim forms must be legible. They must be hand printed, typed or electronically printed. The EI-CBO will not make assumptions and will deny claims that are not legible. The claim forms must also be fully completed with the required data elements as stated in this section. Partially completed forms will be denied (Attachment E) or returned (Attachment F) to the provider unpaid. Ditto marks are not acceptable.

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 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 or print legibly 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.
- If the provider consults with the family via the phone, it is considered administrative time and is non-billable time. Refer to the Early Intervention Service Descriptions, Billing Codes and Rates document found on the DHS and EI-CBO web sites for more information regarding billable/non-billable time.

HCFA/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)
- ICD-9 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)
 - 03 – Regular Nursery/Day Care (offsite)
 - 11 – Service Provider Facility (onsite)
 - 12 – Home (offsite)
 - 16 – Family Day Care (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)
- Taxpayer identification number (payee tax ID) (field 25)
- Patient Account number – if applicable (field 26)
- Total Charge (field 28)
- Name of enrolled provider who performed or supervised services and date (field 31)
- Complete Payee name and address (field 33)

UB-92 Requirements – (Attachment C)

- Complete Payee name and address (field 1)
- Must include the taxpayer identification number (payee tax ID) (field 5)
- Child’s name (last and first) (field 12)
- Child’s complete address (field 13)
- Date of Birth (field 14)
- 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/serv units (field 46)
- Amount Billed (field 47)
- Total amount billed (field 55)
- Indicate the two (2) digit place of service (POS) location code (field 56)
 - 03 – Regular Nursery/Day Care (offsite)
 - 11 – Service Provider Facility (onsite)
 - 12 – Home (offsite)
 - 16 – Family Day Care (offsite)
 - 62 – Early Intervention Program (onsite)
 - 99 – Other Setting (offsite)
- Six (6) digit EI number (field 60)
- ICD-9 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)

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 codes 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.

SERVICE SPECIFIC GUIDELINES

Interpretation

- Interpreters must indicate the type of service provided in box 23 of the HCFA/CMS-1500 whether billed electronically or on paper.
- If billing electronically, multiple disciplines can not 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 as shown below. Example: PT, ST, OT, IM, DT, PT/ST
- 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
 - TI = Translation of the IFSP report
 - PT = Physical Therapy Evaluation (Same for all disciplines)
 - IM = IFSP Meeting (Same for all disciplines)
 - PT/OT = Physical Therapy & Occupational Therapy
- 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 24K.

Please go to <http://www.EICBO.info> for more detailed information or call the EI-CBO for technical assistance if needed.

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 the 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 needs to be attached to the claim for payment approval.
- For children with an active IFSP, regardless of referral date, credentialed evaluators must be used to determine the child's need for **newly** identified services.
- You must bill the EI-CBO for Evaluation/Assessment, IFSP development, audiological exams and Medical Services for diagnostic/evaluation purposes. These services are not billable to insurance or directly to families.

PRIVATE INSURANCE USE

Utilization of private insurance benefits is mandatory. Providers are required to accept insurance and/or EI-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.

Providers 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 insurance 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 or <http://www.eicbo.info> under support and click on "Create Help Ticket" to send your questions via e-mail. Visit the DHS and EI-CBO web sites will contain the latest updates to insurance billing requirements and/or procedures.

RESPONSIBILITIES

Child and Family Connections

- Assist family in completing Insurance, Affidavit, Assignment and Release form
- Provide copies of the family's insurance card to the provider and EI-CBO
- Request approval of pre-billing waivers and exemptions from the EI-CBO
- Update EI-CBO and provider of changes in insurance policy and benefits

Provider

- Verify insurance benefits with all insurance companies covering the family
- Verify that insurance coverage had not changed before each service is performed. The provider must be aware of who their payer will be and their requirements for each service provided
- Bill the insurance company and EI-CBO appropriately
- Update CFC and EI-CBO of changes in insurance policy and benefits
- Follow up with insurance company per EI-CBO instructions

Family

- Assist the CFC and provider in determining insurance benefits and obtaining required documentation, if necessary
- Provide timely notification of changes in insurance policy/benefits to CFC, EI-CBO, and/or provider
- Turn over recouped payments to the provider as appropriate

EI-CBO

- 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

WAIVERS AND EXEMPTIONS

Child and Family Connections offices will determine if pre-billing waivers or exemptions are appropriate for children they are serving. Requests are submitted by the CFC to the Central Billing Office for approval or denial. If approved, direct service providers bill the CBO for all dates of service. If denied, claims must be submitted to the private insurance carrier for payment before billing the CBO. Notice of the approval/denial will be forwarded in writing to the CFC, provider, and family.

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 provider receives payment from the insurance company
- Are effective for the IFSP period during which they are approved

Insurance Exemptions

- Exemptions will only be issued for the following situations:
 - Privately Purchased/Non-Group Plan
 - Lifetime Cap (overall policy or service specific)
- Approval/denial will be forwarded to the family, CFC, and the provider, as appropriate
- Become void if the family's insurance coverage changes

Post-Billing Insurance Waivers

- Will be issued by the CBO based on the denial reason listed on the insurance company EOB
 - This means the provider will not need to bill for this particular service until the beginning of the next benefit year
- Expire at the end of the insurance plan's benefit year (NOT IFSP PERIOD) when the provider will be required to bill insurance company according to program requirements
- If the family's insurance coverage changes, all waivers become void and the provider must bill the new insurance company

PROVIDER 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 provider may experience difficulty 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 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 for any additional information and document the submission of the information.
- After 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 <http://www.ins.state.il.us>.
- IDFPR will investigate the reason for the insurance company's failure to adjudicate the claim and will notify the provider of the outcome in writing.
- If the insurance company agrees to pay after the investigation, the provider submits the claim along with the insurance company EOB to the CBO.
- If the insurance company denies the claim, the provider submits the claim and denial within 90 days to the CBO
- CBO will review based upon normal program requirements.

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CODING REQUIREMENTS

Procedure Coding

- The procedure codes billable to the EI-CBO are identified on the authorization for services. Some of these procedure codes include a modifier that must be included on the claim form in order to receive proper reimbursement.
- A complete listing of these codes can be found in the “Early Intervention Service Descriptions, Billing Codes and Rates” document at <http://www.eicbo.info> or <http://www.dhs.state.il.us/ei>.
- If insurance exists, the procedure codes billed to the insurance company may differ from those found on the authorizations. Providers should refer to the Physicians’ Current Procedural Terminology (CPT-4) 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.

Diagnosis Coding

- Diagnosis coding discussed in this section does not refer to assigning a medical diagnosis but rather a billing diagnosis. A billing 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 developments issues in which each provider 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 diagnosis and procedure coding directly impacts correct and maximum benefit payment.
- Proper coding involves using the ICD-9-CM volumes to identify the appropriate codes for items or services provided (as recorded in the patient record), and using those codes correctly on the medical claim forms.
- Use the ICD-9-CM codes that describe the diagnosis, symptom, complaint, condition, or problem.
- Use the ICD-9-CM 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 your ICD-9-CM 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.)

The following services **do not** require an ICD-9 diagnosis code:

- Evaluation/Assessments
- Family Training and Support which includes Interpretation, Parent Liaison and Deaf Mentor Services
- IFSP Development
- Transportation

CLAIM SUBMISSION

Electronic Claim Submission

Electronic Billing is the process whereby a provider submits claims electronically to the Central Billing Office (CBO). The benefits of submitting electronically are: quicker turnaround (increased cash flow), fewer denied claims, and more efficient book keeping. In order to submit electronic claims the provider must ensure that their software or billing entity is capable of producing a file in the ANSI X12 837P or 837I formats. For more specific information on the format and field requirements please refer to the EI-CBO Electronic Billing Companion Guide at: <http://www.eicbo.info/downloads/CBOCompanionFINAL.pdf>.

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 or via a clearinghouse each of which have their own advantages such as:

EI-CBO

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

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 THIN (<http://www.thinedi.com>).

If you need more information or are ready to begin submitting claims directly please call the Call Center at: (800) 634-8540.

Paper Claim Submission

- 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

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INTERACTING WITH PRIVATE INSURANCE COMPANIES

Verification of Benefits

1. Call the Benefits Verification department of the insurance carrier. The phone number can generally be found on the back of the insurance identification card. If you do not have a copy of the card, use the general phone number for the insurance company provided by the family on the EI Insurance Information form.
2. Identify yourself as a provider and that you want to verify benefit coverage. Give the insurance company representative the name, social security number, 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.)
3. The representative will 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.)
4. 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
 - A referral must be made by the primary care physician
 - Services must be medically necessary
 - Services must be provided by a licensed S&LP (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!***
5. 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.
6. Be sure to 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.
7. 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.)
8. Initiate services, and once performed, bill the appropriate payer.

PRIVATE INSURANCE BILLING FOR PROVIDERS OF EARLY INTERVENTION SERVICES

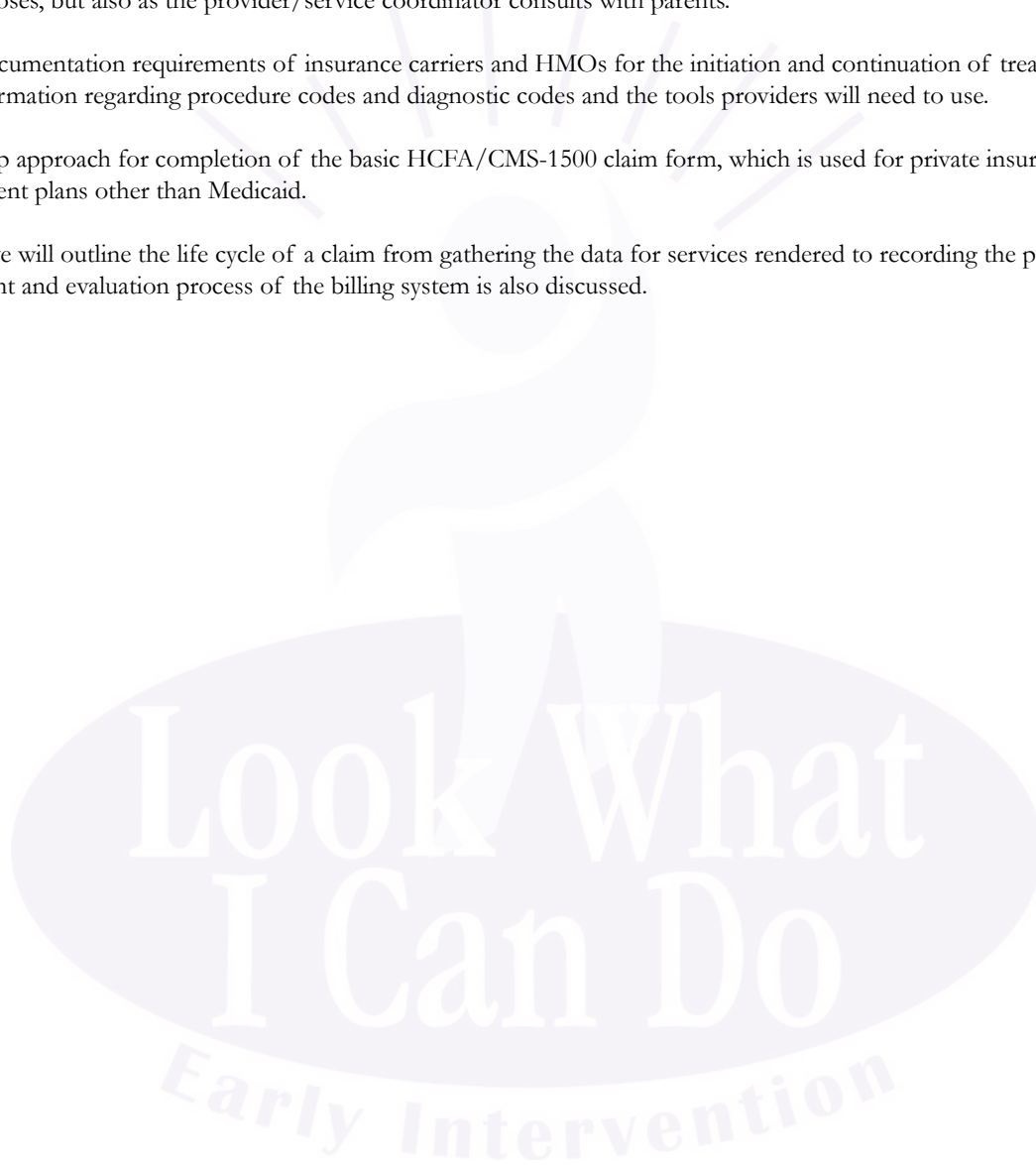
This resource has been designed to provide helpful information to alleviate the fears associated with seeking insurance/third-party reimbursement. By reading the text and following the instructions as provided for filing claims, one can be very successful in receiving payment.

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 tools providers will need to use.

A step-by-step approach for completion of the basic HCFA/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.



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 the term does 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 provider to gather as much information as possible when developing a system to access third-party funding (insurance and HMOs). Understanding the terminology associated with health care and the way in which the system works will help the provider learn how to work within the health care system and maximize reimbursement.

Consumers generally 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 provider becomes an active participant in the third-party process, the need for knowledge regarding the differences among health-care plans will become obvious.

Most third-party payers issue an identification card, which provides the plan information necessary for claims processing. Most plan changes and open enrollment periods within various plans occur between October and January. Therefore, it is wise for the provider to request current plan information during a child's initial enrollment and again in January of each 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 a child insured by the same carrier may have different plan benefits. The provider'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 provider.

With the exception of HMO or PPO (Preferred Provider Organization) plans, most standard indemnity carriers do not require prior authorization for evaluation or 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 procedures which are accepted by most insurance carriers when services are provided by licensed, certified practitioners. Details regarding documentation requirements 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

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 (CHIP), Division of Specialized Care for Children (DSCC), Medicare, and Medicaid. The following pages will give a brief description of each type of plan.

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 a "self-insured plan" for their employees' health care benefits.

Payment for services is made to the beneficiary or assigned provider, based on an indemnity table or schedule of benefits for the medical services. Assignment of benefits by the insured does not always guarantee direct payment to the provider. Some policies limit direct payment to the insured while others disallow assignment of benefits. In these cases, the provider is responsible for tracking funding and seeking payment from the insured.

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. Providers should contact the Illinois Insurance Commission for a list of current carrier sources in Illinois.

Medical 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:

1. **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.
2. **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.
3. **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

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.

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. A listing of some of the largest HMOs and PPOs available in Illinois is provided at the end of this chapter.

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 so as 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. Some ways in which the provider and HMO could work together:

- Contract with the practitioner as a provider.
- Transport the child to an HMO site for service.

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.

HMOs reimburse providers by two methods:

1. 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.

2. **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 enrollee's 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.

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 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.

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 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.

Self-Insured 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.

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-insurance” 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 who 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. For regulatory questions regarding self-funded plans contact:

Pension & Welfare Benefits Administration
Room N-6544
200 Constitution Avenue NW
Washington, D.C. 20210

CHAMPUS/CHAMPVA

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. Outpatient care is subject to a \$50 fiscal year (October 1 to September 30) deductible per individual (\$100 per family), then 75% coverage to a family out-of-pocket maximum of \$1,000 for active-duty sponsors, \$10,000 for all others. These out-of-pocket amounts only apply to CHAMPUS covered expenses. (April 1992)

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
as of 1997

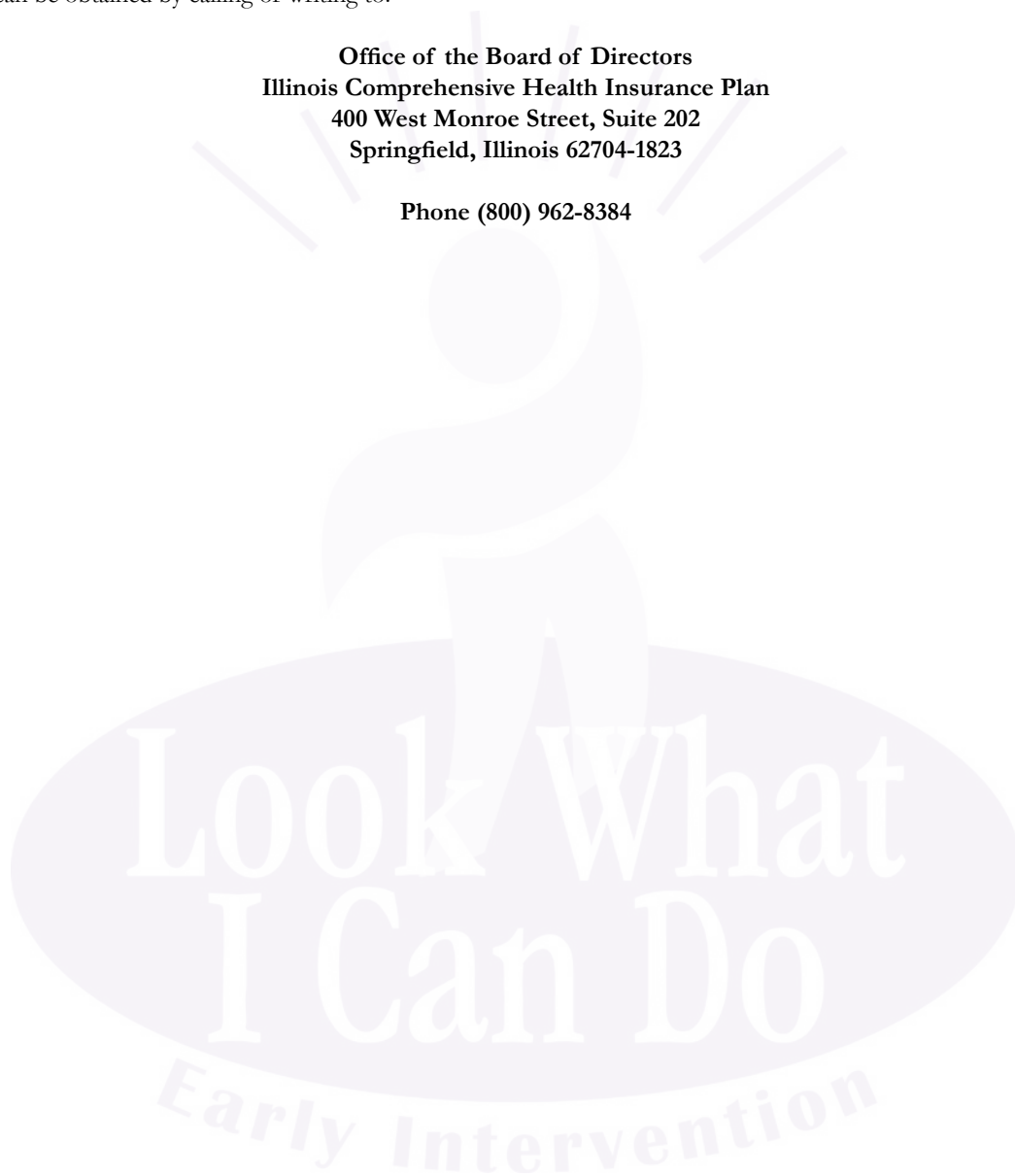
Illinois Comprehensive Health Insurance Plan

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



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. Providers must be able to produce standardized documentation regarding the services provided, and the progress obtained by the child is more likely to receive reimbursement.

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.

Third Party Access Forms

The family must be given assurances that the provider will correct any adverse financial situations that may arise because of the provider's receipt of insurance proceeds.

The family initially might feel it is subject to an increased financial risk because the provider's efforts might:

- cause insurance premiums to rise,
- reduce available lifetime or periodic benefit maximums,
- result in deductible and coinsurance amounts to be paid by the family

It is not possible to provide absolute protection against an increase in premiums, or even to prove that such an increase would happen solely because an insurance plan paid out benefits on claims for medical services not previously filed.

Most insurance plans have lifetime benefit maximums, but such maximums are rarely ever reached because:

- the maximum is set at a relatively high amount (for example, \$1,000,000);
- groups switch to insurance carriers that offer new plans, resetting the maximum benefit; or
- many plans provide for reinstatement of a portion of the lifetime maximum used in any one fiscal period

A definite contingent liability exists for the provider, and that is associated with the possible exhaustion of periodic benefit maximums. For example, some insurance plans will place a limit on the number of therapy treatments covered in a benefit period, although most plans will limit the number for each illness per period. Thus, a provider might exhaust the available physical therapy benefits, leaving no benefits payable for an unexpected acute episode (for example, a broken arm).

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. The initial authorization for evaluation and/or treatment can be obtained by requesting the physician to sign a form created specifically for this purpose, or it can be obtained by telephone. If permission is obtained by verbal orders, written

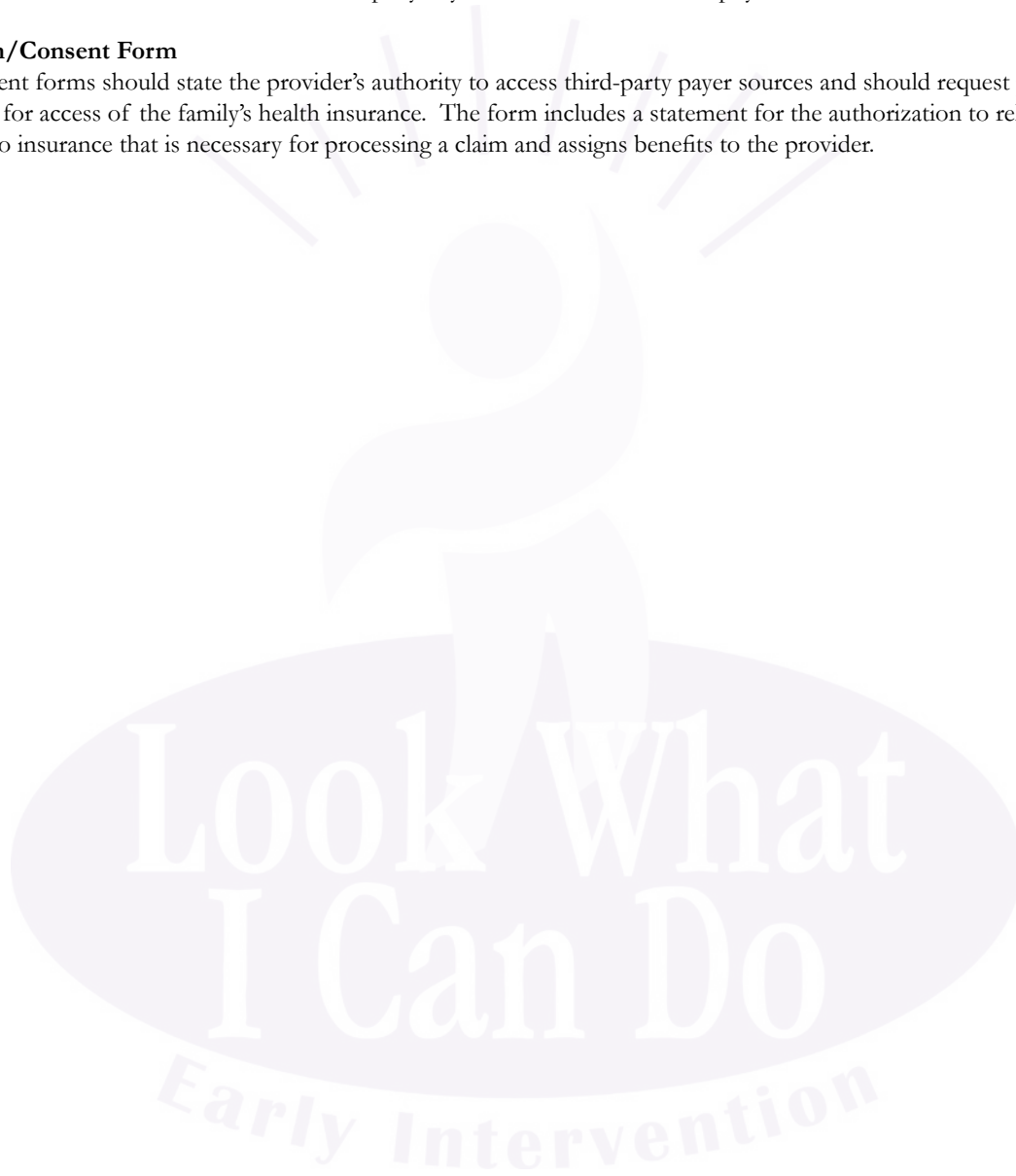
documentation must still be obtained. To document verbal orders, a telephone order form should be completed and sent to the physician for signature, providing a written record of the date the services were authorized. The physician orders should be maintained in the treatment record.

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. An authorization form should accompany any communication with the physician.

Participation/Consent Form

Parental consent forms should state the provider'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.



COLLECTION AND TRANSMISSION OF TREATMENT DATA-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 providers 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 numbers.

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 medically 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 provider should assign third-party activities to employees or contractees 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 provider should establish a system to generate and transmit this medical-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.



Look What
I Can Do
Early Intervention

DIAGNOSTIC CODES

ICD-9-CM is the *International Classification of Diseases Codes, 9th Revision, Clinical Modification*. Developed and maintained by the World Health Organization, ICD-9-CM codes are used to describe illnesses, injuries and accidents for the purpose of medical research and reporting. The ICD-9-CM system numerically classifies medical diagnosis by a code number, which provides need to use when processing claims. The ICD-9-CM includes diseases listed in both a tabular list and an alphabetic index.

Most insurance carriers, HMOs and Medicaid agencies require the use of ICD-9-CM codes in the billing format. There is adequate space for listing up to four 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 an ICD-9-CM 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-9-CM 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 ICD-9-CM code book available from local medical book stores or use an internet search for resources.



Look What
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Early Intervention

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.

The *Current Procedural Terminology*, Fourth Edition (CPT-4), is a systematic listing and coding of procedures and services performed by or under the supervision and/or prescription of a physician. CPT-4 became the procedural coding system in 1985 when the federal Healthcare Financing Administration and the American Medical Association published the Healthcare Financing Common Procedural Coding System (HCPCS), a national-level coding system for reporting health care services to the Medicare and Medicaid Programs.

Under CPT-4, 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. 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 *Physicians' Current Procedural Terminology, (CPT-4)*, 2005. Books listing the codes may be purchased from a local technical book store or use an internet search for resources.



Look What
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Early Intervention

INSURANCE FILING FORM PREPARATION

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

The provider's Business office will bill the appropriate party. If the child is covered only by a private plan, then the provider will file only to the private plan. **If the child is covered by both a private plan and Medicaid or KidCare, bill insurance first.** The EI-CBO will reimburse providers as the payer of last resort. Private insurance plans are billed first. Providers may bill the EI-CBO first only for families with no private insurance Medicaid or KidCare only, or in instances where insurance cannot be billed.

Establishing Rate Schedules

The provider must determine a 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, IDPA, DSCC, KidCare, etc.

Insurance carriers and HMOs routinely reimburse providers 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. Providers may wish to call other local health care providers to obtain data regarding community standards when developing fee scheduled.

Providers of health care routinely calculate U&C charges based on the costs of providing services. Providers 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 practitioners administrative costs.
- Profit margin

In the private sector, a provider'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 provider 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 provider 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 provider's employees. For services by practitioners employed by a provider 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.

The Insurance Claim Form (HCFA/CMS 1500)

Treatment date and charge information flows from the provider to the third-party payer via the claim form. The standard claim form, adopted by the American Medical Association is the Uniform Health Insurance Claim Form, known as the HCFA/CMS 1500, or Standard Claim Form. It is currently accepted by the majority of private insurance carriers, self-funded plans, and

HMOs in the United States. It is important to note that CHAMPUS requires the use of the HCFA/CMS 1500 claim form. In addition, these plans might also require periodic completion by the policyholder of their company-specific claim form to initiate a claim cycle for a particular benefit period.

Providers must use the accepted standard claim forms. These forms are available from a medical supplier, medical bookstore, county medical society, or the American Medical Association in single form, snap out form and continuous forms for use with computer.

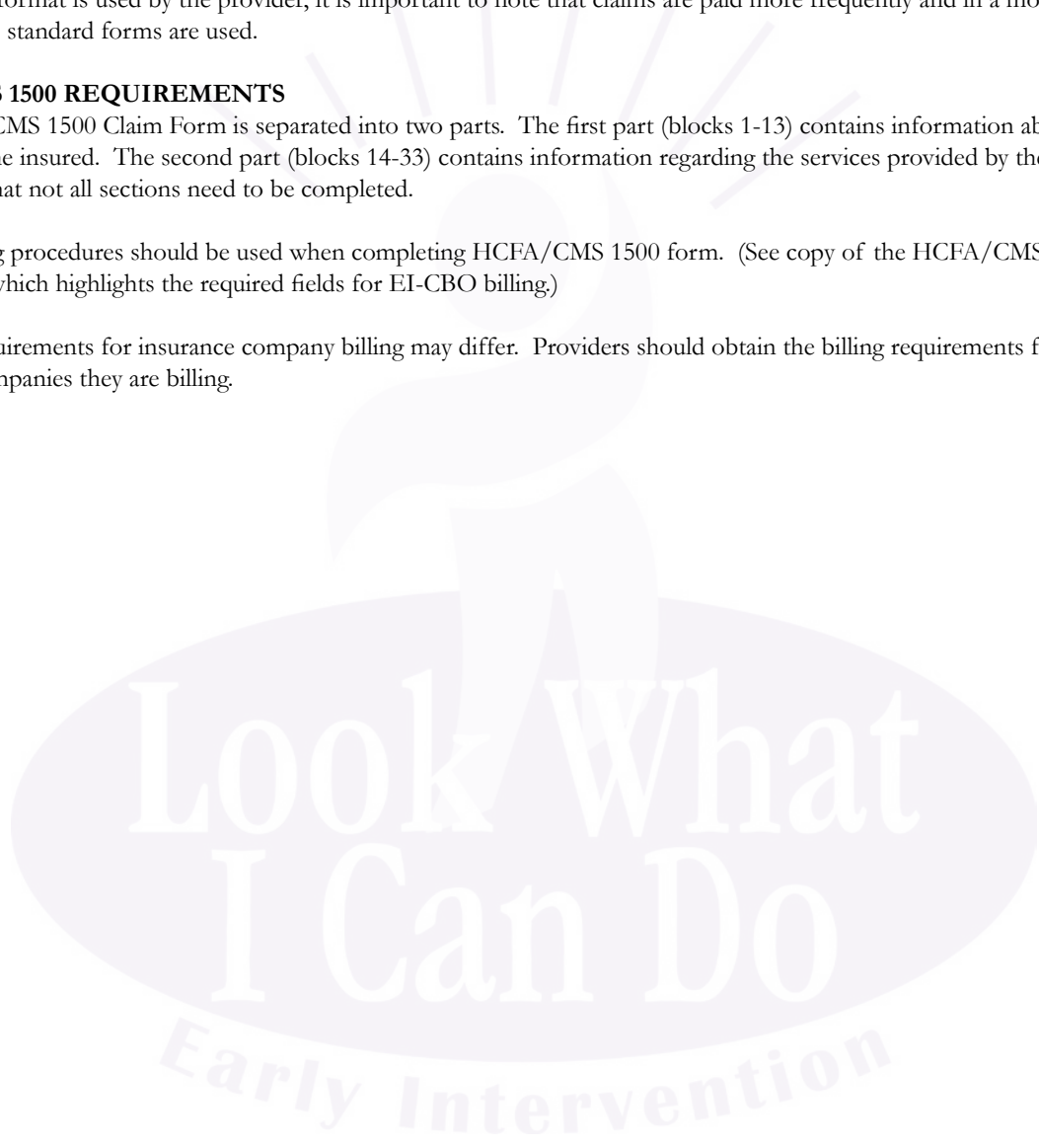
Providers may decide to contract with an agent who chooses to use a computer-generated format of the HCFA/CMS-1500 often referred to as a “superbill” or to complete purely “electronic claims.” Electronic claims, eliminating the use of paper, provide the billing data from the place of service directly to the insurer’s computer system, using a telephone modem. Regardless of which standardized format is used by the provider, it is important to note that claims are paid more frequently and in a more timely manner when standard forms are used.

HCFA/CMS 1500 REQUIREMENTS

The HCFA/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 HCFA/CMS 1500 form. (See copy of the HCFA/CMS 1500 form in this booklet which highlights the required fields for EI-CBO billing.)

NOTE: Requirements for insurance company billing may differ. Providers should obtain the billing requirements from the insurance companies they are billing.



THE INSURANCE REIMBURSEMENT PROCESS

Once the HCFA/CMS 1500 is generated and checked for accuracy, it should be transmitted to the applicable claims office. Timely filing is mandatory, since third-party payers generally require filing within one year of the date of service. A provider 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: For dates of service on or after July 1, 2005, providers must bill the EI-CBO within 90 days of the date of service or within 90 days from the last communication from the insurance company.

With an assignment of benefits, obtained as part of the parent consent/participation, the provider should be paid the appropriate insurance proceeds. Most plans will enclose an explanation of benefits (EOB) to explain the calculations involved in the process. (See samples at end of this chapter. Note the differences in the informational content provided. You will also find varying degrees of consumer orientation and customer service within the third-party financing system.)

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

An 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 provider's 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 claim's adjuster send a copy of the plan booklet/document.

Look What
I Can Do
Early Intervention

REPORTING/TRACKING THIRD-PARTY/MEDICAID PAYMENTS

As a control function, a provider should set up an account 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 provider will want to document the activity. The explanation of benefits reports the processing of the claim and the benefits payable to 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 would also be important to be able to provide the family statement of an individual child's activity (charges billed by service category and amount of funding).

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 provider must provide the Central Billing Office, within 90 days after receipt, a copy of the explanation of benefits and a copy of the claim with the data elements required by the EI-CBO. This information is used for the purpose of cost analysis and demographic data collection.



Look What
I Can Do
Early Intervention

GLOSSARY

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 - that 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 - a 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.

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.

Claim - the written or electronically submitted request for payment of benefits for covered services; standardized claim forms include the HCFA/CMS 1500 and DPA 1443.

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) - when 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 (CPT-4) - listing of medical terms and identifying codes for reporting medical services and procedures, developed by the American Medical Association.

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

Deductible Carryover - allows for covered services incurred within the last three months of the year to be carried over and counted toward the next year's deductible.

Denial - a claim for which payment is disallowed.

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

Duplicate claim - a claim which has been submitted or paid previously.

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

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

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.

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.

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.

Healthcare Financing Administration Common Procedure Coding System (HCPCS) - includes three 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; and

Level 3 are local (state) alpha-numeric codes (W through Z) for procedures to meet local coding needs.

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 nondirect intervention with the child.

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, 9th Revision, Clinical Modifications

(ICD-9-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.

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 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** both signed a contract with a carrier (HMO or PPO) nor agreed to provide services under the terms of the carrier and/or specific plan.

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.

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.

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

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 preestablished standards. There are federal and state guidelines that relate to quality assurance programs within HMOs.

Reimbursement - the amount of money remitted to a provider.

Rejected claim - a claim for which payment is refused as not meeting the minimum guideline of the Medicaid Program.

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.

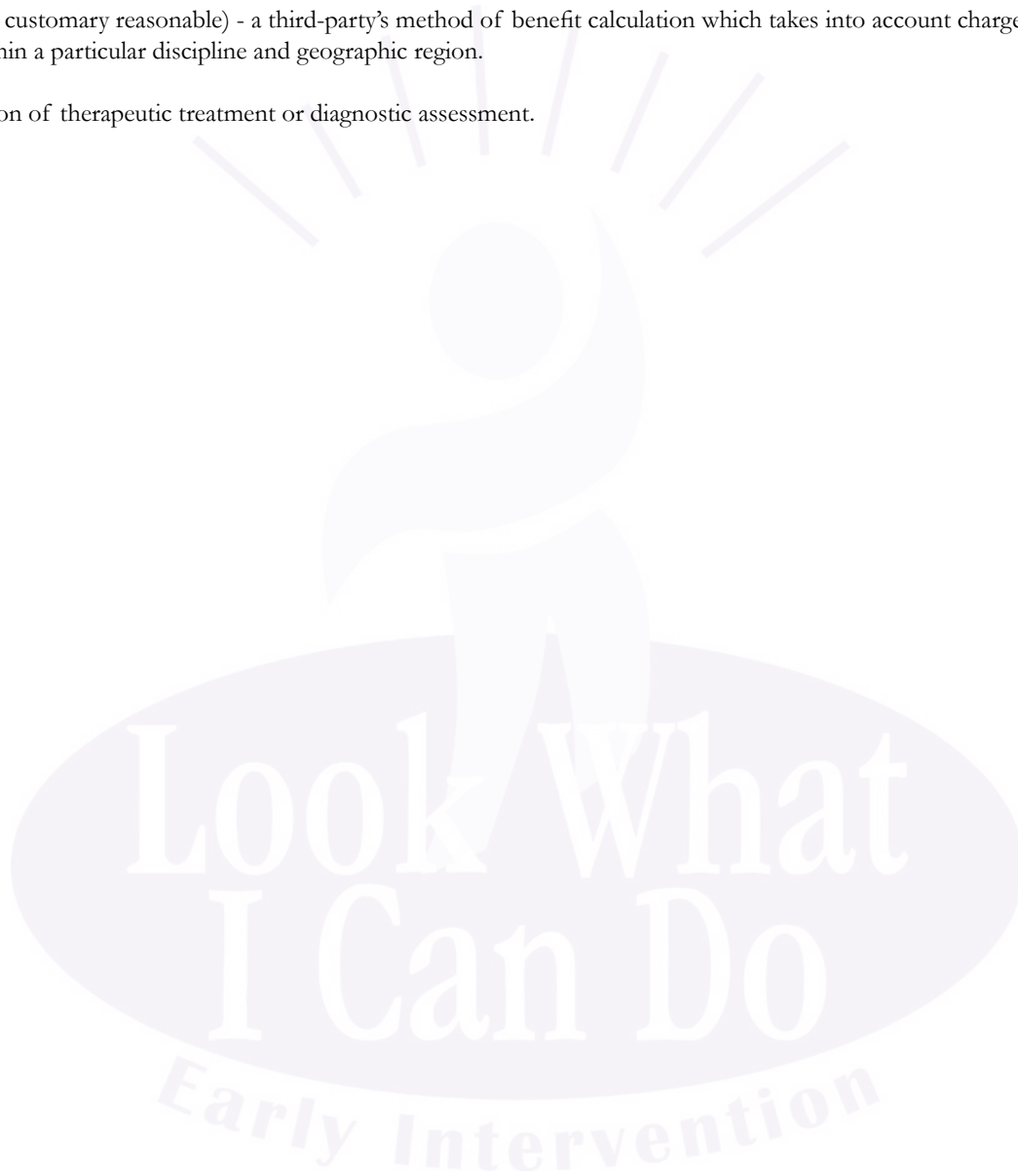
Secondary carrier - the insurance carrier that is second in responsibility within the coordination of benefits.

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 session of therapeutic treatment or diagnostic assessment.



RESOURCES

CPT Physicians' Current Procedural Terminology. American Medical Association.

Diagnostic Classification: 0-3 Diagnostic Classification of Mental Health and Developmental Disorder of Infancy and Early Childhood. Zero to Three/National Center for Clinical for Clinical Infant Programs

ICD-9-CM International Classification of Diseases. Med-Index Publications.

Understanding Medical Insurance: A Step-by-Step Guide. Second Edition. Rowell, Jo Ann.



ATTACHMENT A

Sample Authorization for HSPR0777 Report

Report Number: **REPORT: HSPR0777** → Date the report was run / printed: **06/08/2005** → Page 6

**STATE OF ILLINOIS
CORNERSTONE
EARLY INTERVENTION SERVICE PLAN**

Child's Name: **SAMPLE, CHILD** → Part I.D.#: **D242-3460-3278-00**
 Date of Birth: **09/30/2003** → EI #: **141033**

RESIDENCE: 123 MAIN STREET, YOURTOWN, IL 60000
 CONTACT: SAMPLE MOM
 TELEPHONE: (217) 555-5555
 RELATIONSHIP: MO

TYPE OF AUTHORIZATION: **AUTHORIZATION START DATE: 06/01/2005** → The date range for which the specified services are authorized

METHOD: **AUTHORIZED PAYEE: CHICAGO AND EARLY INTERVENTION**
AUTH TYPE: IFSP-DIRECT SERVICE
METHOD: INDIVIDUAL
PLACE OF SERVICE: 12 / HOME(OFFSITE) → Specifies location if indicated

PROCEDURE CODE: **FREQUENCY: 1 PER WEEK** → Intensity/miles/minutes if indicated
PROCEDURE: 97110 PT SERVICES
FOR: 60 MINUTE(S)

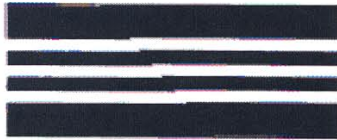
AUTHORIZATION NUMBER: **AUTH NUM: 141033-617-004-00** → Date on which the authorization was previously printed (while valid)
DATE: 06/08/2005
PRIVATE INSURANCE: 01/NO PRIVATE INSURANCE → Date this authorization was created or last updated

STATUS DATE: 06/08/2005

CFC site number, telephone number, and service coordinator's name are printed on Page 1 of the EI - IFSP Report (HSPR0777). Any comments entered will be printed below the Auth Number. Assistive technology service authorizations also include an authorized dollar amount.

ATTACHMENT B CMS - 1500 Form Example

PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

HEALTH INSURANCE CLAIM FORM																																																																																																												
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER (ID) <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) 02 24 04		SEX M <input type="checkbox"/> F <input checked="" type="checkbox"/>																																																																																																					
5. PATIENT'S ADDRESS (No., Street) 1234 EAST STREET					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>																																																																																																							
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ZIP CODE 60066			TELEPHONE (Include Area Code)		CITY			STATE																																																																																																				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:																																																																																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																							
b. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX (M/F)					b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																							
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																							
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE																																																																																																							
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 _____ DATE _____					11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M/F) b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>																																																																																																							
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE (MM DD YY)																																																																																																							
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY)																																																																																																							
19. RESERVED FOR LOCAL USE ASSOCIATE PROVIDER NAME (if applicable)					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)																																																																																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. V571					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																																																																																																							
24. A. DATE(S) OF SERVICE (From MM DD YY To MM DD YY) B. Place of Service C. Type of Service D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) (CPT/HCPCS I MODIFIER) E. DIAGNOSIS CODE					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER																																																																																																							
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>A</th> <th>B</th> <th>C</th> <th>D</th> <th>E</th> <th>F</th> <th>G</th> <th>H</th> <th>I</th> <th>J</th> <th>K</th> </tr> <tr> <th>DATE(S) OF SERVICE (From MM DD YY To MM DD YY)</th> <th>Place of Service</th> <th>Type of Service</th> <th>PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) (CPT/HCPCS I MODIFIER)</th> <th>DIAGNOSIS CODE</th> <th>\$ CHARGES</th> <th>DAYS OR UNITS</th> <th>EPSDT Family Plan</th> <th>EMG</th> <th>COB</th> <th>RESERVED FOR LOCAL USE</th> </tr> </thead> <tbody> <tr> <td>07/15/05</td> <td>12</td> <td></td> <td>97110</td> <td></td> <td>100.00</td> <td>4</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>07/16/05</td> <td>12</td> <td></td> <td>97110</td> <td></td> <td>100.00</td> <td>4</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>07/21/05</td> <td>12</td> <td></td> <td>97110</td> <td></td> <td>100.00</td> <td>4</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>					A	B	C	D	E	F	G	H	I	J	K	DATE(S) OF SERVICE (From MM DD YY To MM DD YY)	Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) (CPT/HCPCS I MODIFIER)	DIAGNOSIS CODE	\$ CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE	07/15/05	12		97110		100.00	4					07/16/05	12		97110		100.00	4					07/21/05	12		97110		100.00	4																																																	25. FEDERAL TAX ID. NUMBER SSN EIN 36-1234567				
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07/21/05	12		97110		100.00	4																																																																																																						
26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 300.00		29. AMOUNT PAID \$																																																																																																			
30. BALANCE DUE \$					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 07/30/05																																																																																																							
32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # ABC THERAPY SERVICE 4321 SOUTH STREET ANYTOWN IL 60066																																																																																																							
SIGNED _____ DATE _____					PIN# _____ GRP# _____																																																																																																							

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

ATTACHMENT C

UB-92 Claim Form Example

ST 1843 rPLY UB-92

County Hospital 551 West Street Anytown, IL 60066		2		3 PATIENT CONTROL NO. 7654321-001				4 TYPE OF BILL										
5 FED. TAX NO. 37-7654123		6 STATEMENT COVERS PERIOD FROM 07-01-05 THROUGH 07-31-05		7 COV. D.	8 NC D.	9 C-1 D.	10 L-R D.	11										
12 PATIENT NAME Doe Child				13 PATIENT ADDRESS 1234 East Street, Anytown, IL 60066														
14 BIRTHDATE 02-24-2004	15 SEX F	16 MS	17 DATE	18 HR	19 TYPE	20 SRC	21 DHR	22 STAT	23 MEDICAL RECORD NO.	24	25	26	27	28	29	30	31	
32 OCCURRENCE DATE	33 CODE	34 OCCURRENCE DATE	35 CODE	36 OCCURRENCE DATE	37 CODE	38 OCCURRENCE SPAN FROM	39 THROUGH	40	41	42	43	44	45	46	47	48	49	
a	b	c	d	a	b	c	d	a	b	c	d	a	b	c	d	a	b	c
38 Doe Child 1234 East Street Anytown, IL 60066				39 CODE	40 VALUE CODES AMOUNT	41 CODE	42 VALUE CODES AMOUNT	43 CODE	44 VALUE CODES AMOUNT	45	46	47	48	49				
42 REV. CD.	43 DESCRIPTION			44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49									
1	Physical Therapy			97110	071205	4	100.00	.	.									
2	Physical Therapy			97110	071405	4	100.00	.	.									
3	Physical Therapy			97110	072005	4	100.00	.	.									
4	Physical Therapy			97110	072205	4	100.00	.	.									
5							.	.										
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19							.	.										
20							.	.										
21							.	.										
22							.	.										
23							400.00	.										
50 PAYER				51 PROVIDER NO.		52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56						
A				B		C	D	E		F		G						
										400.00		POS - 11						
57 DUE FROM PATIENT										58	59	60						
58 INSURED'S NAME Doe, Child				59 P. REL.		60 CERT. - SSN - HIC - ID NO. EI 155155		61 GROUP NAME		62 INSURANCE GROUP NO.								
A	B	C	D	E	F	G	H	I	J	K	L	M						
A	B	C	D	E	F	G	H	I	J	K	L	M						
63 TREATMENT AUTHORIZATION CODES			64 ESC	65 EMPLOYER NAME			66 EMPLOYER LOCATION											
A	B	C	D	E	F	G	H	I	J	K	L	M						
A	B	C	D	E	F	G	H	I	J	K	L	M						
79 PRIN. DIAG. CD.	80	81	82	83	84	85	86	87	88	89	90	91						
V571																		
79 P.C. CODE	80	81	82	83	84	85	86	87	88	89	90	91						
82 ATTENDING PHYS. ID	83	84	85	86	87	88	89	90	91	92	93	94						
83 OTHER PHYS. ID	84	85	86	87	88	89	90	91	92	93	94	95						
84 REMARKS	85	86	87	88	89	90	91	92	93	94	95	96						
a	b	c	d	e	f	g	h	i	j	k	l	m						
b	c	d	e	f	g	h	i	j	k	l	m	n						
c	d	e	f	g	h	i	j	k	l	m	n	o						
d	e	f	g	h	i	j	k	l	m	n	o	p						
Therapist - Ann Therapist										85 PROVIDER REPRESENTATIVE	86 DATE							
Associate Level Provider - Peggy Associate										X								

ATTACHMENT D Transportation Billing Form Example - Page 1

DHS EARLY INTERVENTION TRANSPORTATION BILLING FORM

Illinois Department of Human Services
CENTRAL BILLING OFFICE
3430 Constitution Drive, Suite 118
P.O. Box 19485
Springfield, IL 62794-9485

MUST COMPLETE ENTIRE FORM BEFORE SUBMITTING

Child's Name: Child Doe Payee Name: ABC Transportation Service
 Child's Address: 1234 East Street Payee Address: 5678 West Street
 City, State, Zip: Anytown, IL 60066 City, State, Zip: Anytown, IL 60066
 EI #: 155155 Payee Tax ID#: 36-4567890
 Birth Date: 2 / 24 / 2004 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	PCG	Departure Address Dep. Code / Dep. Time		Destination Address Dest. Code / Dest. Time		*Loaded Mileage	Charge
06/15/05	A0120	99	1234 East St. Anytown		4321 S St Anytown			\$6.98
			R	10:00 am	D	10:20 am		
06/15/05	A0425	99	1234 East St. Anytown		4321 S St Anytown		6	\$3.00
			R	10:00 am	D	10:20 am		
06/15/05	A0120	99	1234 East St. Anytown		4321 East St Anytown			\$6.98
			D	11:35 am	R	11:55 am		
06/15/05	A0425	99	1234 East St. Anytown		4321 East St Anytown		6	\$3.00
			D	11:35 am	R	11:55 am		
		99						
		99						
Departure/Destination Code - (use Alpha code in column)							Billed Charges	\$19.96
D – Medical Services -or- R – Residence							Total Charges	\$19.96

- 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 nine (9) months 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.

 Name of Enrolled Provider or Transportation Company (Print Legibly) Date

Revised 12/03

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
Central Billing Office
3430 Constitution Drive, Suite 118
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 nine (9) months 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 applicable.

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.

Revised 12/03

ATTACHMENT E

Situation Code Meanings - Page 1

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	Services are not authorized.	There is no authorization in the CBO system for the services being billed.	You should contact the Call Center 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.
7	Claim exceeds the 9 month filing limit.	The CBO requires all provider billings related to a child's authorization be received no later than 9 months following the completion of the services.	If the claim was delayed due to primary insurance you should resubmit the claim to the attention of the Claim Processing Supervisor for review.
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 Call Center if an error was made by the CBO. If you billed incorrectly, resubmit the claim with the correct information and write "corrected" 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.	If an EOB is needed by the CBO a letter will be sent to the provider. The provider is given 90 days to send the EOB to the CBO or the claim will be denied.	Even after the initial denial the provider can still submit the claim to the CBO with the EOB attached.
21	Authorized procedure limit has been exceeded. Please check your authorization for frequency/intensity of services.	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 procedure. If the provider was unable to attend the IFSP meeting contact the CFC for a letter. Attach the letter to the evaluation claim and submit to the CBO for payment.
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 and you cannot find the PCS, contact the Call Center who will request a copy of the CBO Provider Claim Summary.
28	The amounts billed to insurance and the CBO don't match.	This means the provider has billed one amount to the insurance company and a different amount to the CBO.	Review the claims billed to insurance and the CBO. Resubmit the claim to the CBO with the same billed amount billed to insurance.
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 has to 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 companies attached.
31	CBO records indicate this child's insurance has	This means the family has a new insurance carrier.	The provider should contact the family or CFC to obtain

ATTACHMENT E

Situation Code Meanings - Page 2

	changed. Resubmit the claim with an EOB from the current insurance carrier.		the latest insurance information.
33	This service was previously paid by insurance and therefore the denial submitted is not payable by the CBO.	This means the CBO has an EOB from the insurance showing payment had been made on other dates of service.	Check the denial reason on the insurance EOB. The provider may need to resubmit the claim to the insurance depending on the denial reason. May need to call for technical assistance.
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, with 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 given 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 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 is missing. Ex: PT, OT, ST written next to the procedure code.	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.	You need to write the type of service you interpreted for in box 23 of the CMS-1500 form. See the Billing Information for Providers booklet at www.etcbo.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 it.	The provider should refund insurance their payment and resubmit 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 it's original form.	The provider should obtain a corrected EOB from the primary insurance or provide the CBO with a original unaltered copy along with the claim.
47	The insurance carrier's EOB received is 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 services or from the last communication from the insurance company.	If the claim was delayed due to primary insurance you should resubmit the claim to the attention of the Claim Processing Supervisor for review.
49	The ICD-9 treatment diagnosis is missing or invalid.	The CBO requires a ICD-9 treatment diagnosis on the claim form.	The provider should correct the claim and resubmit the claim to the CBO.
99	Freeform message.	This is a freeform message entered by a EI Claims processor. This is information only pertinent to a certain claim or provider.	Read the message carefully. Contact the Call Center for further explanation of message.

ATTACHMENT F Returned 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-9 Code
- Local HCPC / Procedure code
- Fee(s) charged for service
- Enrolled Provider supervising Associate

Other Reason(s) for return

- Child not known
- Description of equipment is needed on claim
- Therapist not known at this location
- Physician not known
- DHS billing form no longer accepted. Use CMS 1500 or UB92 form
- Only 6 lines of service per claim (in chronological order)
- Services cannot be paid before they are rendered
- Illegible claim / provider name

- Provider not enrolled in EI system
- 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 / Address. Please verify
- Only 1 discipline per claim
- Other – See CBO Comments

CBO Comments _____

Provider Comments _____

Date Returned to Provider _____ Processor Initials _____

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 return or destruction of the information and all copies.

JANE MARIE DOE
1234 EAST STREET
ANYTOWNUSA, IL 60055

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



Invoice: 20010200
Date: 07/06/2005
Page: 1
Provider: 12-3456789
JANE MARIE DOE

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 above with the Invoice Number shown on the state check.

Provider Service Information	Service Dates	Minutes/Miles	Billed	Not Allowed	Remarks	Benefit Allowed
CHILD DOE						
Ref: 0078						
Claim: 05180T8285						
Speech Ther Ind Offsite	04/05/2005	60 min	130.00	59.56	16	70.44
Speech Ther Ind Offsite	04/12/2005	60 min	130.00	59.56	16	70.44
Speech Ther Ind Offsite	04/19/2005	60 min	130.00	59.56	16	70.44
Speech Ther Ind Offsite	04/26/2005	60 min	130.00	59.56	16	70.44
			520.00	238.24		281.76
				** Paid by Insurance:		-281.76

16 Charges exceed the EI program allowable rate.

CHILD DOE

Claim: 05167ST209

Speech Ther Ind Offsite	04/06/2005	60 min	130.00	59.56	16	70.44
Speech Ther Ind Offsite	04/13/2005	60 min	130.00	59.56	16	70.44
Speech Ther Ind Offsite	04/27/2005	60 min	130.00	59.56	16	70.44
Speech Ther Ind Offsite	05/06/2005	60 min	130.00	59.56	16	70.44
Speech Ther Ind Offsite	05/11/2005	60 min	130.00	59.56	16	70.44
			650.00	297.80		352.20

16 Charges exceed the EI program allowable rate.

A waiver from the Early Intervention insurance billing requirement has been approved for the above child. Billing the child's primary and/or secondary insurance carrier is not required for dates of service within the waiver period. Claims will be honored by the Central Billing Office in accordance with all Early Intervention program requirements. If you have any questions regarding this billing information, please contact the Central Billing Office Help Desk at 1-800-634-8540.

Reason	Status	Period	Service
Waived - Service not covered	Approved	06/01/05 - 12/31/05	Speech Therapy

Total benefit payable: 352.20

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 PV44459033364

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 70-2186
711

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 Bear Topinka
Judy Bear Topinka, Treasurer, State of Illinois

This document has a colored background and contains an artificial watermark on the reverse side.

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

⑈0 6 ⑈: 0 7 1 1 2 1 8 6 6 ⑈: ⑈4 3 0 2 4 5 4 ⑈

FOR ADDITIONAL HELP

For problems or questions regarding...

...**child enrollment and authorizations**, contact the local Child and Family Connections office.

...**insurance & billing**, contact the Early Intervention Central Billing Office (EI-CBO) Call Center at 800-634-8540. the call center's hours of operation are Monday through Friday, 7:30 a.m. to 5:30 p.m.

...**training**, contact the Illinois Early Intervention Training at United Cerebral Palsy Association of Greater Chicago at 708-444-8460 ext. 23 or visit their web site at <http://www.illinoiseitraining.org>.

...**payment information**, visit the Illinois Office of the Comptroller to check payment status at <http://www.ioc.state.il.us>.

...**monitoring**, contact the Early Intervention Monitoring Project at 800-507-5057 or visit their web site at <http://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 web site at <http://www.wiu.edu/users/mimppc/providerconnections>.

You can also visit the DHS Early Intervention web site at <http://www.state.il.us/agency/dhs/eisnp.html> or <http://www.eicbo.info> for the latest Early Intervention program information.

...**insurance**, contact the Illinois Department of Financial & Professional Regulation at 877-527-9431. Further information is available at their web site at <http://www.ins.state.il.us>.



Look What
I Can Do
Early Intervention