Children's Integrated Services

Guidance for Early Intervention System of Payments for Specialty Providers

July 2026

VERMONT
DEPARTMENT FOR CHILDREN AND FAMILIES
CHILD DEVELOPMENT DIVISION

Contents

Introduction

First, the only requirement for a provider to deliver and bill for services for Children's Integrated Services Early Intervention (CIS EI) is to be enrolled as a Medicaid provider.

Second, all providers must refer to any published billing information provided by the Department for Vermont Health Access.

The General Billing and Forms Manual is a great resource to learn about forms, timelines, and other standard Medicaid billing requirements.

Generally, CIS EI claims must adhere to Medicaid rules. While we do have federal dollars (known as the Payor of Last Resort, or POLR), Medicaid is automatically tested before claims reach POLR.

Welcome to the world of Children's Integrated Services Early Intervention!

Children's Integrated Services Early Intervention (CIS EI) is a federally funded program under Part C of the Individuals with Disabilities Education Act (IDEA). CIS EI is an entitlement program, meaning every enrolled child is entitled to receive the services that are listed in their care plan (Known as the 'One Plan'). The grant funding that the State of Vermont (the State) receives through IDEA Part C is used to pay for services for those families who would not otherwise be able to access them without financial assistance.

To ensure these funds, known as the Payor of Last Resort, or POLR, are available for the families who need it most, specialty providers are asked to follow a system of payments. Essentially, this system tests private insurance first, then public insurance (Medicaid), and then finally POLR.

Because Medicaid insurance is tested before claims hit POLR, the CIS Program generally adheres to Medicaid rules and standards.

This document will guide you through the high-level process for billing for EI clients.

If you have any questions, please email AHS.DCFCDDCISEI@vermont.gov to set up a one-on-one meeting.

Who are CIS EI clients?

CIS EI clients are children who have an observable delay. Children are evaluated using a 5 domain assessment to determine eligibility into the program.

Children may be automatically eligible for CIS EI based on medical conditions. These children do not receive a 5-domain evaluation when they enter the program but are assessed once they are old enough and/or healthy enough.

How Long are Children Eligible for CIS EI?

CIS EI serves identified eligible children from birth up to their third birthdate. This means that once the child is three, billing will not use the CIS EI system of payments.

Between birth and age three, children may enter and exit the program a number of times. If the child is not actively enrolled, billing will not use the CIS EI system of payments.

Common Definitions:

CIS One Plan Service Grid: Page 9 of the CIS One Plan document reflects what services the child is receiving, by whom, and how often. It serves three main purposes:

1. The family can see what providers they are working with to achieve their One Plan goals.
2. Under IDEA Part C, the service grid is the legally binding document that describes the services that the child is entitled to.
3. The State uses the service grid to verify payment requests. It is important that when submitting billing to the State, the most recent copy is attached to ensure faster processing.

Early Intervention Financial Assistance Request Form: This form, completed by the family, authorizes the State to pay CIS EI specialty providers on their behalf. A copy of this form is required for any invoices submitted to the State. The child's service coordinator should be giving this to you with a copy of the plan, but it can also be found on the CIS Website. For reference, a copy of this form is located at the end of this document.

Explanation of Benefits/ Remittance Advice (EOB/RA): This is the summary provided by insurance companies that illustrates the status of all claims submitted for processing, including how much money has been paid. The end of this document has examples from AETNA, Blue Cross Blue Shield, and Medicaid.

Family Infant Toddler Program (FITP): Is the old name for CIS EI. Once CIS was established, the name of the program changed from FITP to CIS EI. The MMIS system is old, which is why the technical terms still refer back to this acronym. When you are working with your Gainwell Representative, they may refer to the program as such.

FITP (FI) Voucher: The thing that makes all the billing work! The voucher indicates that the child is enrolled in CIS EI in the MMIS system. It is created through a data transfer between the State and MMIS system. The voucher must be 'active' for any billing to process.

Sometimes the voucher is not active. This can be for several reasons including:

- The State may not have received the child's information from the region to enter them into the State database.
- There is a data mismatch between a record that already exists in the MMIS system. This includes:
    - Spelling mismatches
    - Date of Birth mismatches
    - Social Security Number mismatches

If you are not able to find a client in the MMIS system when attempting to bill, this most likely means the FI voucher is not active. Reach out to the child's Primary Service Coordinator or CIS EI supervisor to ensure data has been sent to the State.

Gainwell: Gainwell is the organization that holds the contract with the State of Vermont to maintain the Medicaid Management Information System (MMIS). Using a system of automatic edits, MMIS tests submitted claims against different funding streams, which may include:

- WIC
- Economic Services Division
- Medicaid
- CIS EI Payor of Last Resort (POLR)

MMIS is sometimes used interchangeably with Medicaid and Gainwell.

Gainwell Provider Representative: The people who work at Gainwell can walk you through common questions or challenges related to billing. They represent primarily the Medicaid side of the process and can help with the details of claim submissions, troubleshooting denials, or other general questions.

- The general provider call line is 800-925-1706.
- Email your specific provider representative.
- Email the general provider representative email vtproviderreps@gainwelltechnologies.com

Internal Control Number (ICN): The ICN is the claim number automatically generated on each Medicaid EOB/RA. It is located above the service code for each claim line. When troubleshooting billing challenges, please provide this number. Please refer to #5 in the example of the Medicaid EOB at the end of this document.

Medicaid: Medicaid is a funding source held within the MMIS system. The CIS EI program is not Medicaid, but must follow the rules and standards set by them.

Medicaid Management Information System (MMIS): The payment mechanism that processes claims for all providers. Gainwell is the organization contracted with the State of Vermont to maintain and support it. It is sometimes used interchangeably with Medicaid and Gainwell. Using a system of automatic edits, MMIS tests claims against different funding streams, which may include:

- WIC
- Economic Services Division
- Medicaid

- CIS EI Payor of Last Resort (POLR)

MMIS is usually accessed through the Provider Electronic Solutions (PES), a free software supported by Gainwell. This detailed instruction manual will tell you what you need to know to set up the software and how to use it. It is not mandatory to use the PES.

If you have questions or need additional support, please reach out to your Gainwell Provider Representative.

Notice of Decision: The document generated once a CIS EI Prior Authorization (PA) has been entered into the MMIS system by the State. It shows the:

- PA number,
- Code(s) authorized,
- Unit(s) assigned, and
- Date range the PA is active for.

Once you receive this (usually via the mail to the address recorded in your Medicaid enrollment), submit your claim through the MMIS system. The end of this document has an example.

Payor of Last Resort (POLR): Is the pot of money from the IDEA Part C grant that is set aside to pay for CIS EI services for those families who would not be able to access those services otherwise. CIS EI is an entitlement program, so any services on the CIS One Plan are required to be delivered regardless of families' ability to pay.

Prior Authorization (PA): PAs are used to allow payment for a limited number of codes. These codes require additional information to be provided to the State prior to billing.

PAs are submitted to the State. Once approved, the State enters it into the MMIS system. Providers will know this has been done because they will receive the Notice of Decision document in the mail. The address it is sent to is the same one as is listed in your Medicaid provider enrollment. Once the Notice of Decision is received, the provider may bill through the MMIS system for payment.

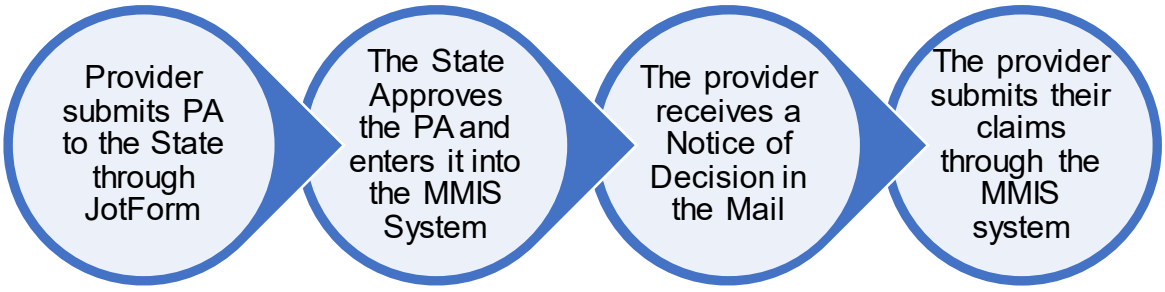


Figure 1 Prior Authorization Process

The end of this document has a full list of codes that are active for CIS EI and includes a column telling you if a PA is needed.

Provider Electronic Solutions (PES): The (free!) Gainwell Provider Electronic Solutions (PES) program is designed to provide the provider with a faster and more efficient method of transaction submission and processing. Handling time and errors are reduced, eliminating delays in processing, and decreasing turnaround times. PES is a transaction entry software package developed by Gainwell that meets the standards implemented by HIPAA. The software allows for electronic transaction submission directly to the Gainwell Oxi Translator.

Suspended Claims: When claims are submitted through MMIS, they are approved, denied, or put into suspension. Claims are 'suspended' when they've been caught by an edit in the MMIS system that needs to be reviewed by a human. If a claim is 'suspended', this does not automatically mean that it has been denied. It may take some time for the decision to be made depending on the complexity of the edit or the capacity at Gainwell.

Unique Identification Number (UID): This is the number generated when a client is in the MMIS system. Clients who are enrolled in Medicaid already have this number readily available. If clients have private insurance, then their data must be submitted to the State via childcount to establish a record and create a UID. You should receive the UID from the Primary Service Coordinator or the EI supervisor.

CIS EI Documentation Every Provider Needs to Begin Providing Services:

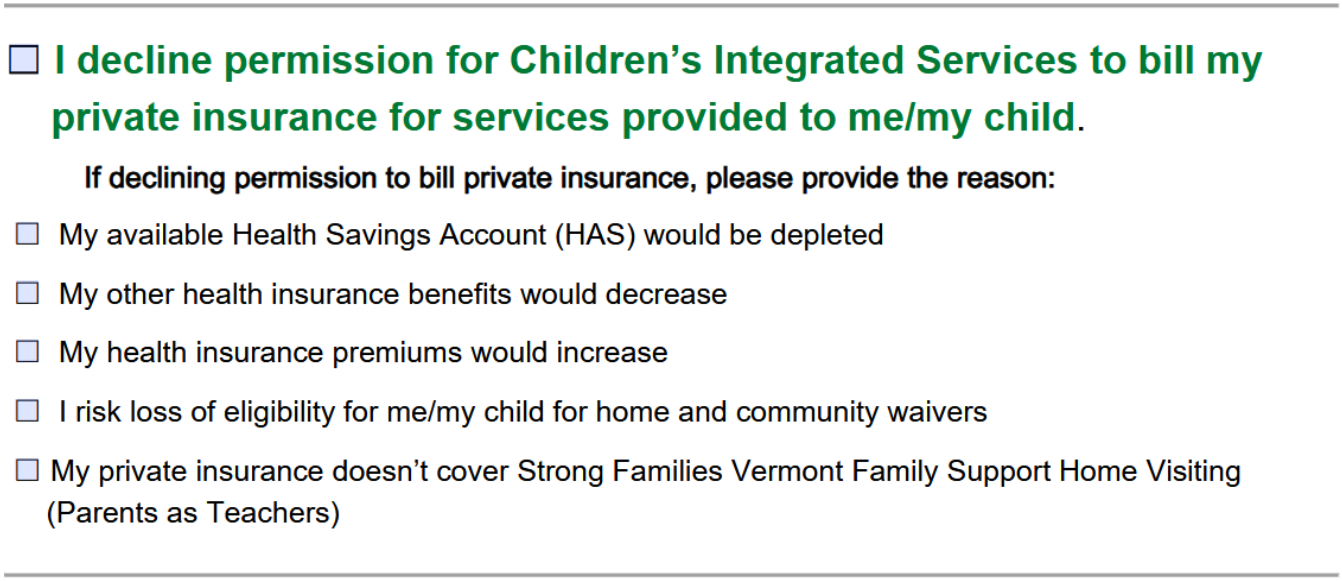
To be reimbursed for the provision of services, you must receive the following from the child's Primary Service Coordinator or CIS EI supervisor:

Children's Integrated Services Permission to Bill Private and Public Insurance Completed and signed by the family, this form authorizes or denies access to insurance. Families are not able to decline access to Medicaid, but they are able to decline access to their private insurance.

It is **essential** that you have the most recent copy of this. Families can and do change their insurance status and their permission to bill private insurance for services at any time.

The system of payments for CIS EI is set up to test private insurance first. This ensures that the federal POLR dollars are available to families that need it most. A family may choose to decline access to their private insurance, but they must not be counseled into it.

If a family, of their own accord, denies access to their private insurance, the entire form must be completed, meaning that one of the boxes that indicates the reason for denial at the top of page 2 must be checked.



☐ **I decline permission for Children's Integrated Services to bill my private insurance for services provided to me/my child.**

If declining permission to bill private insurance, please provide the reason:

- ☐ My available Health Savings Account (HAS) would be depleted
- ☐ My other health insurance benefits would decrease
- ☐ My health insurance premiums would increase
- ☐ I risk loss of eligibility for me/my child for home and community waivers
- ☐ My private insurance doesn't cover Strong Families Vermont Family Support Home Visiting (Parents as Teachers)

Figure 2: Private Insurance Denial Reasons

It is possible for a family to allow access to their private insurance for one service and deny access to another service. If this is the case, there must be two signed forms, each identifying the specific service and the family's decision regarding consent for that service.

If the family declines access to their private insurance, you will need to attach this form to any claims submissions. For more information, please see below.

Providers should also be aware if a family has a health savings account, and if they allow permission to bill this. If billed inappropriately, the provider must go through a recoupment process by re-imbursing the private insurance and re-billing through the MMIS system.

An example of the form may be at the end of this document.

Current CIS One Plan Service Grid

Service grids should include at minimum:

- The name and date of birth of the child.
- The date the family signed their consent to begin services.
- The name of the service delivered.
- The name of the provider delivering that service.
- The frequency of the service delivered.
- The first date of service (known as the 'actual start date')

Note: for your records and reference you should also have a copy of any Outcomes pages for the outcomes you and your services support.

EI Request for Financial Assistance Form

This form, completed by the family, authorizes the State to pay CIS EI specialty provider bills on their behalf. A copy of this form is required for any invoices submitted to the State. You should receive this from the child's service coordinator or CIS EI supervisor, but it may also be found on the CIS Website. For reference, a copy of this form is located at the end of this document.

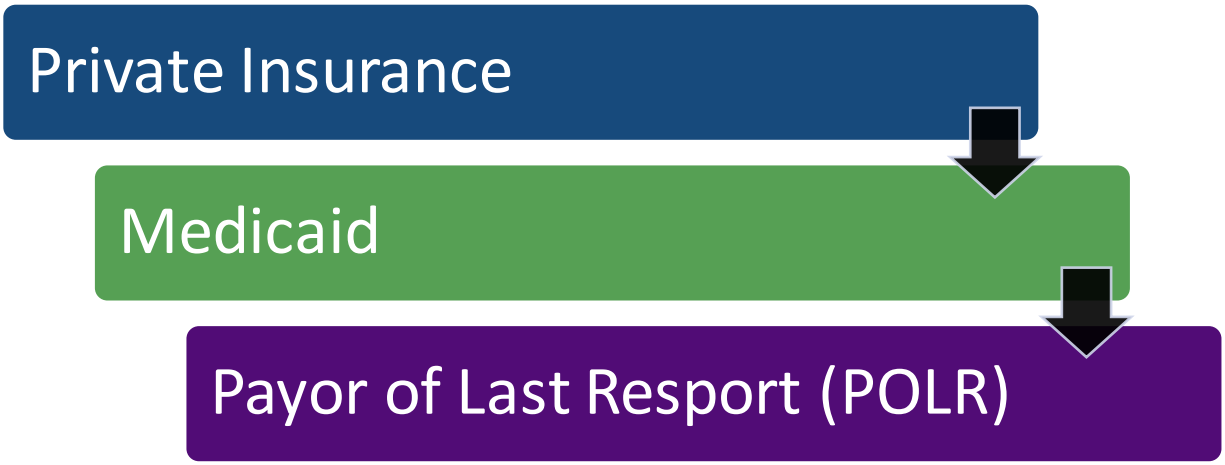
How does this all work?

Data for every CIS EI client is submitted to the State monthly by the regional CIS program. The State transfers data to the MMIS system on a weekly basis to establish and maintain the FITP voucher. If you are unable to locate a client in MMIS, this may point to an error with the FITP voucher.

If you are not getting these documents for each client you serve through CIS EI, you should reach out to the child's Primary Service Coordinator or the EI supervisor to request them.

Vermont System of Payments Based on Child's Insurance Status:

To ensure CIS EI federal funds (known as the Payor of Last Resort, or POLR) are available for the families who need it most, specialty providers are required to follow a system of payments. Essentially, this system tests private insurance first, then Medicaid, and then finally POLR.



The CIS EI Program is not Medicaid, but it does generally follow Medicaid rules and standards.

This section will walk you through the high-level process for billing for CIS EI clients based on their insurance status.

There are six possible insurance statuses:

1. A client has no insurance.
2. A client only has Medicaid.
3. A client has both Medicaid and Private Insurance **and allows** access to bill their private insurance.
4. A client has both Medicaid and Private insurance **and does not allow** access to their private insurance.
5. A client only has Private Insurance **and allows** access to bill their private insurance.
6. A client only has Private Insurance **and does not allow** access to bill their private insurance.

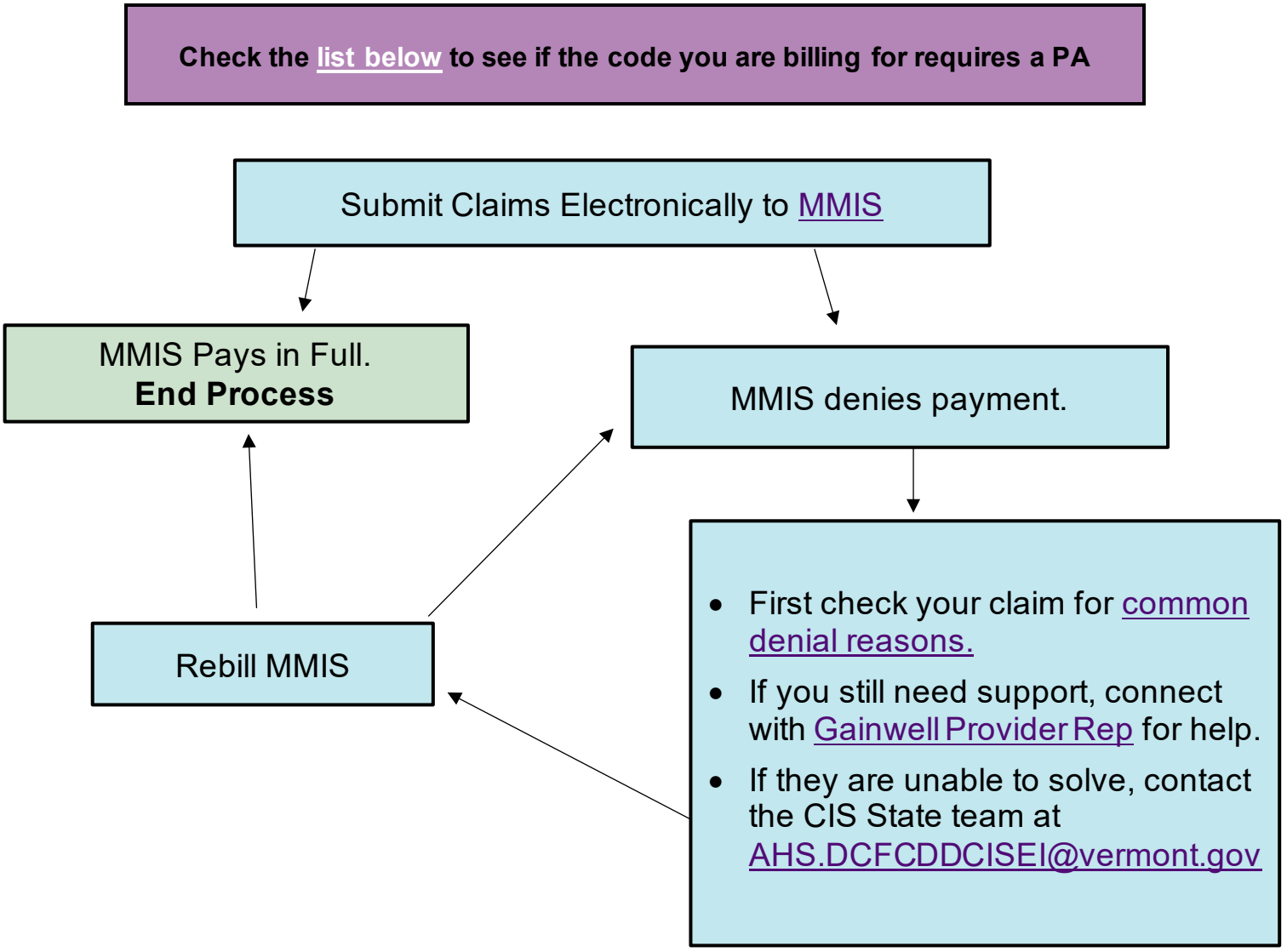
Before billing, ensure that you are aware of the current insurance status and have the most recent copy of the completed Permission to Bill Private and Public Insurance Authorization Form.

If the family has denied access to their private insurance, make sure the top section of page 2 showing a reason for denial is completed.

How To Bill for A Client Who Either Has Only Medicaid Insurance Or Does Not Have Any Insurance At All.

The CIS EI State Team is not Medicaid and cannot tell providers how to bill or what codes to use.

1. Submit claims electronically to MMIS. Many providers use the free PES system from Gainwell.
    a. If there is a denial, review your claim for common billing errors.
    b. If you're unable to figure out why you were denied, contact the Gainwell Provider Representative for help.
    c. If the Gainwell Provider Representative is unable to help you solve the denial reason, contact the CIS EI State team at AHS.DCFCDDCISEI@vermont.gov



How To Bill for A Client Who Either Has Both Medicaid And Private Insurance Or Private Insurance Only And Allows Access To Bill Their Private Insurance

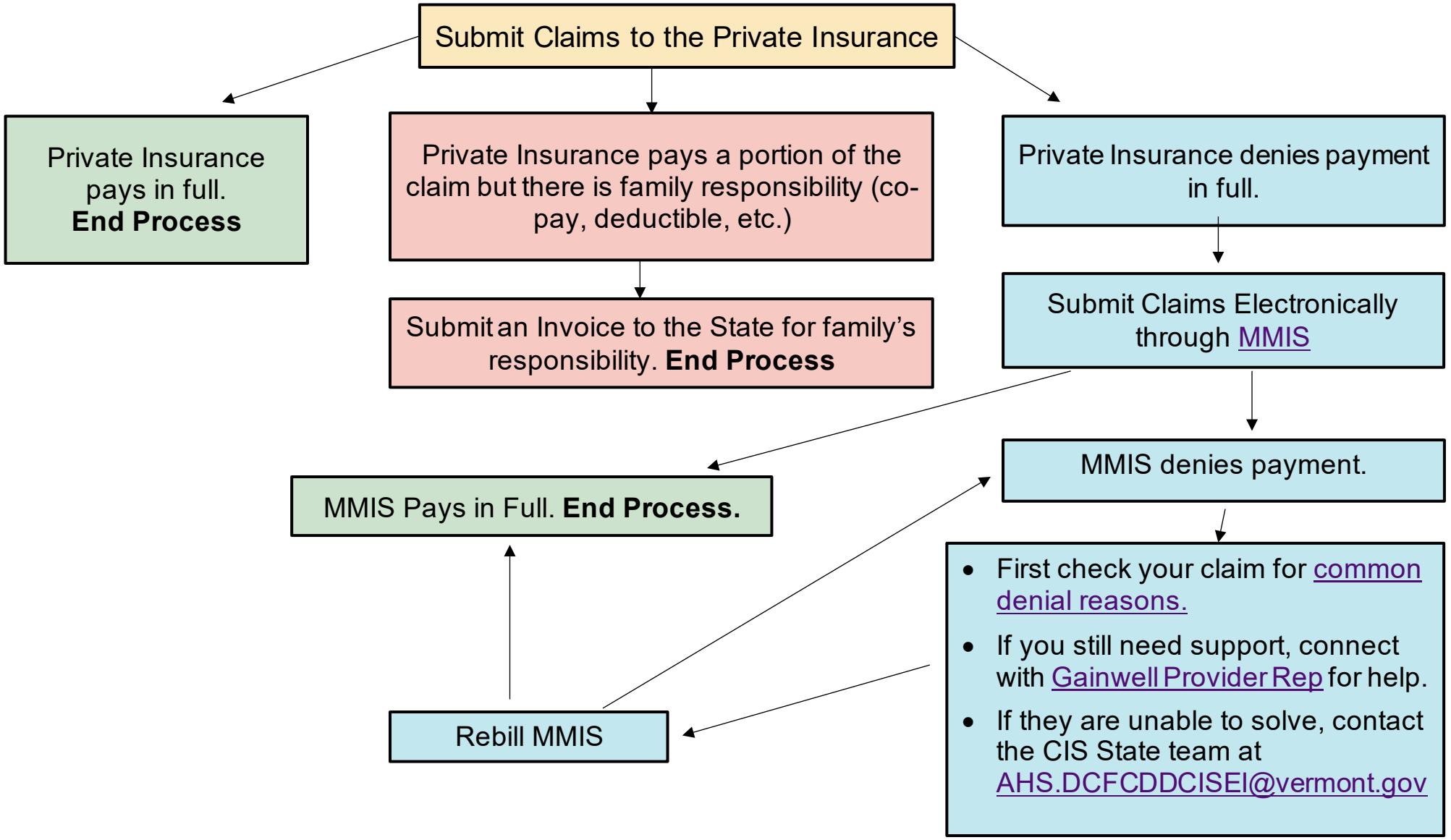
The CIS EI State Team is not Medicaid and cannot tell providers how to bill or what codes to use.

1. Submit claims to Private Insurance first.
    a. If Private Insurance pays everything, this ends process.
    b. If Private Insurance pays a portion of the claim and there is a family co-pay/ deductible/ co-insurance, submit an invoice to the State. This ends the process.
    c. If Private Insurance denies everything, move to step 2.
2. Submit claims electronically to MMIS. Many providers use the free PES system from Gainwell.
    a. If there is a denial, review your claim for common billing errors.
    b. If you're unable to figure out why you were denied, contact the Gainwell Provider Representative for help.
    c. If the Gainwell Provider Representative is unable to help you solve the denial reason, contact the CIS State team at AHS.DCFCDDCISEI@vermont.gov

Check the list below to see if the code you are billing for requires a PA

Vermont Medicaid has a webinar to describe how to attach secondary electronic claims.

Client Has Either Both Medicaid + Private Insurance or Private Insurance Only and DOES Allow Access to Bill Their Private Insurance



What if a family has given permission to bill their private insurance, but the provider is out of network?

Depending on the family's plan, some private insurance companies **will** pay for services delivered by providers out of network.

Because of this, providers who are out of network should still test the family's insurance at least one time. If there is some coverage and there is a family copay or deductible, the State will reimburse using the invoice process described below.

If it is established that that code is not covered, then the next claim can bypass billing private insurance and go straight to billing through MMIS.

Every family's plan is different, so even if you have two clients that have the same private insurance company, one may deny but the other may pay out.

The below are instructions pulled from the insurance companies' website that direct providers how to verify coverage:

- **AETNA**: Verify benefits via the Aetna provider portal on Availity, confirming patient eligibility, and checking for plan-specific OON benefits (often restricted to emergencies). Aetna pays OON claims based on "recognized charges" (often 80th percentile of data) or Medicare rates, allowing providers to bill members for the balance.

- **Anthem**: Verify benefits through Availity Essentials for coverage details. While OON providers can balance bill for amounts above the allowed rate, HMO and EPO plans often offer no OON coverage

- **Blue Cross Blue Shield (BCBS):** verify benefits through Availity Essentials, calling the number on the member's ID card (e.g., 1-800-676-BLUE for BlueCard), and checking for specific out-of-network benefits. While reimbursement is often available, it is typically lower, accompanied by higher patient cost-sharing, and subject to negotiation under the No Surprises Act, particularly if out-of-network benefits are absent.

- **CIGNA**: Check benefits on the Cigna for Health Care Professionals portal, calling the number on the patient's ID card, or using the Cost of Care Estimator. Non-participating providers are reimbursed based on a "Maximum Reimbursable Charge" (MRC), which is typically a percentile of billed charges in a specific geographic area

- **MVP**: Determine if you will be paid by MVP Health Care for out-of-network (OON) services by verifying the patient's plan type (e.g., PPO often allows OON, while HMOs may not). Payment is generally based on a percentage of the allowed amount rather than billed charges, and OON deductibles must often be met first.

- **United Health:** Verify benefits before appointments, registering on the UHC provider portal, and using Optum Pay to track claims. Payment is determined by UHC

benchmarking (often 80th percentile of FAIR Health data), Viant, or negotiated rates, rather than billed charges.

How To Bill for A Client Who Either Has Both Medicaid and Private Insurance Or Has Only Private Insurance And Does Not Allow Access To Bill Their Private Insurance

The CIS EI State Team is not Medicaid, and cannot tell providers how to bill or what codes to use.

1. Use the 1500 form to fill out the claim submission. Instructions for the form can be found here.
2. Include in the packet the Children's Integrated Services Permission to Bill Private and Public Insurance form that illustrates the family's denial to access private insurance.

   Make sure the reason for denial is checked on the top of page 2. If nothing is checked, the claim will deny.
3. Email the 1500 forms to the Gainwell Provider Representative.

Check the list below to see if the code you are billing for requires a PA.

Why do I need to submit claims via the 1500 form when a family denies access to their private insurance?

The MMIS system is set up to automatically deny claims for clients who are identified as having private insurance. By submitting the 1500 form and Insurance Authorization denial by mail or by email, a human at Gainwell will manually enter an override into the system to allow payments to be made.

Client Denies Access to Private Insurance

Submit Claims on the 1500 Form and include the CIS Permission to Bill Private and Public Insurance form by mail or email to Gainwell Provider Representative.

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MMIS Pays in Full. **End Process.**

Invoice Requirements

Invoices Should be Submitted to the State When:

- After billing private insurance, there is a family share. Examples include:
  - Co-pay
  - Deductible
  - Co-Insurance
- Requested by the CIS State team.

Invoice Format

Invoices must be sent with all required attachments to the State via JotForm.

The State does not have a standard template for invoices. The minimum information that all invoices must include are:

- Provider name.
- Provider's business name (if different from Provider's name).
- Provider business address (This should match the address on the current W9).
- Date of invoice.
- Invoice number (for future reference).
- Name of Client(s) served.
- Date(s) of service.
- Codes you're using.
- Charges for each date.
- Total dollar amount requested- must be equal to or less than the amounts on the EOB/RA for the client share. If it's greater than what the EOB/RA lists, the State will deny the invoice, notify you, and shred it.

A Medicaid 1500 form may also be used as an invoice- Instructions for completing this

The State must follow Medicaid rules around timely filing. However, because private insurance sometimes takes a long time to return their EOB/RAs, the date(s) of service may be well over six months before an invoice can be submitted to the State. Because of this, the State uses the date of the invoice submitted to CIS EI to determine timeliness. This means the date of the invoice must be within 6 months of the date it was submitted to the State.

If you submit an invoice, you don't need a CIS PA too.

Required Documents Invoices Must be Accompanied by:

1. The EOB/RA from the insurance provider that illustrates the payments that are the family's responsibility.
2. The most recent CIS One Plan Service Grid covering the dates of services listed on the invoice. This must include the actual start date of service.
3. A signed Early Intervention Financial Assistance Request form (example here) located on the CIS Website.

First Time Submission Only: W9 Form

If this is your first time submitting an invoice to the State, you must also submit a W-9 to be set up as a vendor in the State system. You only need to submit the W9 one time.

The most recent version of the W-9 form can be found in the forms section of the IRS website.

W-9 forms must be **physically signed and dated within the last six months**. The State does not accept electronically signed W-9 forms.

W-9 forms will not be accepted if there is any reason to question the authenticity of the form. This includes but is not limited to the following situations:

- Any original information is crossed out, written over, or covered up.
- Form is electronically signed in any manner. This includes drop and drag signatures.
- Form is partially typed and partially handwritten.
- Form is handwritten in multiple colors of ink.

The State of Vermont Financial Operations has the right to request a new W-9 form at anytime if it is deemed that something is questionable, illegible, or unclear.

State of Vermont employees must not fill out any portion of a W-9 on a supplier's behalf or instruct a supplier how to fill out the form.

State of Vermont employees must not instruct a supplier on how to properly complete a W-9 form. The IRS provides comprehensive instructions to help suppliers fill out the forms correctly. If a supplier needs assistance with completing a W-9 form properly, then they should seek the assistance of their tax professional, accountant, or the IRS directly.

Prior Authorization (PA) Guidance

All PAs must be accompanied by:

1. A Service Grid that aligns with the service, service date(s), and service frequency/month. Be sure to always submit the most recent service grid signed off on by the family to expedite the State's ability to process your request.
2. The Children's Integrated Services Permission to Bill Private and Public Insurance form.
3. A doctor's prescription/diagnosis when using the Treatment of swallowing dysfunction and/or oral function of feeding CPT code with the additional V1 modifier.

Details of Prior Authorization

PAs must be accurate and complete. If they are not accurate (i.e. do not match services listed on the Service Grid) or are not complete (i.e. are missing required data fields or accompanying documents), they will be denied and you will be notified via email from AHS.dcfcddcisei@vermont.gov.

For a complete list of all codes that require a PA, please see below.

PAs cover a six-month period. The first month that the requested start date is in begins the count. For example, if the requested start date of the PA is January 1, the PA would run from January 1- June 30. If the first date of service was January 31, the PA would still run from January 31- June 30.

When submitting a new PA for a child that is within three months of their third birthdate, the State will automatically enter a second PA segment to cover the time between the end of the first PA and the day before the third birthdate. If the birthdate is more than 3 months from the requested start date of the PA, then a second PA will need to be submitted to cover the time period up to the third birthdate.

Make sure you include any modifiers you may need. The PA is entered into the MMIS system to exactly match the PA request form. If the modifier is not on the request form, it will not be in MMIS and you will get denied if you bill with it.

Once a PA request has been received, the State verifies the information using the service grid and other information from the State's database. The number of units assigned to the PA are determined based on the frequency of the service shown on the service grid.

If the frequency of service is increased after a PA is already in place, continue to bill against it until you run out of units/ are denied. Once this happens, submit a new PA with an updated service grid. The PA's requested start date should be the day after the last date of service that paid out to ensure there is no gap in coverage.

PA requests will be processed within 10-12 business days. You will receive a Notice of Decision via the mail from the MMIS system once the PA is authorized. At that point, you can submit claims through MMIS.

If you notice an error on the Notice of Decision, email AHS.dcfcddcisei@vermont.gov right away. Please use a clear subject line.

If you have a PA and a claim is denied, please first reach out to your Gainwell Provider representative for support. If they are not able to help, reach out to the State at AHS.dcfcddcisei@vermont.gov.

Prior Authorizations (PAs) forms can be found on the CIS Website and must be submitted through JotForm. For detailed instructions on how to fill out the PA form, please see the Prior Authorization Guidance For Providers document on the CIS Website.

Information on the Most Common Billing:

The CIS EI State Team is not Medicaid and cannot tell providers how to bill or what codes to use.

Providers must use their professional judgement to make these decisions. Please refer to the Medicaid fee schedule for more information on each code.

Billing for Evaluations: There are two kinds of evaluations that may happen within CIS EI:

5-Domain Evaluation: is used to determine a child's eligibility for CIS EI. It is usually performed in conjunction with one other provider (usually the Primary Service Coordinator or developmental educator). This multidisciplinary evaluation is paid directly from the State to the regional CIS program. If you participate in this evaluation, seek reimbursement directly from the CIS program you are working with.

Specialty Evaluation: is used to determine the intensity and frequency of specialty services and is performed by the specialist providers (such as OT/PT/SLP). This type of evaluation is paid via MMIS.

To acknowledge the greater complexity of delivering services to children enrolled in CIS EI, there is a higher reimbursement rate of $200 when billed a specific way.

- 97163 GP V1 for Physical Therapists;
- 97167 GO V1 for Occupational Therapists; and
- 92523 GN V1 for Speech Language Pathologists.

The addition of the V1 modifier may be used once within a 12-month period without a PA.

To add the second modifier to your claim (if you're using the Gainwell PES system), you would select the first modifier in field 1 and then use your keyboard and tab over to field 2. It will un-shade the field and you will be able to enter the second modifier.

You are still able to use these codes without a V1 modifier as allowable under Medicaid rules.

As of July 2026, there are not any specific evaluation codes for the Vermont Association for the Blind and Visually Impaired (VABVI) or the Early Hearing Detection and Intervention (EHDI) programs. This is currently being actively explored with the Medicaid Policy Unit and Gainwell.

Evaluation to Determine if Child is Eligible for CIS EI	• Billing would be reimbursed to the Specialty Provider by the CIS Region
Evaluation to determine the intensity and/or frequency of a specific specialty service	• Specialty Provider bills through the MMIS system. The V1 modifier will pay out at the higher $200 rate.

Billing for Meetings: Meetings can be held with the child's team as often as is necessary based on the needs of the family.

Clients are allowed 6 meeting units per year. Any claims for meetings after these 6 units will automatically be denied in MMIS without a PA from CIS EI. If you know that you will be meeting with a family more than 6 times, or if you know the child is served by another provider, best practice would be to get a PA.

Billing for Mileage: If services are delivered more than 70 miles round trip, CIS EI will pay the Medicaid rate (which can be found on the fee schedule) for mileage. Please submit a PA request prior to billing through MMIS. This code excludes Home Health Agencies and VNAs.

Common Billing Tips and Tricks:

The CIS EI State Team is not Medicaid and cannot tell providers how to bill or what codes to use.

If the child has an underlying medical condition that is the root of the reason they need services, put that diagnosis in the 1st position as your diagnosis when billing MMIS or Part C as the Payor of Last Resort. Then put diagnosis(es) associated with your work in subsequent positions.

If the family has a Health Savings Account (HSA), make sure that the family consents to using it. If they need to change permissions, they can call the insurance company who should be able to take care of it. This information should be collected when the Children's Integrated Services Permission to Bill Private and Public Insurance form is completed.

If you are attempting to bill and cannot find the child in the MMIS system, there may be something wrong with the FITP Voucher. Please reach out to the Primary Service Coordinator or EI supervisor to ensure all data has been sent to the State.

Common Denial Reasons

Check and make sure that:

- The spelling of the first and last name is correct.
- The date of birth is correct (especially year).
- The SSN/UID is correct.
- The date of service is correct (especially year).
- The correct modifiers are used.
- The location of service is correct. Information related to telehealth services can be found on the Department of Vermont Health Access (DVHA) webpage.
- This is not a duplicate request.
- This claim was submitted within 6 months of the date of service. Medicaid rules state that claims for services more than 6 months from the date of service will automatically deny.

  If you know that you are billing for dates of service beyond six months, submit the claim and get the denial. Once a denial has been made, you can resubmit your claim with a timely filing consideration request. Medicaid rules state that you cannot submit a timely filing request until there is that specific denial on file. Requests must be submitted via email to VT-reconsiderations@gainwelltechnologies.com. Beginning July 1, 2026, Vermont Medicaid will no longer access paper submissions.

The Medicaid EOB will indicate a reason for denial. See below for a visual.

Full List of Codes Covered by CIS EI

The CIS EI State Team is not Medicaid, and cannot tell providers how to bill or what codes to use.

The table below shows the current active code list for the Early Intervention Program. Early Intervention follows Medicaid rules. Providers are encouraged to do their own investigations as to which code and modifier combinations are the most appropriate.

The professional organizations may provide support and details on appropriate code usage.

- Occupational Therapist- https://www.aota.org/
- Physical Therapist- https://www.apta.org/
- Speech and Language Therapist https://www.asha.org/

Remember, when selecting the codes, refer to the Medicaid Fee Schedule for the most current reimbursement rates.

If you there is a CPT code that you believe should be covered by CIS EI, please email the State team at AHS.DCFCDDCISEI@vermont.gov and we will review.

Procedure Code Description	Procedure Code	Allowed Modifiers	Is a PA Needed?
Individual, in-person treatment of speech, language, voice, communication, and/or auditory processing disorders	92507	GN	No
Treatment of speech, language, voice, communication, and/or hearing processing disorder in a group setting	92508	GN	No
Evaluation of speech continuity, smoothness, rate, and effort	92521	GN	No
Evaluation of speech sound production	92522	GN	No
An evaluation of speech sound production combined with an evaluation of language comprehension and expression	92523	GN	No
Analysis of voice and resonance production	92524	GN	Yes
Treatment of swallowing dysfunction and/or oral function of feeding	92526	GN, GO, V1	Only the V1 modifier
An automated, qualitative screening of evoked otoacoustic emissions (OAE) to assess cochlear hair cell function	92558	N/A	No

Procedure Code Description	Procedure Code	Allowed Modifiers	Is a PA Needed?
Evaluation for use of voice artificial device to supplement oral speech	92597	GN	Yes
Evaluation with prescription of speech-generating and alternative communication device, first hour	92607	GN	Yes
Evaluation with prescription of speech-generating and alternative communication device, each addition(see book)	92608	GN	Yes
Evaluative and Therapeutic Otorhinolaryngologic Services	92609	GN, GO, GP	No
Evaluation of swallowing function	92610	GN, GO, GP	No
Evaluation of swallowing function image	92611	GN, GO, GP	No
Measurement of range of motion in arm, leg or each spine section	95851	GO, GP	No
Measurement of range of motion of hand	95852	GO, GP	No
Repositioning exercises of head for treatment of dizziness, each day	95992	GO, GP	No
Test to assess the loss of the ability to speak, write, and understand language	96105	GN, GO, GP	No
Test to assess the ability to complete specific functional tasks applicable to environment	96125	GN, GO, GP	No
Other physical medicine service or procedure	97039	GO, GP	Yes
Therapeutic procedure/exercise to develop strength, endurance, range of motion and flexibility	97110	GN, GO, GP	No
Neuromuscular reeducation	97112	GO, GP	No
Aquatic therapy services	97113	GO, GP	No
Therapeutic procedure: gait training	97116	GO, GP	No
Massage therapy, including effleurage, petrissage, and or tapotement	97124	GO, GP	No
Therapeutic interventions that focus on cognitive function (First 15 Minutes)	97129	N/A	No- but only one provider may bill for this service for the same child on the same day.

Procedure Code Description	Procedure Code	Allowed Modifiers	Is a PA Needed?
Therapeutic interventions that focus on cognitive function	97130	N/A	No- but only one provider may bill for this service for the same child on the same day.
Unlisted therapeutic procedure	97139	GN, GO, GP	No
Manual therapy techniques,	97140	GN, GO, GP	No
Therapeutic procedure(s), group (2 or more individuals), which is a service-based, untimed code used to bill for group therapy sessions where a qualified therapist provides ongoing supervision and guidance to multiple patients simultaneously. Key aspects include that the code is billed per patient per session, not by time, and the patients do not need to be performing the same activities.	97150	GN, GO, GP	No
Physical therapy evaluation: low complexity	97161	GP	No
Physical therapy evaluation: moderate complexity	97162	GP	No
Physical therapy evaluation: high complexity	97163	GP	No
Physical therapy reevaluation	97164	GP	No
Occupational therapy evaluation: low complexity	97165	GO	No
Occupational therapy evaluations: moderate complexity	97166	GO	No
Occupational therapy evaluations: high complexity	97167	GO	No
Occupational therapy reevaluations	97168	GO	No
Therapeutic activities	97530	GO, GP	No
Stimulation of the sensory system of patients with established dysfunction of sensory processing	97533	GO, GP	No
Self-care/Home Management Training	97535	GN, GO, GP	No

Procedure Code Description	Procedure Code	Allowed Modifiers	Is a PA Needed?
Wheelchair management (e.g., assessment, fitting, training), a 15-minute unit of time spent evaluating a patient's need for a wheelchair, custom-fitting it for proper posture and comfort, and training the patient and/or their caregiver on its safe and effective use	97542	GO, GP	No
The initial 30 minutes of face-to-face caregiver training (without the patient present) regarding strategies to facilitate a patient's functional performance, such as ADLS, transfers, or safety	97550	GN, GO, GP	No
Subsequent 15 minutes of caregiver training in strategies and techniques to facilitate the patient's functional performance (see book)	97551	GN, GO, GP	No
Group caregiver training in strategies and techniques to facilitate the patient's functional perform(see book)	97552	GN, GO, GP	No
First 30 minutes of caregiver training without the patient present	97750	GN, GO, GP	No
Assistive technology assessment	97755	GN, GO, GP	No
Orthotic(s) management and training (including assessment and fitting when not otherwise reported), specifically for an initial encounter, billed in 15-minute increments	97760	GO, GP	No
Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	97761	GN, GO, GP	No
Subsequent, face-to-face encounters (every 15 minutes) for orthotic(s) or prosthetic(s) management and training, including assessment, fitting adjustments, and training for upper extremities, lower extremities, or the trunk	97763	GN, GO, GP	No
Other physical medicine or rehabilitation service or procedure	97799	GN, GO, GP	Yes
Initial assessment and intervention for Medical Nutrition Therapy (MNT), conducted face-to-face with an individual patient, billed in 15-minute units	97802	N/A	No

Procedure Code Description	Procedure Code	Allowed Modifiers	Is a PA Needed?
Medical Nutrition Therapy (MNT) reassessment and intervention, provided individually, face-to-face with a patient, billed in 15-minute units	97803	N/A	No
Extended mileage (More than 70 miles round trip)	99082	N/A	Yes
Instrument-based ocular screening (e.g., photoscreening, automated-refraction), bilateral; with remote analysis and report	99174	N/A	No
Medical team conference- with the family present	99366	N/A	No
Medical team conference- no family, with doctor	99367	N/A	No
Medical team conference- no family	99368	N/A	No
Case management, per month". This HCPCS code is used to bill for comprehensive, coordinated care for patients with complex needs, such as chronic illnesses, multiple health conditions, or challenges managing their medical treatment.	T2022	GN, GO, GP	No
Family training & counseling	T1027	N/A	Yes
Sign language, oral interpreter	T1013	N/A	No
Nutritional counseling	S9470	N/A	No
Speech therapy	S9128	GN	No
Home care training related to the safety of the child	S5111	N/A	No

Medicaid Special Investigations Unit

Vermont Medicaid pays only for services that are actually provided and that are medically necessary. In filing a claim for reimbursement, the code(s) should be chosen that most accurately describes the service that was provided. It is a felony under Vermont law 33VSA Sec. 141(d) knowingly to do, attempt, or aid and abet in any of the following when seeking for receiving reimbursement from Vermont Medicaid:

- Billing for services not rendered or more services than actually performed
- Providing and billing for unnecessary services
- Billing for a higher level of services than actually performed
- Charging higher rates for services to Vermont Medicaid than other providers
- Coding billing records to get more reimbursement
- Misrepresenting an unallowable service on bill as another allowable service
- Falsely diagnosing so Vermont Medicaid will pay more for services

For more information on overpayments and potential interest charges, visit the General Provider Manual, section 6.

Suspected fraud, waste or abuse should be reported to the DVHA Special Investigations Unit, telephone 802.241.9210, or the Vermont Medicaid Fraud Control Unit of the Vermont's Attorney General's Office, telephone 802.828.5511.

Example of Permission to Bill Public and Private Insurance Form

Children's Integrated Services
Permission to Bill Private and Public Insurance

Date: _____

Child's Name: _____

Child's Social Security Number: _____

Child's Date of Birth: _____

Office Use Only
CIS-02 Supplemental with Family
Version 3.21
Ins. Co #: _____ (office use only)

Primary Insurance Information

Name of Insurance Company: _____ Insurance Company Phone: _____

Insurance Company Address: _____

Policy Number: _____ Group or Contract Number: _____ Policy Effective Date: _____

Employer or Group Name: _____ Policy Holder Name: _____

Consent to Bill Insurance

- I give my permission to AHS Children's Integrated Services (CIS) to bill my private or public insurance for the specified services listed in my/my child's One Plan.
- I understand that I may refuse to give this consent.
- I understand, if my child qualifies for Part C Early Intervention program services and I refuse consent to bill my private or public insurance for One Plan services this refusal will not affect services for my child that are covered by the Part C Early Intervention Program.
- I understand that by giving permission to seek payment from my insurance, information about me/my child's CIS may be shared in this process.
- I understand that if I choose not to sign this form, any benefits for which my child and family are entitled will not be affected.
- I understand that I may revoke consent to bill my private or public insurance at any time. If I revoke this consent it will apply to billing for services from that date forward. I can revoke my consent by writing to the address below.
- I understand I will be informed about Early Intervention financial support, if this is a service my child is entitled to, in the system of payments brochure.

☐ I give my permission for Children's Integrated Services to bill: ☐ Private Insurance ☐ Medicaid

For services provided to me or my child for CIS One Plan services or Part C Early Intervention services. I understand that information about my/my child's services including early intervention services may be shared in that process.

OR

☐ I decline permission for Children's Integrated Services, including Part C Early Intervention, to bill my private insurance for services provided to me/my child.

If declining permission to bill private insurance, please provide the reason:

☐ My available health savings account would be depleted.
☐ My health insurance premiums would increase
☐ My other health insurance benefits would decrease.
☐ I risk loss of eligibility for me/my child for home and community waivers.

I certify, the information I have provided on this form is correct and agree that I will notify DCF/CDD of any changes to this information. Changes should be mailed to: Vermont DCF Child Development Division – Children's Integrated Services, 280 State Drive, NOB 1, Waterbury, VT 05671-2090

Client, or Parent/Guardian Signature: _____ Date: _____

Example of Children's Integrated Services One Plan Service Grid

VERMONT
DEPARTMENT FOR CHILDREN AND FAMILIES
CHILD DEVELOPMENT DIVISION

Integrated One Plan
Version 4-13

Services

This is a summary of supports/services needed to achieve the outcome(s) identified in your plan. This plan was developed by you and your CIS team.

Supports and Services	Outcome #s	Qualified Provider's Title/Agency	Location (Is the location client's natural environment?)	How long/ month? (hours/month)	Planned Start Date	Actual Start Date	Payer
Service Coordination 1		2			3		4 Private Ins. Medicaid POLR
				30 day timeline met or # days past date of consent: Timeline not met due to family circumstances (Explain):			
	New Outcome New Frequency Outcome Cont. Service Ended		Home Community Service Provider Location Justification for SPL on file				Private Ins. Medicaid POLR
				30 day timeline met or # days past date of consent: Timeline not met due to family circumstances (Explain):			
	New Outcome New Frequency Outcome Cont. Service Ended		Home Community Service Provider Location Justification for SPL on file				Private Ins. Medicaid POLR
				30 day timeline met or # days past date of consent: Timeline not met due to family circumstances (Explain):			
	New Outcome New Frequency Outcome Cont. Service Ended		Home Community Service Provider Location Justification for SPL on file				Private Ins. Medicaid POLR
				30 day timeline met or # days past date of consent: Timeline not met due to family circumstances (Explain):			

Client Name: | Date of Referral: | Date of Signed Consent: | Page 9

It is important that all providers have the most recent copy of the service grid that reflects their services.

The State uses this document to verify payment requests, primarily focusing on:

1. The name of the service
2. Who is delivering that service.
3. How often that service is delivered.
4. and the date that the service actually began

If you need a copy of the service grid, please reach out to the child's Primary Service Coordinator or the EI Supervisor.

VERMONT
DEPARTMENT FOR CHILDREN AND FAMILIES
CHILD DEVELOPMENT DIVISION

Example of Notice of Decision (NOD) Form

Authorization is valid only if the patient is eligible on the date of service.

MAIL TO:	BENEFICIARY'S NAME [redacted] 1
FITP CHILD DEVELOPMENT SERVICES 2 NO 103 S MAIN ST WATERBURY, VT 05671-2901	BENEFICIARY'S ID NUMBER XXX-XX-XXXX 2 — DATE OF BIRTH [redacted]
	PRESCRIBING (REQUESTING) PROVIDER NAME [redacted] 3
	PRIOR AUTHORIZATION NUMBER [redacted] 4 — DECISION DATE [redacted]
	PA RECEIVED DATE 01/01/2020

Member Information:

DTL 1.

The Department of Vermont Health Access has taken the following action on your request for medical services: Approved.

Your request for service is: Approved. The dates of service are as follows: Start 08/15/2019; Stop 01/02/2020.

DTL 2.

The Department of Vermont Health Access has taken the following action on your request for medical services: Approved

Your request for service is: Approved. The dates of service are as follows: Start 08/15/2019; Stop 01/02/2020.

Provider Information:

5 6 7

1. DTL	2. A/D/I	3. START DATE/ STOP DATE	4. REVENUE CODE PROCEDURE NDC DIAGNOSIS	5. Units	Dollars	Occurrence	POS
1	A	08/15/2019 01/02/2020	440	26			

ADDITIONAL COMMENTS: CIS/EI:AUTHORIZING SPEECH THERAPY SERVICES PERFORMED BY THIS HHA

1. DTL	2. A/D/I	3. START DATE/ STOP DATE	4. REVENUE CODE PROCEDURE NDC DIAGNOSIS	5. Units	Dollars	Occurrence	POS
2	A	08/15/2019 01/02/2020	99366 - 99368	6			

ADDITIONAL COMMENTS: CIS/EI:AUTHORIZING SPEECH THERAPY MEETINGS PERFORMED BY THIS HHA

Department of Vermont Health Access
Attn: Clinical Unit
NOB 1 South, 280 State Drive
Waterbury, VT 05671-1010
FAX: 802-879-5963

[redacted]
Name

NODs are generated after a **PA** has been entered into Gainwell. The key elements are:

1. Child's name
2. Child's date of birth
3. Provider's NPI and Business Name
4. PA number
5. Start Date/Stop Date is the date range that the PA is active for
6. Indicates what code is authorized. Any modifiers indicated on the PA form will also be represented here.
7. Number of units that the PA is authorized for.

Example of CIS Financial Assistance Request Form

Financial Assistance Request forms should accompany any invoices related to family responsibilities.

Children's Integrated Services
Early Intervention Financial Assistance Request

Please provide the following information so that we may process your request for financial assistance:

Parent/Guarding Name(s) _____

Mailing Address: _____

Child's Name: _____ Child's DOB: _____

Please list below:

- The service you are requesting EI financial support, for example Occupational therapy, Physical therapy, nutrition services etc.
- Frequency: how often? Weekly, bi-weekly, monthly etc.
- The amount of the co-pay per visit or the amount to be applied toward your deductible that you are requesting financial assistance with.

Requesting financial assistance for the following services:

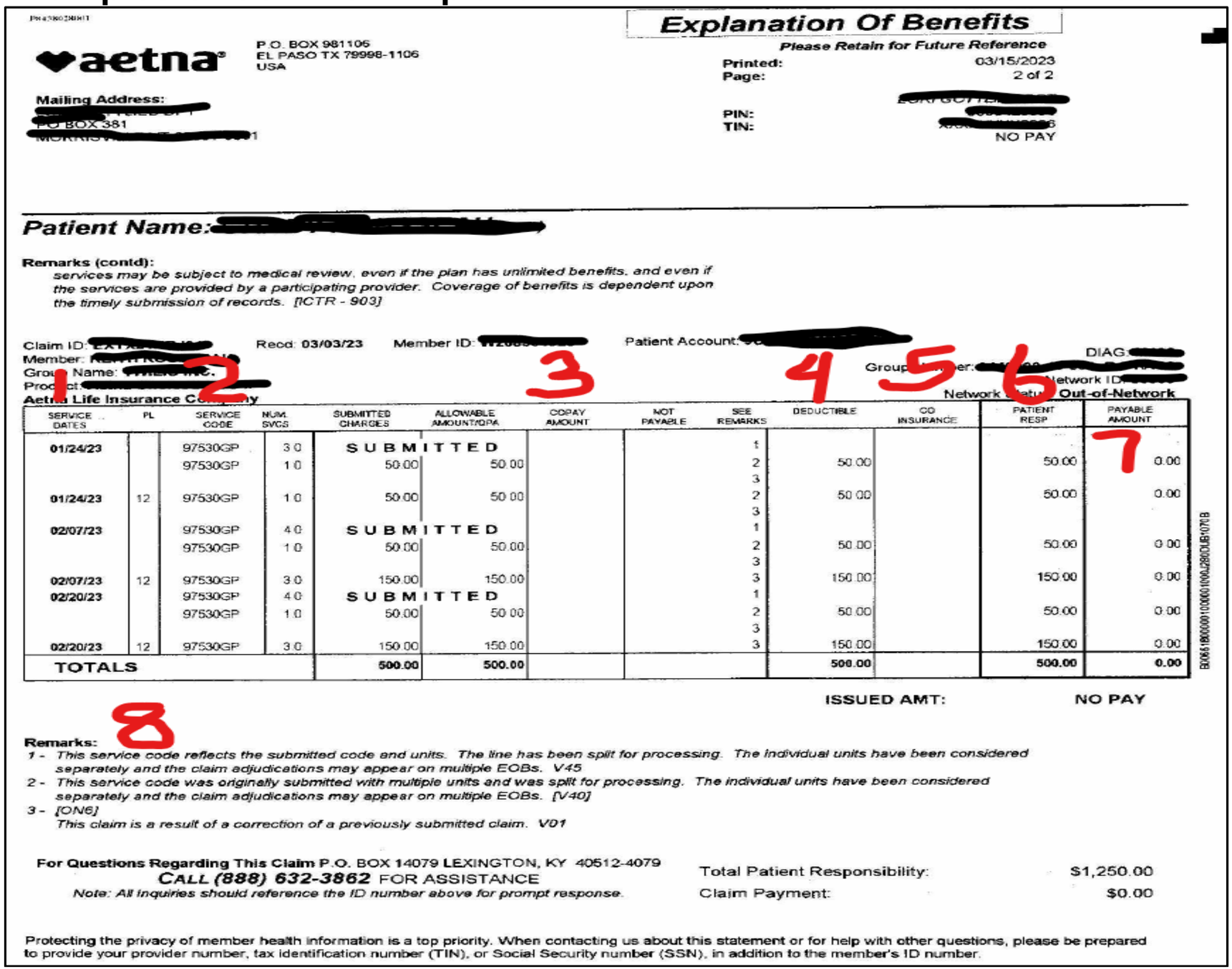
Service	frequency	Co-pay (per visit) or annual deductible amount

Parent Signature: _____ Date: _____

- Your provider will submit an invoice to CIS/Early Intervention for any insurance co-pays on the services your child receives. If you as a parent receive any invoices from your child's provider, please mail or fax them to the address below. You are not responsible for any additional charges for your child's approved services.
- Your provider will submit an invoice to CIS/Early Intervention for the services your child receives when your insurance company denies payment because your deductible has not met. The charge for the service will get applied toward your deductible but the payment for the service will be come from CIS/Early Intervention. If you as a parent receive any invoices from your child's provider, please mail or fax them to the address below. You are not responsible for any additional charges for your child's approved services.

CIS-Early Intervention
Attn: EI Invoicing
NOB 1 North, 280 State Drive
Waterbury, VT 05671-1040

Examples of Common Explanation of Benefits/ Remittance Advice AETNA



aetna

P.O. BOX 981106
EL PASO TX 79998-1106
USA

Explanation Of Benefits

Please Retain for Future Reference

Printed: 03/15/2023
Page: 2 of 2

Mailing Address:
[redacted]
PO BOX 381
[redacted]

PIN: [redacted]
TIN: [redacted]
NO PAY

Patient Name: [redacted]

Remarks (contd):
services may be subject to medical review, even if the plan has unlimited benefits, and even if the services are provided by a participating provider. Coverage of benefits is dependent upon the timely submission of records. [ICTR - 903]

Claim ID: [redacted] Recd: 03/03/23 Member ID: [redacted] Patient Account: [redacted]
Member: [redacted]
Group Name: [redacted] Group [redacted] DIAG: [redacted]
Product: [redacted] Network ID: [redacted]
Aetna Life Insurance Company Network Status: Out-of-Network

SERVICE DATES	PL	SERVICE CODE	NUM. SVCS	SUBMITTED CHARGES	ALLOWABLE AMOUNT/OPA	COPAY AMOUNT	NOT PAYABLE	SEE REMARKS	DEDUCTIBLE	CO INSURANCE	PATIENT RESP	PAYABLE AMOUNT
01/24/23		97530GP	3.0	SUBMITTED				1				
		97530GP	1.0	50.00	50.00			2	50.00		50.00	0.00
								3				
01/24/23	12	97530GP	1.0	50.00	50.00			2	50.00		50.00	0.00
								3				
02/07/23		97530GP	4.0	SUBMITTED				1				
		97530GP	1.0	50.00	50.00			2	50.00		50.00	0.00
								3				
02/07/23	12	97530GP	3.0	150.00	150.00			3	150.00		150.00	0.00
02/20/23		97530GP	4.0	SUBMITTED				1				
		97530GP	1.0	50.00	50.00			2	50.00		50.00	0.00
								3				
02/20/23	12	97530GP	3.0	150.00	150.00			3	150.00		150.00	0.00
TOTALS				500.00	500.00				500.00		500.00	0.00

ISSUED AMT: NO PAY

Remarks:
1 - This service code reflects the submitted code and units. The line has been split for processing. The individual units have been considered separately and the claim adjudications may appear on multiple EOBs. V45
2 - This service code was originally submitted with multiple units and was split for processing. The individual units have been considered separately and the claim adjudications may appear on multiple EOBs. [V40]
3 - [ON6]
This claim is a result of a correction of a previously submitted claim. V01

For Questions Regarding This Claim P.O. BOX 14079 LEXINGTON, KY 40512-4079
CALL (888) 632-3862 FOR ASSISTANCE
Note: All inquiries should reference the ID number above for prompt response.

Total Patient Responsibility: $1,250.00
Claim Payment: $0.00

Protecting the privacy of member health information is a top priority. When contacting us about this statement or for help with other questions, please be prepared to provide your provider number, tax identification number (TIN), or Social Security number (SSN), in addition to the member's ID number.

Important Fields to Notice:

1. Service Dates: the date that is being billed for
2. Service Code: This is the code that is being billed for.
3. Copay Amount: This is a family responsibility. If there is a dollar amount here, submit an invoice to the State for payment.
4. Deductible: This is a family responsibility. If there is a dollar amount here, submit an invoice to the State for payment.
5. Co-Insurance: This is a family responsibility. If there is a dollar amount here, submit an invoice to the State for payment.
6. Patient Resp: this is the summary of how the amount of payments the family are responsible for.
7. Payable Amount: This is how much the claim actually paid out.
8. Remarks: This will tell you why something was denied or reduced.

Example of Common Explanation of Benefits/Remittance Advice: Blue Cross Blue Sheild

BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

01045 8607978 002136 004271 0002/0003 k001045

FOR RELATED INQUIRES PLEASE CALL OR WRITE:

BLUE CROSS BLUE SHIELD OF VERMONT
P.O BOX 186
MONTPELIER, VT 05601-0186

PROVIDER NUMBER	TAX ID
[redacted]	[redacted]
REFERENCE NUMBER	**PAYMENT DATE**
[redacted]	11/14/2023

1 2 3 4 5

PROVIDER VOUCHER

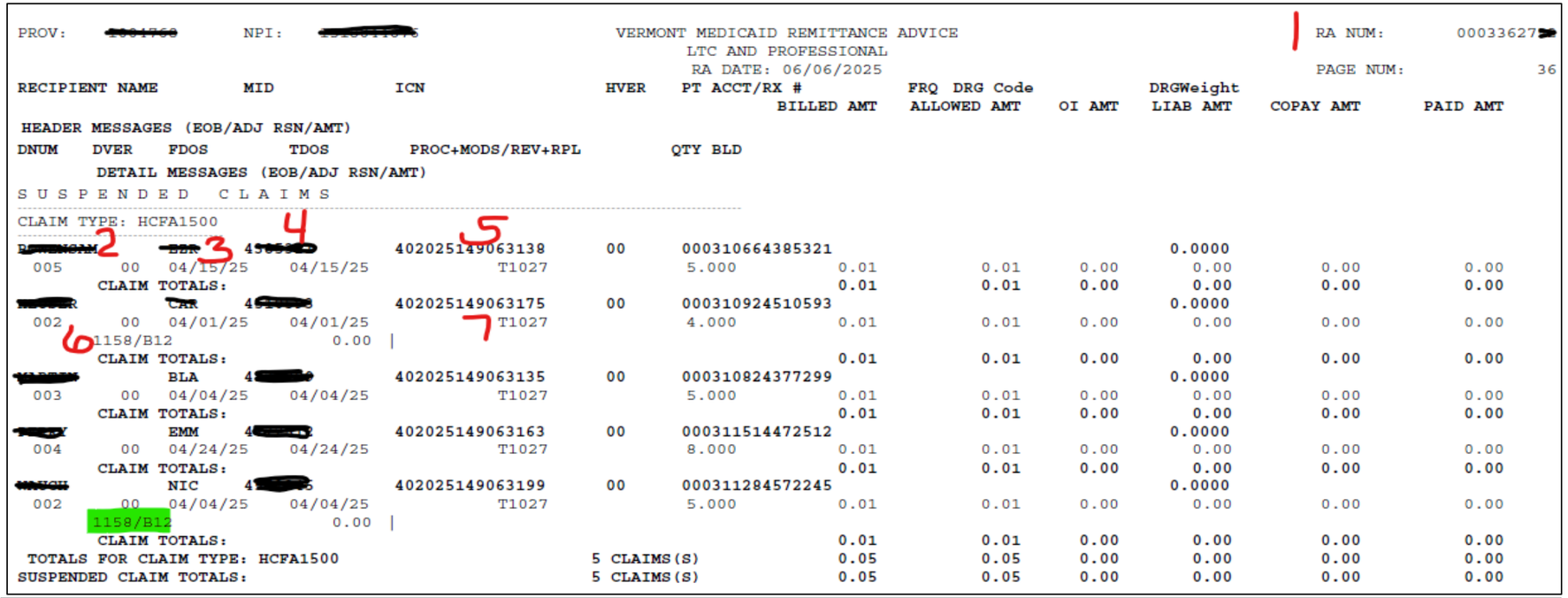
SERVICE DATES FROM/TO	PROCEDURE CODE / CVD/NCVD	TOTAL CHARGES	ALLOWED AMOUNT	OTHER INSURANCE DOLLARS	PROVIDER'S LIABILITY	SUBSCRIBER'S LIABILITY	APPROVED TO PAY	AMOUNT PAID	RSN CODE
SUB ID: [redacted]		PATIENT: [redacted]							
CLAIM#: [redacted]									
08/23/23									
08/30/23	4 9 92507	$115.00	$102.18	$0.00	$12.82	$30.00	$72.18	$72.18	A
08/30/23									
09/06/23	4 9 92507	$115.00	$102.18	$0.00	$12.82	$30.00	$72.18	$72.18	A
[redacted]									
CLAIM TOTAL----		$690.00	$613.08	$0.00	$76.92	$180.00	$433.08	$433.08	B
A-PROCEDURE CODE MODIFIERS GN									
B-A COPAY OF $180.00 WAS REQUIRED FOR THIS CLAIM. /Z550/									
SUB ID: [redacted]		PATIENT: [redacted]							
CLAIM#: [redacted]									
06/21/23	4 9 92523	$250.00	$241.31	$0.00	$8.69	$30.00	$211.31	$211.31	A
06/21/23									
1922737212									
06/27/23	4 9 92523	$250.00	$241.31	$0.00	$8.69	$30.00	$211.31	$211.31	A
06/27/23									
07/05/23	4 9 92507	$115.00	$102.18	$0.00	$12.82	$30.00	$72.18	$72.18	A
07/05/23									
07/12/23	4 9 92507	$115.00	$102.18	$0.00	$12.82	$30.00	$72.18	$72.18	A
07/12/23									
07/19/23	4 9 92507	$115.00	$102.18	$0.00	$12.82	$30.00	$72.18	$72.18	A
07/19/23									
07/26/23	4 9 92507	$115.00	$102.18	$0.00	$12.82	$30.00	$72.18	$72.18	A
07/26/23									
CLAIM TOTAL----		$960.00	$891.34	$0.00	$68.66	$180.00	$711.34	$711.34	B

6

Important Fields to Notice:

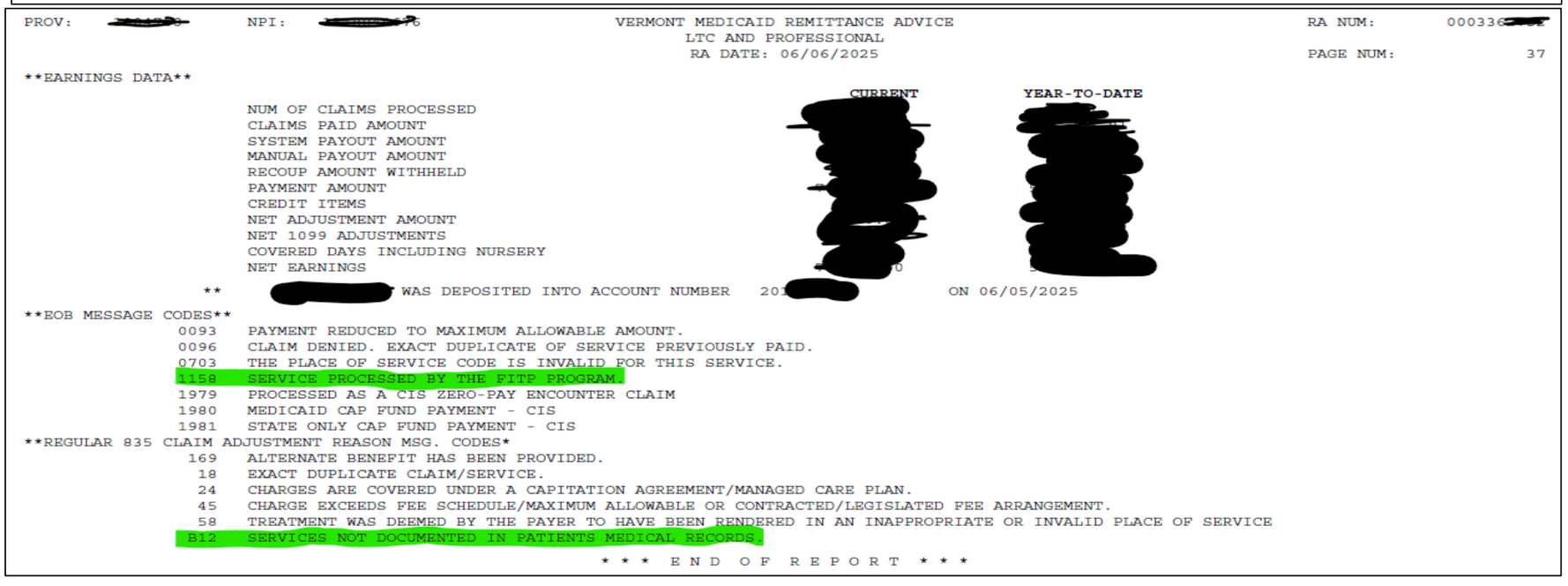
1. Service Dates: the date that is being billed for
2. Procedure Code: This is the code that is being billed for.
3. Other Insurance Dollars: This may be a family share. If there is a dollar amount here, it may be reimbursed via invoice to the State.
4. Subscriber's Liability: This is the family responsibility. If there is a dollar amount here, it may be reimbursed via invoice to the State.
5. Approved to Pay: this is the amount Blue Cross will pay to the provider. If this is $0, submit a PA to the State.
6. RSN Code: This will tell you why something was denied or reduced.

Example of Common Explanation of Benefits/ Remittance Advice: Medicaid/Gainwell



PROV: [redacted] NPI: [redacted] VERMONT MEDICAID REMITTANCE ADVICE LTC AND PROFESSIONAL RA DATE: 06/06/2025 RA NUM: 00033627[redacted] PAGE NUM: 36

RECIPIENT NAME	MID	ICN	HVER	PT ACCT/RX #	FRQ DRG Code	BILLED AMT	ALLOWED AMT	OI AMT	DRGWeight LIAB AMT	COPAY AMT	PAID AMT
HEADER MESSAGES (EOB/ADJ RSN/AMT)											
DNUM DVER FDOS TDOS	PROC+MODS/REV+RPL	QTY BLD									
DETAIL MESSAGES (EOB/ADJ RSN/AMT)											
S U S P E N D E D C L A I M S											
CLAIM TYPE: HCFA1500											
[redacted]	BER	4[redacted]		402025149063138	00	000310664385321				0.0000	
005 00	04/15/25 04/15/25	T1027				5.000	0.01	0.01	0.00	0.00	0.00	0.00
CLAIM TOTALS:							0.01	0.01	0.00	0.00	0.00	0.00
[redacted]	CAR	4[redacted]		402025149063175	00	000310924510593				0.0000		
002 00	04/01/25 04/01/25	T1027				4.000	0.01	0.01	0.00	0.00	0.00	0.00
1158/B12	0.00 |											
CLAIM TOTALS:							0.01	0.01	0.00	0.00	0.00	0.00
[redacted]	BLA	4[redacted]		402025149063135	00	000310824377299				0.0000		
003 00	04/04/25 04/04/25	T1027				5.000	0.01	0.01	0.00	0.00	0.00	0.00
CLAIM TOTALS:							0.01	0.01	0.00	0.00	0.00	0.00
[redacted]	EMM	4[redacted]		402025149063163	00	000311514472512				0.0000		
004 00	04/24/25 04/24/25	T1027				8.000	0.01	0.01	0.00	0.00	0.00	0.00
CLAIM TOTALS:							0.01	0.01	0.00	0.00	0.00	0.00
[redacted]	NIC	4[redacted]		402025149063199	00	000311284572245				0.0000		
002 00	04/04/25 04/04/25	T1027				5.000	0.01	0.01	0.00	0.00	0.00	0.00
1158/B12	0.00 |											
CLAIM TOTALS:							0.01	0.01	0.00	0.00	0.00	0.00
TOTALS FOR CLAIM TYPE: HCFA1500			5 CLAIMS(S)				0.05	0.05	0.00	0.00	0.00	0.00
SUSPENDED CLAIM TOTALS:			5 CLAIMS(S)				0.05	0.05	0.00	0.00	0.00	0.00



PROV: [redacted] NPI: [redacted] VERMONT MEDICAID REMITTANCE ADVICE LTC AND PROFESSIONAL RA DATE: 06/06/2025 RA NUM: 000336[redacted] PAGE NUM: 37

EARNINGS DATA

	CURRENT	YEAR-TO-DATE
NUM OF CLAIMS PROCESSED	[redacted]	[redacted]
CLAIMS PAID AMOUNT		
SYSTEM PAYOUT AMOUNT		
MANUAL PAYOUT AMOUNT		
RECOUP AMOUNT WITHHELD		
PAYMENT AMOUNT		
CREDIT ITEMS		
NET ADJUSTMENT AMOUNT		
NET 1099 ADJUSTMENTS		
COVERED DAYS INCLUDING NURSERY		
NET EARNINGS		

** [redacted] WAS DEPOSITED INTO ACCOUNT NUMBER 20[redacted] ON 06/05/2025

EOB MESSAGE CODES

0093	PAYMENT REDUCED TO MAXIMUM ALLOWABLE AMOUNT.
0096	CLAIM DENIED. EXACT DUPLICATE OF SERVICE PREVIOUSLY PAID.
0703	THE PLACE OF SERVICE CODE IS INVALID FOR THIS SERVICE.
1158	SERVICE PROCESSED BY THE FITP PROGRAM.
1979	PROCESSED AS A CIS ZERO-PAY ENCOUNTER CLAIM
1980	MEDICAID CAP FUND PAYMENT - CIS
1981	STATE ONLY CAP FUND PAYMENT - CIS

**REGULAR 835 CLAIM ADJUSTMENT REASON MSG. CODES*

169	ALTERNATE BENEFIT HAS BEEN PROVIDED.
18	EXACT DUPLICATE CLAIM/SERVICE.
24	CHARGES ARE COVERED UNDER A CAPITATION AGREEMENT/MANAGED CARE PLAN.
45	CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
58	TREATMENT WAS DEEMED BY THE PAYER TO HAVE BEEN RENDERED IN AN INAPPROPRIATE OR INVALID PLACE OF SERVICE
B12	SERVICES NOT DOCUMENTED IN PATIENTS MEDICAL RECORDS.

* * * E N D O F R E P O R T * * *

The top screenshot is the individual claim information.

Important Fields to Note:

1. Number of the remittance advice
2. Client name. The names are sometimes abbreviated.
3. Date of service
4. Client UID
5. ICN Number- this is the number that should be provided when working with either the Gainwell Provider rep, or with the State Team.
6. Denial reason/or note. See the highlighted portion reflected in the bottom screenshot.
7. Code that was billed.

The bottom screenshot is the last page that shows the payment summary and any EOB denial reasons.

The top screenshot shows an EOB reason 1158/B12. Looking at the bottom screenshot, it tells us that 1158 is ‘Service Processed by the FITP Program’ and B12 is ‘Services Not Documented in Patient Medical Record’.

When troubleshooting denials, you should look here first to determine why a claim denied.