**Title: PAYMENTS TO PROGRAMS**

**Purpose:** *To provide financial support to programs providing Birth to Three services within available appropriations and in accordance with CMS SPA 17-0019.*

**Overview:** Agencies that contract with the Office of Early Childhood (OEC) to provide Early Intervention Services (EIS) will enter child and service information into the Birth to Three Data System. This information will be transmitted to a third-party billing contractor, herein known as the central billing office (CBO), who will create claims on behalf of EIS Programs and will submit the claims electronically to payers including Medicaid and commercial insurance plans. Payments from these claims will be made to EIS Programs directly from Medicaid and commercial insurance plans. The lead agency will pay EIS programs monthly for the unpaid balances of non-workable insurance claims and certain additional EI services and activities, these authorized services are defined below. Providers are prohibited from seeking payment for EI services from the parent. Providers are also prohibited from billing Medicaid and commercial insurance directly for services the OEC has required to be submitted by the CBO.

A glossary and acronym list are located at the end of this procedure.

ENROLLMENT

As billing providers, EIS programs are required to bill third party insurance through the CBO, including commercial insurance and Medicaid prior to seeking funds from the lead agency. All agencies must enroll with the commercial insurance clearinghouse used by the CBO and with the Connecticut Medical Assistance Program (CMAP) to receive payment for services.

**National Provider Identifier (NPI) numbers**

A separate and distinct NPI is required for agencies with lines of business other than EI. These are obtained at https://nppes.cms.hhs.gov/NPPES/Welcome.do. The EI NPI must match the NPI used to enroll in Medicaid and is associated with the billing contractor’s records.

**Commercial Insurance**

Commercial Insurance Electronic Data Interchange (EDI) transactions require EIS programs to enroll with the clearinghouse used by the CBO, so that the CBO may submit claims by electronic means through the clearinghouse on behalf of the EIS programs. Additionally, EIS programs must enroll with each commercial payer to allow payers to accept electronic claims, known as 837s, from the CBO’s clearinghouse and send insurance remittance data electronically in a HIPAA-compliant 835 format to the CBO.

Once a provider is enrolled, claims submitted by the CBO will be paid directly to the EIS Program. The CBO will track the payments and claims decisions through receipt of the Electronic Remittance Advice (ERA) file called an 835. 835s are received by the CBO only and are visible via the CBO’s billing portal. Programs will be able to determine the decision on claims through reports and queues available as the data is updated in real time. The CBO only receives the 835s for the EI line of business for those that have multiple lines of business.

**Medicaid**

Providers must enroll with CMAP to receive payment for services to allow the CBO to submit 837 and receive 835s. Once a provider is enrolled, claims submitted by the CBO will be paid directly to the EIS Program. The CBO will track the payments and claims decisions through receipt of the 835. 835s are received by the CBO only and are visible via the CBO’s billing portal. Programs will be able to determine the decision on claims through reports and queues available as the data is updated in real time. The CBO only receives the 835s for the EI line of business for those that have multiple lines of business.

GENERAL PROCESS FLOW

The timing of this process depends on the payer. Medicaid pays clean claims every two weeks. Commercial plans vary. The lead agency will issue payments monthly. The faster accurate insurance and service data is entered in the Birth to Three data system and the faster workable claims are managed, the faster payments will be paid or adjudicated to non-workable status and paid by the lead agency.

ORDER OF PAYMENT

**Commercial Insurance**

It is very important for EIS programs to obtain and maintain the most recent and accurate insurance information for each family. The lead agency will not bill self-funded plans or plans linked to a Health Spending/Savings Account (HSA) without parent consent. EIS programs must confirm with families regarding the type of insurance plan they have. As needed the CBO will contact families when the program no longer is in contact with them.

The CBO will submit an eligibility request file (a.k.a. 270) to the commercial payer prior to submitting a claim. If the eligibility response (a.k.a. 271) file is received with an adverse response and the response is workable, meaning additional or corrected information is needed, the EIS Program will be requiredto contact the family to obtain corrected insurance or HRA/ HSA information. The HRA/HSA billing consent form has an end date so families who want to spend down their accounts until 12/31 of a calendar year can do so.

All claims’ data is available on the CBO EI Billing portal. Once eligibility is determined, a claim is submitted and a response is received, EIS Programs are required to utilize data provided in the CBO Early Intervention billing and claiming system to address workable denials or rejections. Claims will not move to the next payer when issues are workable per the Adjudication Matrix (Appendix 1) and remain unresolved. Data for claims must be correct and within required timelines for timely filing. Timeliness can be a program requirement (e.g., lead agency requires EIS Programs to get their attendance in the Birth to Three data system for monthly FCP fees within 15 calendar days of the event) or an insurer’s specific requirement. The CBO will work with EI programs to assure they are acting on claims which must be resubmitted to insurers. If the claim has an issue that will lead to CBO assistance such as, correcting CPT/HCPCS, then the CBO will work the claim within a couple of days and resubmit it to the insurer.

If it is determined that a program has not put services in the Birth to Three data system or the correct insurance information was not obtained and the claim is not timely with a commercial insurer, then it will not get paid and it will NOT move to the next payer. The CBO has internal controls to determine if programs do not seem to be working their queues and will reach out to determine if more training is required.

The CBO will bill the Usual and Customary rates, as received by SPIDER, on behalf of EIS programs. In the event providers do not have usual and customary rates established, they will submit the provider rate at 200% of the State EI service rate.

If it is determined to be advantageous to the system, EIS programs will be required to enroll with commercial payers and secure in-network status.

For any mandated private insurance coverage, the plan will be billed for early intervention services and only consent to share personally identifiable information (PII) with the CBO and plan is needed from the parent (Form 1-3). Actual consent to bill insurance and share PII is required for non-mandated plans and to bill Health Savings Accounts (HSA). (Form 1-3a and Form 1-3\_HSA)

**Medicaid**

As with Commercial Insurance plans, it is important for EIS Programs to obtain and maintain the most recent and accurate Medicaid eligibility information for each child on their caseload.

The CBO will submit a 270-eligibility request file to Medicaid prior to submitting a claim. If the 271-eligibility response file is received with an adverse response and the response is workable, the EIS Program will be required to obtain corrected Medicaid eligibility information.

The CMAP requires contracted Birth to Three Providers to enroll as a Medicaid “Special Services” (provider type 12) and “Birth to Three Billing Provider” (Specialty 583). Enrollment with Medicaid can be completed through the DSS website, www.ctdssmap.com and select “Provider Enrollment.” After completing enrollment, a provider will receive an Application Tracking Number (ATN) to track the status of their enrollment. Once successfully enrolled the Provider will receive a Provider Enrollment Approval Notice, AVRS ID and initial password.

When a child is enrolled in the Medicaid Program, parent consent has already been provided to bill. If the family has both private insurance and Medicaid coverage for the child, claims for payment of early intervention services will first be billed to private insurance and only the remaining balance will be billed to Medicaid for payment. Medicaid pays claims up to the fee schedule amount.

If the Medicaid response is received and it is determined to be a workable denial or rejection, the EIS program is required to use the information available in the CBO Early Intervention billing and claiming system and on the [ctdssmap.com](http://www.ctdssmap.com) secure site to address the claims. However, changes should NOT be made on the [ctdssmap.com](http://www.ctdssmap.com) site for claims submitted by the CBO. Claims will not move to the next payer when issues are workable per the Adjudication Matrix (Appendix 1) and remain unresolved. In some cases, workable denials or rejections will be addressed by the CBO but in other cases only the EI Program can resolve the issue.

**Lead Agency Funds (a.k.a. Escrow Payments)**

EIS programs will receive payment from lead agency funds (escrow) using the state Birth to Three rates for services that are partially reimbursed or denied by the insurer (subject to workable denials or rejections per the attached Adjudication Matrix (Appendix 1).

QUALITY ASSURANCE/AUDIT PROCESS

EIS Programs will receive timely feedback and opportunity to correct deficiencies. If continued errors occur, resulting plans of action may include desk audits and on-site fiscal audits.

The lead agency shall complete standard methodology and process for completing regular *post-payment* reviews of each program’s claims. The post payment review process assists the lead agency to monitor and improve quality over time and provides staff confidence in the application of Birth to Three regulations and policies.

* The goal of the lead agency, or its contractor, is to complete monthly qualitative reviews of a sample of adjudicated and paid claims. Claims will be reviewed using a standardized quality assurance review tool.
* The lead agency’s review will include random sampling, focused sampling based upon service area and focused sampling based upon billing practices. As a practical matter, the sampling plan will also consider the amount of time that the accountability team has to dedicate to this activity – the purpose is not simply to add work but to identify and address strengths, risks and weaknesses in a systematic way.
* The results of this quality review will be provided in a written report by the lead agency, or its contractor. Deficiencies in the application of regulations or policies will be documented and voided claims and earned take-back provisions will be employed to ensure all claims activities are sound and true.

The lead agency’s system of general supervision will include onsite fiscal audits and desk audits as related to track changes in behavior and to assure that programs are prepared for possible CMS audits. The lead agency will work with the QA division at DSS and programs to develop tools and the processes as described in the Accountability procedure.

BIRTH TO THREE SERVICES PAYMENT AND CRITERIA

The Birth to Three System works closely with CMAP to coordinate the billing and payment for services. Service maximums are per child not per program and will not reset if a child is transferred to another program. If the program notices in the available data systems that they are approaching the approved service limits as identified, authorization from the lead agency to exceed the limits must be approved prior to the service being delivered (See Prior Authorization below). In addition, any discovery of a misuse of units must be reported to the lead agency. Evaluations, Assessments, an IFSP meeting and EI services can occur on the same day if necessary.

**Payment for Initial and Continuing Eligibility Evaluations**

For the determination of specific activities which meet the criteria for an evaluation please refer to the draft State Plan Amendment 17-0019 and DSS regulations.

One unit equals one person regardless of length of the evaluation visit. Evaluations are required by IDEA to be multidisciplinary so billing for two professionals with the same discipline for and initial evaluation is not permitted. At times, it may be beneficial to the child to include a third practitioner on the evaluation team. The reason that this third person is required must be documented in the record and may be billed as a unit using the evaluation code. Programs can bill up to 4 units per calendar year without prior authorization (PA). If four people completed the initial evaluation, that would use up all evaluation units for the calendar year. Any additional units would need PA. Prior Authorization for more than 4 units per calendar year is only for OEC Escrow payments as Medicaid will not cover any units over the annual limit.

If the evaluation cannot be completed by 2 practitioners in the same day, treat this as 2 separate service delivery items.

If the initial evaluation is completed more than 45 days from referral the program will not be reimbursed unless it is delayed based on documented family circumstances and the indicator in the Birth to Three data system attesting to this is marked.

After the initial evaluation, evaluations may be completed annually to determine a child’s continuing eligibility without the use of a standardized test. Children continue to be eligible until they are age appropriate in all areas. Please refer to the Evaluation and Assessment procedures for more guidance about evaluation vs. assessment.

**Payment for Assessments**

For the determination of specific activities which meet the criteria for an assessment please refer to the draft State Plan Amendment 17-0019.

One (1) unit is equal to 15 minutes therefore an assessment greater than 7 minutes rounds up to 15 minutes (1 unit) and an assessment greater than 22 minutes rounds up to 30 minutes (2 units). Programs may bill up to 32 units per calendar year per child without prior authorization. Prior Authorization for more than 32 units per calendar year is only for OEC Escrow payments as Medicaid will not cover any units over the annual limit. When it is determined that there is a need to exceed the limit of 16 units per day, a prior authorization request must be submitted (see Prior Authorization section below). Assessments should not be scheduled without first determining whether prior authorization is needed. Billable assessments are those that result in a written report. A completed Child Outcome Summary (COS) form is not considered a report and may not be billed as an assessment.

Initial assessments are required by IDEA to be multidisciplinary so billing for two professionals with the same discipline for an initial assessment is not permitted.

**Payment for IFSP Meetings (develop, review and revise forms as needed)**

For the determination of specific activities which meet the criteria for an IFSP meeting please refer to the draft State Plan Amendment 17-0019.

There must be written prior notice to the family documented for every IFSP meeting. IFSP meetings include interim/initial meetings, periodic reviews and re-writing the IFSP annually. There must be evidence on the IFSP that the team reviewed the plan. A licensed practitioner (see Birth to Three Personnel Standards) must sign the IFSP but is not required to deliver IFSP services or be at the meeting. The child is not required to be present since the IFSP is developed in collaboration with the child’s caregivers.

One (1) unit is equal to 15 minutes therefore an IFSP meeting greater than 7 minutes rounds up to 15 minutes (1 unit) and an IFSP meeting greater than 22 minutes rounds up to 30 minutes (2 units). Programs may bill up to 40 units per calendar year per child without prior authorization. Prior Authorization for more than 40 units per calendar year is only for OEC Escrow payments as Medicaid will not cover any units over the annual limit.

If the IFSP meeting cannot be completed in the same day, treat this as 2 separate service delivery items.

If the initial IFSP is completed more than 45 days from referral the program will not be reimbursed unless it is delayed based on documented family circumstances and the indicator in the Birth to Three data system attesting to this is marked.

IFSP meetings are required by IDEA to be multidisciplinary. To assist with transition from one interventionist to another, billing for two professionals with the same discipline for a periodic review may be permitted. No IFSP planning may occur without the service coordinator and parent present. The Lead agency interprets applicable training for IFSP planning to mean that the person is licensed, certified or has completed Service Coordination training.

Visits to support the caregiver for the benefit of the child in planning for transition out of Birth to Three in any setting are considered an EI Treatment Service unless the IFSP is modified. In that case, prior written notice must be provided, and the program could bill for an IFSP meeting.

**Payment for Early Intervention Treatment Services (EITS)**

EI Treatment Services will be billed to commercial payers, Medicaid, and the Birth to Three System as appropriate using HCPCS and CPT codes as assigned to the “What Will Happen” and “Delivered by” fields in the lead agency data system, as long an identified caregiver is present. Modifiers will be used as appropriate for Commercial payers and Medicaid.

State EITS rates fall into two categories; professional and paraprofessional. How these billing categories are applied is included in the Birth to Three System Personnel Standards procedure.

The rates are further grouped based on the total amount of time EITS are provided in the day per practitioner. The total services per practitioner per day up to 1.5 hours (6 units) will be billed without a modifier at a higher rate. If more than six units are billed per practitioner per day, all the units in the day are paid using a modifier (TF) that results in a lower rate. The rates are not per discipline and only apply to EITS not Evaluations, Assessments or IFSP meetings.

One (1) unit is equal to 15 minutes therefore an EITS greater than 7 minutes rounds up to 15 minutes (1 unit) and an EITS greater than 22 minutes rounds up to 30 minutes (2 units). Programs can only bill for up to 32 units per day. There is no prior authorization or payment for more than 32 units of EITS per day. Joint visits, co-treats, or team meetings with the family and up to two EI Practitioners may be billed as EI Visits unless the IFSP is reviewed in accordance with IDEA in which case it may be billed as an IFSP meeting (see above). For more information about what is required, see the prior authorization section below.

Practitioners with disciplines listed on the IFSP team may cover for one another to address the outcomes on the IFSP as long as the services being provided are within the practitioner’s professional scope of practice. The rates used for billing are based on the discipline of the person providing the service and signing the visit note.

The state rates include travel related costs for EIS practitioners. When transportation is listed in the IFSP or is needed to provide a service to the child the program that is billing for the Part C service that requires transportation is the one that is expected to provide the transportation or reimbursement for transportation as defined in the Services Procedure.

**OEC Prior Authorization (PA) Requirements**

The Birth to Three data system in sync with the CBO will track the number of units billed per day and per calendar year. Daily and annual maximums cannot be overridden with prior authorization (PA) for Medicaid reimbursement. Visits exceeding the maximums listed above must have PA for each claim that is over the maximum limit (per child per calendar year regardless of which EIS program provides the service). The information about total units used is available in the Birth to Three Data System.

Before providing any units of service over an annual or daily limit, programs must enter the following information using the Birth to Three data system:

* the child’s Birth to Three number,
* the service (evaluation, assessment, IFSP) that needs PA
* the reason that the annual or daily maximum must be exceeded.

Prior Authorization for supporting families in towns not on the program’s list of towns, for special circumstances regarding interpreter services, completing an evaluation within one month of a previous evaluation, or for visits with more than two practitioners at the same time is requested by emailing CTBirth23@ct.gov. The email must include the child’s Birth to Three number and a detailed explanation of the reasons the PA is being requested.

The lead agency will respond within 3 business days. Appeals can be made by emailing the Part C Coordinator or her designee additional information for consideration who will respond within 2 days via email. The date that PA is approved is recorded and will be compared to the date the service is provided. The OEC will not pay for any services that require PA that occur before the PA approval date. All PA approvals must be included in a child’s record. See Records Procedure for more information.

**General Administrative Payments (GAP)**

A GAP will be paid to programs for services such as team meetings without the family present that are not billable but are needed for high quality EI. The GAP will be paid for each child whose IFSP on the 1st of the billing month plans for fewer than 9 hours of service per month and as long as at least one billable service was provided and approved during the billing month. The lead agency will pay the GAPs monthly in arrears. The rate to be paid will be posted on the lead agency website. The count will be generated by the Birth to Three data system when the monthly invoice is processed. GAPs will not be paid retroactively based on data entry errors. Programs should correct the data before signing off their monthly invoice. Regular desk audits will be completed to assure that IFSP data is entered correctly. If it is identified that IFSP’s or services were entered into the Birth to Three data system incorrectly and a payment was made in error, the associated GAP payments will be deducted from future payments. GAPs for children who transfer to another program are paid to the program with the IFSP on the 1st of the month if a service was provided and approved by the sending program before the transfer. Receiving programs will be paid the GAP in the following month if a new IFSP was written on or before the 1st of the billing month. The GAP will also be paid when the only service on the IFSP is provided by BESB as long as there is at least EI visit from the service coordinator in the month.

**Entering Billing Data**

The Birth to Three data system is the system of record for any child, family, insurance, services data. Therefore, it is important that for program reporting, billing, and claiming that the data entered is timely and accurate. The accuracy of data input results in greater amounts of paid claims and less time spent by program in researching and correcting incorrect data. Clean unpaid claims will move to the next payer 90 days after date the service was approved in the Birth to Three data system. Services approved in the Birth to Three data system after the monthly invoice is signed will not move to escrow. Acceptable reasons for missing this timely filing requirement include

* major illness lasting more than 5 days of a key staff person
* major weather event or power outage lasting more than 5 days
* the Birth to Three Data System is down for more than 5 days
* other major event resulting in a disruption of travel for more than 5 days

Requests for overriding the timely filing requirement should be sent to the Part C Coordinator or designee at CTBirth23@CT.gov with Timely Filing Override Request in the subject and should include the B23#, dates, specific services, and a clear description of the override reason.

**Errors, Misbilling and Potential Fraud**

All data entry errors must be corrected and verified through the data system and all other means, including but not limited to contacting PCG, commercial insurance and Medicaid.  Programs shall develop and implement a process to consistently monitor for and correct any misbilling or potential fraud.  In addition, the Lead Agency and the appropriate billing overseer must be notified in writing of any misbilling of a single event of $400 or more, or potential fraud, within three calendar days of becoming aware of such gross misbilling or potential fraud.  The Lead Agency's policy is to promote consistent, legal, and ethical organizational behavior by assigning responsibilities and providing guidelines to enforce controls. Violations of law, agency policies, or standards of ethical conduct will be investigated, and appropriate actions will be taken. All employees or contractors who suspect fraud, waste, or abuse (including employee misconduct that would constitute fraud, waste, or abuse) are required to immediately report the questionable activity to the Lead Agency.

OTHER BILLABLE SERVICES AND ACTIVITIES

**Reimbursement for Assistive Technology Devices**

Seeking third party payment for assistive technology devices is required per attached Appendix 2 chart if the child is covered by commercial health insurance or Medicaid. It is not required if the child has no health insurance coverage.

Prior authorization (PA) for Medicaid AT devices and DME will be obtained by the DME vendor or by the program submitting for PA through CHNCT (see Appendix 2). For commercial insurance or no insurance, prior authorization, when required in accordance with requirements outlined on Appendix 2, is submitted to the lead agency using Form 3-11 which is emailed securely to CTBirth23@ct.gov. Once a request for AT is approved by the lead agency, the program works with a Durable Medical Equipment (DME) vendor to purchase the item and submit for third party reimbursement.

DME vendors will submit prior authorization for devices to Medicaid or insurances. Birth to Three providers are encouraged to use DME Medicaid enrolled providers when submitting for DME items. When accessing Medicaid funding, DME vendors must accept Medicaid state rates (Provider Fee Schedule as posted on ctdssmap.com) as full payment. For commercial or no insurance, DME vendors may invoice Birth to Three programs for costs not covered by insurance, up to the Medicaid state rate. The lead agency will reimburse providers for costs up to the Medicaid state rate for approved AT devices. Families should never be billed for approved AT devices.

For Medicaid and commercial insurance, reimbursement for certain devices not billed through a DME vendor such as hearing aids and inexpensive, small AT devices will require prior approval in accordance with the Department of Social Services Provider fee schedule and prior authorization requirements. The Medicaid Program's medical administrative services organization (ASO), currently Community Health Network of Connecticut, Inc. (CHNCT) will review prior authorizations submitted by Birth to Three programs. Birth to Three providers can contact CHNCT member services number for a list of participating Medicaid enrolled DME providers at 1-800-859-9889. The Prior authorization process is delineated on the CHNCT website. (See appendix 2)

Reimbursement up to the Medicaid state rates, for partial or full costs of AT devices when there is commercial or no insurance will require prior approval from the lead agency in accordance with PA requirements for Medicaid, using Form 3-11 emailed securely to CTBirth23@ct.gov.

The lead agency will accept requests for approval for reimbursement of modifications to previously approved devices. In this instance, the program must submit the previously approved Form 3-11 clearly marked with a “REVISED” date that reflects the nature, purpose, and costs of the proposed modifications.

Using Form 3-11 (if PA was needed) or Form 3-12 (if PA was not needed), programs can bill the lead agency for costs not covered by insurance up to the Medicaid state rate or actual acquisition cost if the AT device is not available on the fee schedule. Programs must submit documentation as listed on Appendix 2 with their request for reimbursement for items purchased.

To meet timely filing requirements for reimbursement of AT Forms 3-11 and Form 3-12 must be submitted to the lead agency no later than 6 months from the date the device was dispensed. Otherwise, reimbursement will be denied.

**Refer to AT Reimbursement Chart (Appendix 2) at end of this procedure for details on submitting for reimbursement for AT.**

**Interpretation**

Reimbursement for interpretation will be paid to programs for services that meet requirements. The rate to be paid will be posted on the lead agency website. Requirements include reimbursement for the actual cost of interpreting services including phone interpretation for evaluations, assessments, IFSP Meetings, and EI Treatment Services conducted with interpretation by qualified personnel. Programs are encouraged to use the approved state vendors listed at <https://portal.ct.gov/das/ctsource/portal-page>. Go to CTsource Contract Board – search interpreter.

Interpreting services must be performed by an individual who is a sub-contractor of the EIS Program r specifically qualified and paid for interpretation services.  Interpreting services performed by a therapist simultaneously conducting an early intervention treatment service, evaluation, assessment or IFSP meeting will not be reimbursed.

Charges related to travel, parking, mileage and/or any other miscellaneous expenses are not allowed.  For services less than 2 hours and cancellations under 24 hours, if the interpreter service vendor bills the EIS program, the lead agency will reimburse programs for the amount billed up to 2 hours. However, programs should make every attempt to negotiate waiving minimums as part of providing services remotely.  Those cancellations must be entered into the Birth to Three Data System.   Invoices are reconciled using the Birth to Three Data System.

To receive payments, the program must submit documentation no later than 6 months from the date of service for the interpreting service along with proof of the interpretation services payment to the vendor. Which consists of:

* A vendor invoice with the child’s name, language, date, rate, and duration
* A copy of the canceled check or a zero-balance bill from vendor

**Distance Payments**

For the purpose of enhancing program quality and to help offset unforeseen program costs beyond the control of statewide EIS programs that specialize in supporting families with children who are Deaf or Hard of Hearing (DHH), a payment equal to the rate of one hour of EITS by a professional will be available as a Distance Payment.

The payment will only be applied if the visit occurs in person at the child’s home, childcare, or other community setting for children without disabilities and the town is outside of a local catchment area based on a list as established by the lead agency. Programs may also request the payment for visits when the family was not present for a confirmed appointment and the home visitor had already driven to the town. If the practitioner is traveling from his or her home, from visiting another child or from a satellite office to the setting where the EIS are being provided, the distance travelled must be greater than 20 miles.

To receive this payment, programs will bill the OEC on the monthly invoice using the “Other” section and fax or securely email a report supplied by the Lead Agency to the OEC AP inbox at oec.ap@ct.gov. If a family is not present for a previously confirmed visit or if the visit is not in the child’s home, the program must provide a list to oec.ap@ct.gov and include the billable amount under the “Other” section of the invoice. The list must include the child’s B23# number, name, town traveled to, proof of travel (i.e., mileage reimbursement or travel time submitted to the program) and a copy of the note left for the family.

**Reimbursement for Transportation to Audiological Visits**

Programs may be reimbursed for the actual cost of transportation services to audiological visits provided under Part C as part of an IFSP. Transportation services are defined as necessary to enable an eligible child and a member of the child’s family to travel to and from audiologists’ office where an audiological service is to be provided.

Transportation services reimbursement for families is approved only for audiological assessments or a visit to an audiologist’s office where specialized equipment is needed using a Birth to Three contracted provider. All services must be completed by at least one licensed audiologist. Only one reimbursement per family per day is permitted. Additional charges related to travel, parking, mileage and/or any other miscellaneous expenses are not allowed. Regardless, if reimbursement is being requested, programs must document that a parent was offered reimbursement for transporting their own child to Birth to Three audiological visits even if they decline.

Children who are Medicaid eligible have access to the non-emergency medical transportation covered by Medicaid. Veyo is the contracted provider in Connecticut to arrange transportation for HUSKY Health members. It may be necessary for service coordinators to complete a medical necessity form on Veyo to request a specific Birth to Three Provider. The form can be found on the Veyo website. There is no reimbursement for transportation for children who are eligible for HUSKY.

Transportation services include transportation by public common carriers, provider transportation service vehicles, taxicabs, car service or private automobile. All transportation services must meet federal and state regulations including using a child’s car seat, insured and registered vehicle, and licensed driver.

Transportation services must be by most economical means appropriate for the child. Rental car reimbursement will not be approved.

Mileage for transportation services may be reimbursed to a provider up to the most currently issued IRS optional standard mileage rate. Mileage reimbursement is for the most direct route from the home or starting point to the destination. If the most direct route is unavailable (e.g., road closed due to construction), then the provider must note the reason for additional mileage. Copies of maps showing the mileage must accompany PA requests.

Documentation of mileage or transportation is maintained by the Provider in a record that details the visit, including the child's B23 case number, date the service was delivered, the type of EI service provided, the name of the practitioner and discipline, the start and destination address, and the total number of miles.

The Lead Agency may audit mileage logs to substantiate mileage was delivered in accordance with the amount paid to providers.

To receive payments, the program must submit documentation no later than 6 months from the date of service along with proof of payment to the vendor or family. Which consists of:

* documentation that includes the child’s B23 case number, date of service, type of service, name of practitioner and discipline, start and end destination address and total number of miles.
* the vendor invoice
* a copy of the canceled check to the family/vendor or a zero-balance bill from vendor
* a copy of map showing the mileage

The amount will be included on the monthly Birth to Three invoice using the “Other” section with supporting documentation transmitted securely to the Lead Agency at OEC.AP@ct.gov and copied to BirthtoThreeFiscal@ct.gov.

MONTHLY SERVICE INVOICE SUBMISSION

Programs will bill the lead agency monthly for escrow payments (the amount reimbursed by third party payers subtracted from the posted state rates), GAPs and other payments identified on the monthly invoice. After confirming that all the data related to services provided in the billing month has been correctly entered and approved, programs must click the invoice signoff button. Signoff must occur by the close of business on 15th of each month or the close of business on the first Monday if the 15th falls on a weekend.

Programs should save copies of the invoice (using the Print Invoice button) and related reports before signoff and anytime changes are made during reconciliation.

After signoff, programs must send an email to OEC.AP@ct.gov with the subject line reading, “Birth to Three (insert month) invoice signed off and attached”. The program’s monthly invoice must be attached to the email. If the program is requesting reimbursement for “Adjustments” then supporting documentation must also be attached. Any PII must be redacted from attached documents and replaced with the child’s Birth to Three number. Supporting documentation for “Adjustments” may include bills for interpretation and assistive technology forms. Supporting documentation for “Other” may include documentation for distance payments and GAP issues. NOTE: If the invoice is revised, all required documentation must be resent to OEC.AP@ct.gov.

Payments to programs will be processed through the state’s CORE-CT system. Once an invoice has been entered into CORE for payment, an email from “Osc.Apd@ct.gov” is automatically sent to programs. This may not be to the Birth to Three program office if there is another email address in the CORE system.

The lead agency fiscal office will reconcile the invoice with available reports and documentation. If any discrepancies are found during their review, the program will be notified via email. Birthtothreefiscal@ct.gov is used for communication to reconcile any concerns or questions with the invoice.

**Issues with the Birth to Three Data System**

Any questions, discrepancies or errors related regarding payment and the Birth to Three Data System should be submitted to CTBirth23@ct.gov with “data system” in the subject line.



Escrow payments for claims approved on time and fully adjudicated during invoiced month will be populated by the CBO. These values should be compared to reports available from the third-party billing contractor.

GAP will be calculated by the lead agency using available data in the Birth to Three data system as described above in the GAP section of this procedure.

Adjustments require supporting documentation.

**Appendix 1: Adjudication Matrix Summary**

In EI Billing the CBO posts guidance regarding the Adjudication Matrix and directs Programs regarding actions to take on claims. Both the CBO and EIS programs will work on claims that are workable. In some cases, the CBO will be able to work the claim and resubmit quickly, in other cases the EIS program will need to collect or submit or correct information as identified under each category. For more information regarding the adjudication matrix search the EI Billing Portal.

**Payment terms and Acronyms**

270 - Eligibility request

271 - Eligibility response

835 - Electronic remittance advice

837 - Electronic claims

Adjudication Matrix – a list of how claim errors will be processed

ATN - Application Tracking Number

CBO - Central Billing Office

CMAP - Connecticut Medical Assistance Program

CMS – Centers for Medicare and Medicaid Services

CPT - Current Procedural Terminology

EDI - Electronic Data Interchange

EFT – Electronic Funds Transfer

EI Billing – the CBOs web-based portal for EIS programs to use

ERA - Electronic Remittance Advice

EIS - Early Intervention Services

EITS- Early Intervention Treatment Service

Escrow – funds held by the lead agency (state, federal part C and Part B,

FCP – Family Cost Participation

GAP - General Administrative Payments

GAINWELL- manages the billing data for DSS

HCPCS – Healthcare Common Procedure Coding System

HSA - Health Spending/Savings Account

NPI - National Provider Identifier numbers

OEC - Office of Early Childhood (OEC)

PA - Prior Authorization

PII - Personally Identifiable Information

SPA - State Plan Amendment

Workable - items in a program’s “Needs Attention Queue” are those which can be ‘fixed’ and resubmitted to insurers. (Non-workable claims move to escrow.)

Example 1 - Cause: A claim is submitted to insurer X, the claim is denied

Resolution: It is determined that the claim is denied due to there being another commercial insurer that should have been billed as the primary insurance. The family had forgotten to provide that insurance information upon intake. Once the insurance information is obtained and the claim is submitted to the primary insurance company, the claim is then reimbursed appropriately.

Example 2 - Cause: When checking eligibility through an electronic transaction the return decision states the child is not eligible.

Resolution: The program would check the insurance number with the family, and it turns out numbers were transposed. The correct data is put into the Birth to Three data system and the claim is resubmitted by the CBO and paid.

In some cases, the CBO will ‘work’ and resubmit claims.

Example 3 - Cause: A claim is submitted and rejected due to the wrong procedure code being sent to an insurer

Resolution: PCG checks the procedure code, determines the appropriate HCPCS or CPT code, then resubmits the claim and the claim is reimbursed appropriately.

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| **As needed (see below), prior to purchasing, submit Form 3-11 to lead agency or secure prior authorization (PA) from:** http://www.huskyhealthct.org/providers/prior-authorization.html#PA is NOT necessary for all AT devices. Rules/rates for AT reimbursement are the same for all children and mirror the DSS process for DME. (www.ctdssmap.com. Go to “Information”, select “Publications”. Scroll to Chapter 8, select “Birth to Three” provider type. Click “View Chapter 8”). Medicaid Rates available on Provider Fee Schedule (ctdssmap.com)  |
|  | *DME: Large Equipment* | *DME: Small AT Devices* | *Hearing Aids, Assistive Listening Devices, etc.* |
| Medicaid | -Work with Medicaid enrolled DME vendor to purchase AT device-DME vendor submits PA and all claim info to Medicaid and accepts Medicaid state rate as payment in full  | -E1399 code (misc. DME) -Work with Medicaid DME vendor (if DME vendor is willing to submit PA for approval for low-cost devices) **OR**-Program submits PA to CHNCT using E1399 code as required. (See fee schedule) http://www.huskyhealthct.org/providers/prior-authorization.html# Actual Acquisition Cost (AAC) + shipping required.-Program bills DXC Technology directly for AAC + shipping approved on PA - Medicaid state rate is considered payment in full. | -As needed, Birth to Three Provider submits PA to CHNCT using appropriate code found on the Birth to Three fee schedule. PA form found at: http://www.huskyhealthct.org/providers/prior-authorization.html# AAC + shipping required.- Program bills DXC Technology directly for Actual Acquisition Cost (AAC) + shipping approved on PA- Medicaid state rate is considered payment in full. |
| CommercialInsurance ORNo Insurance | - Submit PA to lead agency (LA) using 3-11-Work with DME vendor to purchase approved AT-Re-submit 3-11 after insurance payment is known-DME vendor bills program for balance up to state rate (after insurance) -Program bills lead agency for balance (No later than 6 months from the date of service) | -Program works with DME vendor (Vendor may not want to submit for low-cost devices) OR-For AT devices that cost less than the set Medicaid threshold for PA, program orders AT device and bills LA on Form 3-12 (AAC + shipping)-For AT devices costing more than the set Medicaid threshold, Form 3-11 is submitted for prior approval, program orders AT device and billing the LA using Form 3-11 (AAC +shipping) (No later than 6 months from the date of service) | - PA requested from lead agency (Form 3-11) only when needed, mirroring requirements in DSS Birth to Three fee schedule:-Program bills insurance directly -Program bills lead agency using Form 3-11- or 3-12 for expenditures not reimbursed by insurance up to the Medicaid state rate or as prior authorized on Form 3-11 (in alignment with Medicaid) (No later than 6 months from the date of service) |
| DocumentsNeededFor all insurances | Medical vendor responsible for documents required by Medicaid & other insurance. If submitting 3-11 or 3-12 to LA for balance after Commercial or no insurance see next column for documentation | Prescription, medical necessity documentation, pricing invoices (done in PA process for Medicaid)Delivery receipt. When submitting 3-12 or 3-11 to lead agency include above AND proof of payment (cancelled check or 0 vendor balance), proof of insurance acceptance/denial if above the Medicaid threshold for PA. Use Form 3-11 when PA required. | Prescription, medical necessity documentation, pricing invoices (done in PA process for Medicaid). Delivery receipt. When submitting 3-11- or 3-12 to lead agency include above AND proof of payment (cancelled check or 0 vendor balance), proof of insurance acceptance/denial if above the Medicaid threshold for PA. Use Form 3-11 when PA required |
| Signed Delivery Receipt must include: Provider name, client name, Itemization of DME delivered including product description, brand name, model name and number, serial number (if applicable), quantity delivered, amount billed per item, and date of delivery. All prescriptions must include: client’s name, address, date of birth, diagnosis related to DME need, detailed description of medical need of item including quantities and directions for use (as appropriate), length of need of item, name and address of prescribing practitioner, prescribing practitioner’s signature and date. During Medicaid audit if program billed Medicaid for item and is missing prescription or delivery receipt, then money is recouped.  |
| IPADs are not considered DME and not reimbursable through Medicaid or commercial insurance. IPADs are LOANED through NEAT. |