The CIS EI System of Payments Specialty Provider Reference Guide

Contents

INTRODUCTION 3

WELCOME TO THE WORLD OF CHILDREN'S INTEGRATED SERVICES EARLY INTERVENTION (CIS EI)! 3

COMMON DEFINITIONS: 3

Accountable Care Organization (ACO): 3
CIS One Plan Service Grid: 3
Early Intervention Financial Assistance Request Form 4
Explanation of Benefits/ Remittance Advice (EOB/RA): 4
Family Infant Toddler Program (FITP): 4
FITP (FI) Voucher 4
Gainwell system: 5
Gainwell Provider Representative 5
GlobalScape: 5
Internal Control Number (ICN): 5
Medicaid: 5
Notice of Decision: 6
Payor of Last Resort (POLR): 6
Prior Authorization (PA): 6
Suspended Claims: 6
Unique Identification Number (UID): 6

CIS EI DOCUMENTATION EVERY PROVIDER NEEDS TO BEGIN PROVIDING SERVICES: 6

Documentation needed when serving any child 6
Children's Integrated Services Permission to Bill Private and Public Insurance 7
Current CIS One Plan Service Grid 7
EI Request for Financial Assistance Form 7
How does this all work? 7

SYSTEM OF PAYMENTS BASED ON CHILD'S INSURANCE STATUS: 8

Client Only Has Medicaid Insurance or is Uninsured Flow Chart 8

Client has only Medicaid Insurance or is uninsured 8

Family/Guardian has *only* Private Insurance and authorizes private insurance to be billed: 9

Family/Guardian has *only* Private Insurance and denies access to bill their private insurance: 9
Client Only Has Private Insurance Flow Chart 10

Family/Guardian has *both* Private Insurance and Medicaid and authorizes private insurance to be billed: 11

Family/Guardian has *both* Private Insurance and Medicaid and denies access to private insurance: **11**
Client has Both Private Insurance and Medicaid Flow Chart 12
What Happens When Claims Are Special Batched to Gainwell for Clients Who Have Both Private Insurance and Medicaid and Denied Access to Their Private Insurance 13

INVOICE REQUIREMENTS 14

Invoices Should be Submitted to the State When: **14**

Invoice Format **14**

Required Documents Invoices Must be Accompanied by: **15**

First Time Submission Only: W9 Form **15**

PRIOR AUTHORIZATION (PA) GUIDANCE 16

PAs Should Be Submitted to the State When **16**

All PAs must be accompanied by: **16**

Details of Prior Authorization **16**

INFORMATION ON THE MOST COMMON BILLING CODES: 17
Billing for Evaluations 17
Billing for Meetings 18
Billing for Mileage 18
Billing for Additional Supports for Families 18

COMMON BILLING TIPS AND TRICKS: 18

EXAMPLE OF PERMISSION TO BILL PUBLIC AND PRIVATE INSURANCE FORM 20

EXAMPLE OF CHILDREN'S INTEGRATED SERVICES ONE PLAN SERVICE GRID 21

EXAMPLE OF NOTICE OF DECISION (NOD) FORM 22

EXAMPLE OF CIS FINANCIAL ASSISTANCE REQUEST FORM 23

EXAMPLES OF COMMON EXPLANATION OF BENEFITS/ REMITTANCE ADVICE AETNA 24

EXAMPLE OF COMMON EXPLANATION OF BENEFITS/REMITTANCE ADVICE: BLUE CROSS BLUE SHEILD 25

EXAMPLE OF COMMON EXPLANATION OF BENEFITS/ REMITTANCE ADVICE: MEDICAID/GAINWELL 26

Introduction

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

Second, all specialty 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.

Welcome to the world of Children's Integrated Services Early Intervention (CIS EI)!

CIS EI is a federally funded program under the Individuals with Disabilities Education Act (IDEA) that is known as Part C. CIS EI is an entitlement program, meaning every child is entitled to receive the services that are listed on the CIS One Plan Service Grid, which serves as the legally binding document. 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 and then finally POLR. 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.

Common Definitions:

Accountable Care Organization (ACO): Groups of doctors, hospitals and other health care providers who provide coordinated services for Medicaid clients. Many times, clients in CIS EI are also covered by an ACO. If this is the case, bill through their established processes. Once the ACO runs out, follow the Medicaid/Uninsured process described below.

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

1. the family is able to see what providers they are working with to achieve their One Plan goals.

2. Second, under IDEA Part C, the service grid is the legally binding document that describes the services that the child is entitled to.
3. Third, the State uses the service grid to verify payment requests. It is important when submitting billing to the State, the most recent copy is attached to ensure faster processing.

Early Intervention Financial Assistance Request Form: This is a form completed by the family that authorizes the State to pay any family share through their private insurance. This is required for any invoices submitted to the State for payment. At least one copy should be on file, usually submitted with the first invoice. An example of this form is in the Appendix section of this document here. It can also be found on the CIS Website, second option under the 'Early Intervention Forms' section.

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): This is the old name for the Part C Early Intervention program. Once CIS was established, the name of the program changed to CIS EI. The Gainwell 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! This item is located on the child's record in Gainwell and signifies that the child is enrolled in CIS EI. The voucher is created through a data transfer between the State and Gainwell system. The voucher must be 'active' in order for any billing to process.

Sometimes the voucher is not active. This could 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 system. This includes:
    - Spelling mismatches
    - Date of Birth mismatches
    - Social Security Number mismatches

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

Gainwell system: Gainwell can be considered the 'pocketbook' of the State, meaning there are multiple funding sources that claims filter through. Using a system of automatic edits, the Gainwell system tests claims against different funding streams, including:

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

Gainwell is usually accessed through the Provider Electronic Solutions (PES) software. A detailed instruction manual that includes what you need to know to set up the software and how to use it may be found here: http://www.vtmedicaid.com/assets/pes/PESUserGuide.pdf.

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

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. They should be the first resource that providers reach out to when they encounter a denial through the Gainwell system.

- The Provider call line is: 800-925-1706.
- Find Your local provider representative
- If you have to mail documents to Gainwell, please address it to:

Gainwell Technologies,

PO Box 888,

Williston, VT 05495

GlobalScape: Globalscape is the secure file transfer site that the State uses to maintain compliance with both the Health Insurance Portability and Accountability Act (HIPAA) and Family Education Rights and Privacy Act (FERPA) standards related to protected health information (PHI). To set up a GlobalScape account, please reach out to AHS.DCFCDDCISEI@vermont.gov. Using your email address, the State will create an account.

Internal Control Number (ICN): The ICN is the claim number automatically generated on each EOB/RA from Gainwell. It is located above the service code for each claim line. When troubleshooting billing challenges, please provide this number.

Medicaid: Medicaid is held within the Gainwell system. To access this funding source, you bill Gainwell.

Notice of Decision: This is the document generated once a CIS EI Prior Authorization (PA) has been entered into the Gainwell system by the State. It shows the PA number, the code(s) authorized, the unit(s) assigned, and the date range that the PA is active for. Once you receive this (usually via the mail) submit your claim through the Gainwell system. The Appendix of this document has an example of what the form looks here.

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 Service Grid are required to be delivered regardless of the families' ability to pay.

This funding source is only accessible through either an invoice to the State or through a Prior Authorization (PA).

Prior Authorization (PA): The 'prior' part of the PA is a misnomer- it should really be called a 'post' authorization because this is the document that overrides the final Gainwell denial edit. It acts like a key to unlock access to the POLR funds once both Private Insurance and Gainwell have been tested and denied full payment.

PAs are submitted to the State. The State enters it into the Gainwell system. Providers will know this has been done because they will receive a document called a 'Notice of Decision' in the mail.

For guidance on the PA process, click here.

Suspended Claims: When claims are submitted through Gainwell, they are approved, denied, or put into suspension. Claims are 'suspended' when they've been caught by an edit in the Gainwell 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 Gainwell 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 child count to establish a record and create a UID. You should receive the UID from the Primary Service Coordinator or the EI supervisor.

Social Security Numbers (SSN)s may also be used to submit claims in lieu of the UID.

CIS EI Documentation Every Provider Needs to Begin Providing Services:

Documentation needed when serving any child

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

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

Form completed and signed by the family. (an example of the form may be found here) It is *essential* that you have the most recent copy of this. Families can and do change their insurance status and their permissions to bill for services at any time.

It is possible for a family to allow access to their 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 providers bill inappropriately based on the new insurance permissions, they will need to go through a recoupment process by re-imbursing the private insurance and re-billing through the Gainwell system.

Current CIS One Plan Service Grid (an example can be found here)

Service grids should include at minimum:

- Date that the family signed consent for their services.
- The name of the service delivered.
- 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

If applicable for the family. (an example can be found here). 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.

How does this all work?

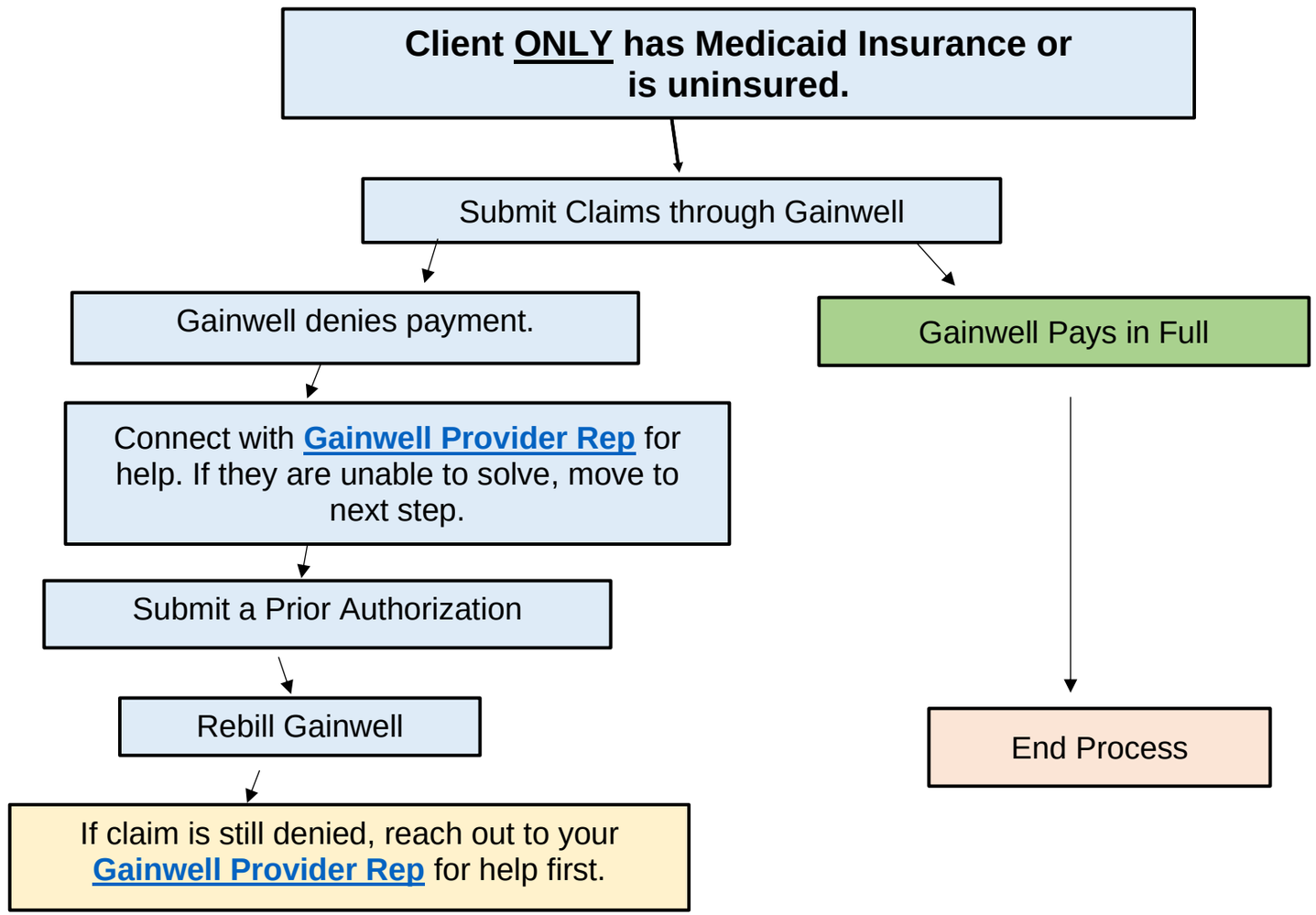
Data for every CIS EI client is submitted to the State monthly by the regional CIS teams. The State transfers data to the Gainwell system on a weekly basis to establish and maintain the FITP voucher. If you are unable to locate a client in the Gainwell system, this may point to an error with the FITP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

System of Payments Based on Child's Insurance Status:

Client has only Medicaid Insurance or is uninsured:

1. Bill for your services through the Gainwell system.
2. If Gainwell denies, or you know it is not a service Gainwell will cover (ex. Travel and meetings), submit a PA.
3. Once you receive the Notice of Decision, submit your claim through the Gainwell system again.

Client Only Has Medicaid Insurance or is Uninsured Flow Chart



Family/Guardian has *only* Private Insurance and authorizes private insurance to be billed:

1. Bill private insurance 1st.
2. If there is a patient share (co-pay/deductible/family share) and the family has completed a EI Request for Financial Assistance Form, invoice the State.
3. If Private insurance denies the full charge, submit a PA to CIS-EI. Once you have received the Notice of Decision, bill through the Gainwell system.
4. Note: you will need to submit your claim through Gainwell accompanied by the EOB/RA from private insurance as proof of the denial. Vermont Medicaid has a webinar to describe how to attach secondary electronic claims.
5. If Private insurance pays in part, but it isn't the full amount Medicaid would pay, seek a PA from CIS.
6. You can find the Medicaid reimbursement rate for codes in the Fee Schedule or by contacting your Gainwell provider representative. CIS EI will reimburse the difference between what insurance covered/denied only up to this amount.

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

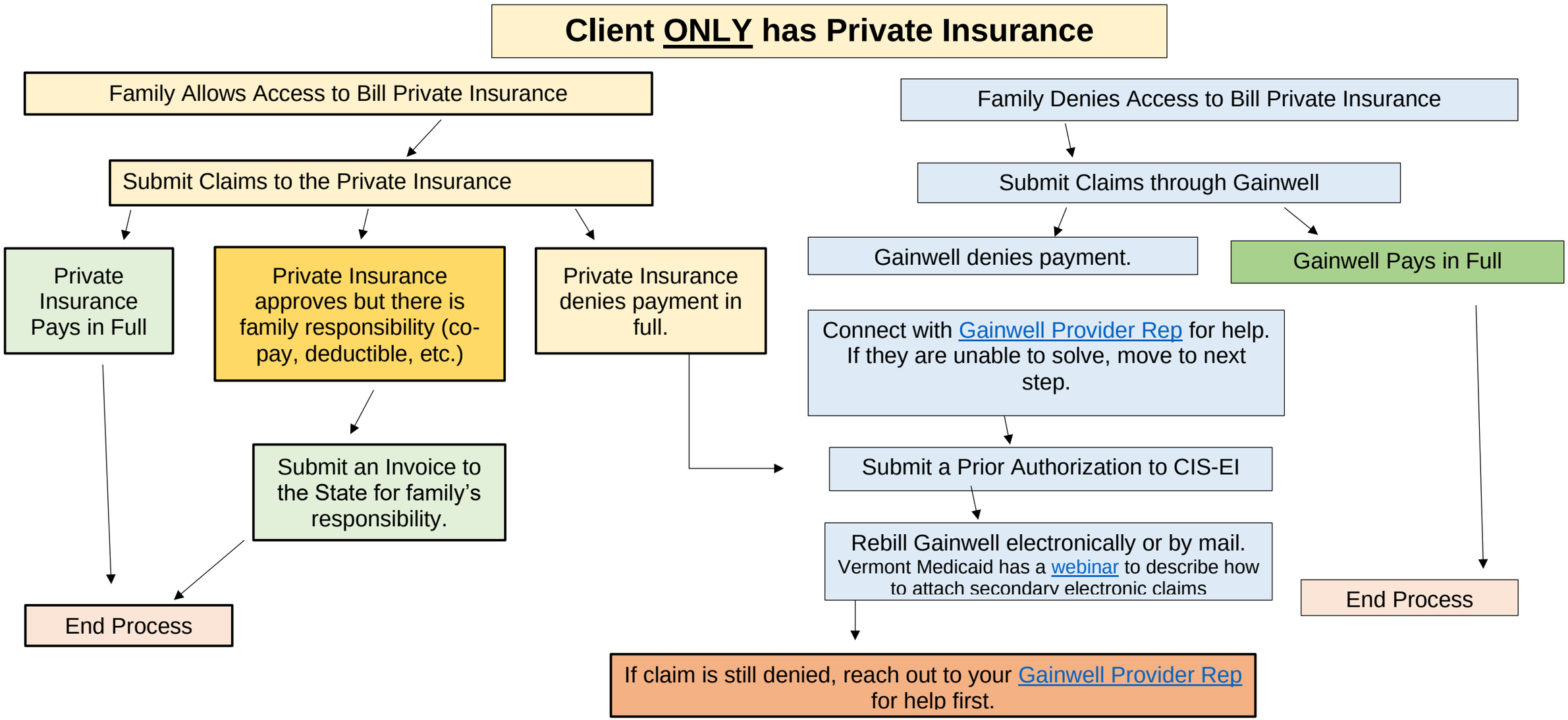
Every family's plan is different, so even if you have two clients that have the same private insurance, one may deny but the other may pay out.

Some providers have been able to call the insurance company prior to billing to see if the codes will be covered.

Family/Guardian has *only* Private Insurance and denies access to bill their private insurance:

1. Bill for your services through the Gainwell system.
2. If Gainwell denies, seek a PA from CIS-EI for services as needed. Once you have received the Notice of Decision, re-bill through the Gainwell system.
3. The State must receive a copy of the insurance form denying access to the client's insurance. This is used to enter a note into the Gainwell system that will override a denial edit.

Client Only Has Private Insurance Flow Chart



Family/Guardian has *both* Private Insurance and Medicaid and authorizes private insurance to be billed:

1. Bill private insurance first.
2. If there is a patient share (co-pay or deductible) and the family has completed a EI Request for Financial Assistance Form, invoice the State with a copy of the EOB/RA that illustrates the family's costs.
3. If Private insurance denies the full charge, submit a PA to CIS-EI. Once you have received the Notice of Decision, bill through the Gainwell system.
4. Note: you will need to submit your claim through Gainwell accompanied by the EOB/RA from private insurance as proof of the denial. Medicaid has a webinar to describe how to attach secondary electronic claims.
5. If Private insurance pays in part, but it isn't the full amount Medicaid would pay, seek a PA from CIS-EI.
6. You can find the Medicaid reimbursement rate for codes on the Medicaid Fee Schedule or by contacting your Gainwell provider representative. CIS EI will reimburse the difference between what insurance covered/denied only up to this amount.

Family/Guardian has *both* Private Insurance and Medicaid and denies access to private insurance:

1. Bill for your services through the Gainwell system.
2. If Gainwell denies, seek a PA from CIS-EI
3. The State must receive a copy of the insurance form denying access to the client's insurance. This is used to enter a note into the Gainwell system that will override a denial edit.
4. Once you have confirmation the PA is in place from the Notice of Decision, complete a 1500 form and with the accompanying documents, mail to Gainwell.

Why is there a Special Process for Clients who Deny Access to their Private Insurance and Who Have Medicaid?

When a family signs up for Medicaid and they indicate that they also have Private Insurance, Gainwell will deny any submitted claims with the edit 'Private Insurance has Not Been Tested'.

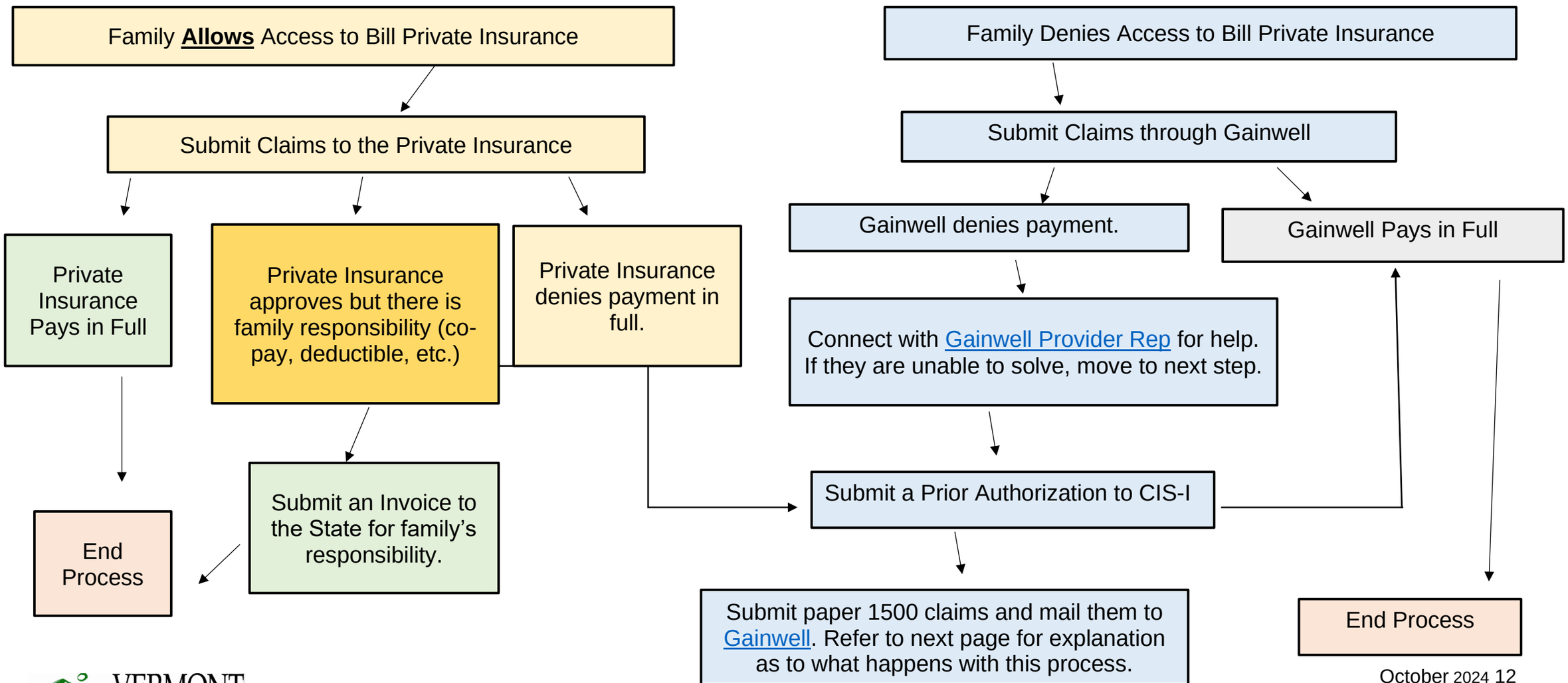
Gainwell has their own rules around what they consider their Payor of Last Resort (which is different than the Part C POLR). Currently, the CIS-EI Denial to Access Insurance Authorizations form is not recognized by the Gainwell system and so therefore does not automatically get past this electronic edit.

To get around this, the folks at Gainwell take the paper claims and manually enter an override. This allows the claim to pass over the Medicaid hard stop, into the rest of the funding sources. Having the CIS-EI PA then allows access the Part C POLR funds.

When submitting claims directly to Gainwell like this, there is no need to rebill. The claim will automatically process after the manual override has been put in place.

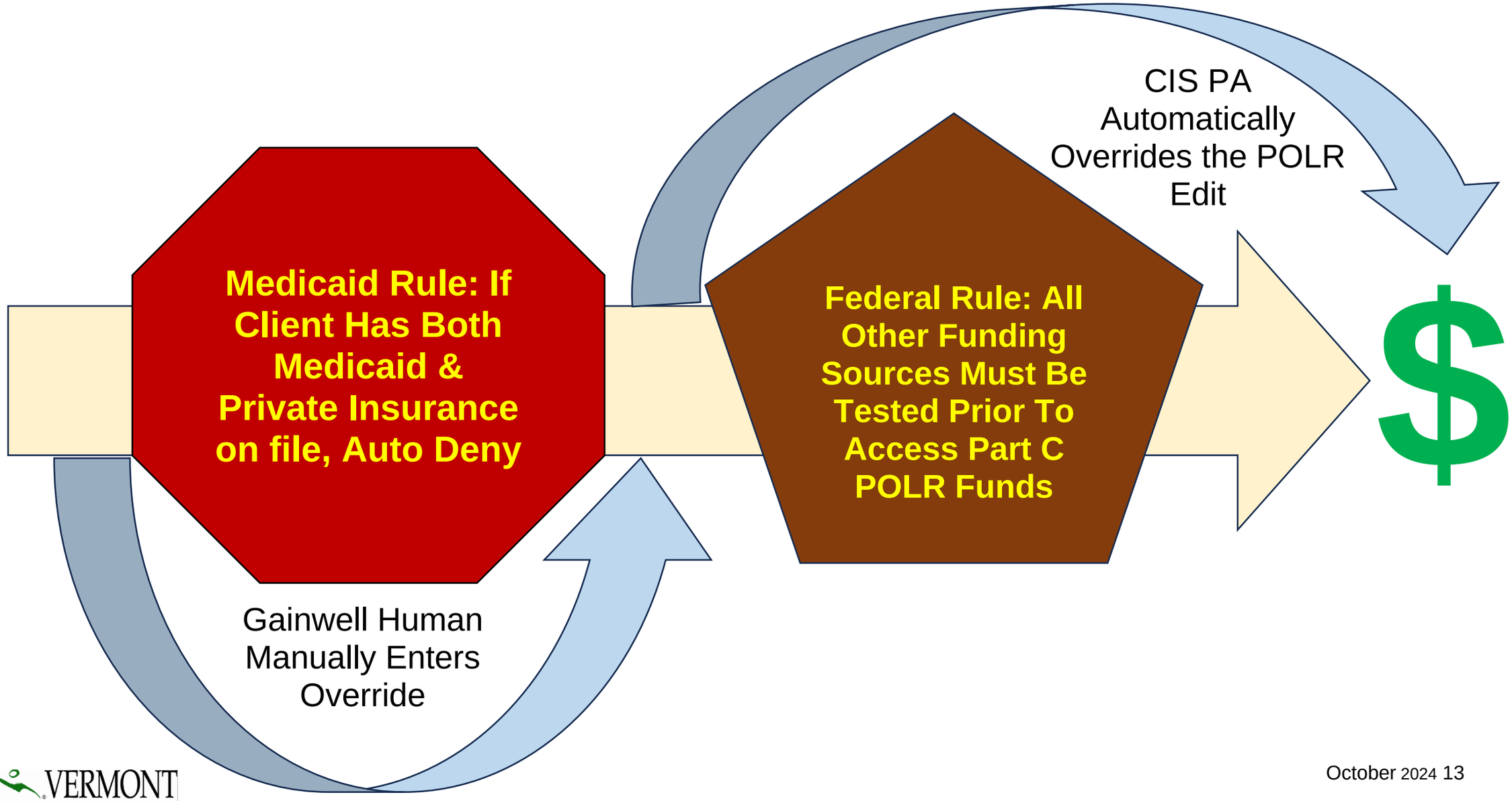
Client has Both Private Insurance and Medicaid Flow Chart

Client has BOTH Private Insurance and Medicaid



VERMONT
DEPARTMENT FOR CHILDREN AND FAMILIES
CHILD DEVELOPMENT DIVISION

What Happens When Claims Are Special Batched to Gainwell for Clients Who Have Both Private Insurance and Medicaid and Denied Access to Their Private Insurance



Invoice Requirements

Invoices Should be Submitted to the State When:

- There is a family share. Examples include:
    - Co-pay
    - Deductible
    - Co-Insurance
- If two providers are serving the same child on the same date of service and are billing for the same code.
    - One provider will submit their claim through Gainwell following the system of payments.
    - The second provider will submit and invoice to the State because Gainwell will only pay the first claim submitted.
    - ❖ It is highly recommended that providers discuss who is doing what billing so that there are no delays in payment.
- When requested by the State team.

Invoice Format

Invoices must be sent securely, with all required attachments, to the State via GlobalScape (contact AHS.dcfcddcisei@vermont.gov if you need a GlobalScapes account)

The State does not have a template because many providers use their own forms. The minimum information that all invoices submitted to the State must include are:

- Provider name.
- Provider 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.
- CPT 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 are submitting an invoice, you do not have to have a CIS PA as well.

Required Documents Invoices Must be Accompanied by:

- The EOB/RA from the insurance provider that illustrates the payments that are the family's responsibility.
- 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.
- A signed Early Intervention Financial Assistance Request form (example here) located as the second option of the Early Intervention Forms section 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

PAs Should Be Submitted to the State When:

- Billing for clients with Medicaid/No insurance/Denied Access to Private Insurance: After you've submitted your claim through the Gainwell system, received a 100% denial and were not able to resolve the denial by working with your Gainwell Provider Representative.
- Billing for clients with Private Insurance: After you've received a 100% denial from the Private Insurance.
- Before you bill for meetings, mileage or parent training code.
- Billing for an additional evaluation within 12 months of the first date of evaluation.

All PAs must be accompanied by:

- 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.
- The Children's Integrated Services Permission to Bill Private and Public Insurance form.
- In the case of an Oral Motor request, the Dr's prescription/diagnosis
- 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.
- You do not need to submit an EOB with PA requests.

Details of Prior Authorization

Prior Authorizations (PAs) forms can be found on the CIS Website, third option under the 'Early Intervention Forms'.

PAs must be submitted through GlobalScapes. If you need a GlobalScapes account, contact: AHS.dcfcddcisei@vermont.gov.

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 4 months or more from the requested start date of the PA, then a second PA will need to be submitted to the State 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 Gainwell system to match the PA request form. If the modifier is not on the request form, it will not be in Gainwell 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 provided 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 request will **be processed within 10-12 business days**. You will receive a Notice of Decision via the mail from the Gainwell system once the PA is authorized. At that point, you can begin billing against that PA.

If you notice an error on your PA, 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.

For detailed instructions on how to fill out the PA form, please see the CIS website.

Information on the Most Common Billing Codes:

The State of Vermont cannot tell providers how to bill or what codes to use.

Providers must use their professional judgement to make these decisions. Below are some common codes that many CIS EI specialty providers use, and common conditions around them. 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- this is performed in conjunction with one other provider (usually the Primary Service Coordinator or developmental educator) to determine if the child is eligible for CIS EI. This multidisciplinary evaluation is paid directly to the regional providers. If you partake in this evaluation, seek reimbursement directly from the CIS regional provider you are working with.

Specialty Evaluation: this is performed by specialists (such as OT/PT/SLP) to determine the intensity and frequency of their service. All clients are entitled to one specialty evaluation per discipline per 12-month period.

The first evaluation within the 12-month period should be billed using the Vermont system of payments.

Any subsequent evaluations during the 12-month period will need to follow the PA process described above before billing Gainwell.

PAs for second evaluations performed 6 months or more from the first evaluation will be processed and entered once the service is confirmed on the service grid.

PAs for second evaluations performed less than 6 months from the first evaluation require a reason as to why it must occur. Acceptable reasons include, but are not limited to, when the child has experienced a traumatic event that has had an impact on their development, or if a new provider is coming on to serve a client and wants to do their own evaluation.

Providers are encouraged to review the Medicaid Fee schedule to select the evaluation codes that are most appropriate.

Billing for Meetings: Meetings can be held with the child's team as often as is necessary based on the needs of the family. The most common codes used to bill for this activity are the code range 99366-99368. This code should pay out for most clients, however there are many situations where Gainwell will deny. It is recommended that if providers choose to use this code range, they submit a PA request prior to billing through Gainwell to avoid initial denials.

Only one provider may bill for this code per service date. If you are denied, please reach out to the State via AHS.dcfcddcisei@vermont.gov for more support.

Billing for Mileage: If services are delivered more than 70 miles round trip, CIS EI will pay the Medicaid rate for mileage using the code 99082. Please submit a PA request prior to billing through Gainwell. This code excludes Home Health Agencies and VNAs.

Billing for Additional Supports for Families: When coaching/ developing steps and/or strategies with the adult parent/guardian(s) directly related to ensuring and maintaining the safety of the child, many specialty providers use the S5111 code. This code will require a PA prior to any billing.

Only one provider may bill for this code per service date. If you are denied, please reach out to the State via AHS.dcfcddcisei@vermont.gov for more support.

Common Billing Tips and Tricks:

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 Gainwell or Part C as the Payor of Last Resort. Then put diagnosis(es) associated with your work in subsequent positions.

Children who are enrolled in Medicaid and have an identified diagnosis should receive 30 dates of service without a need for a PA. In some cases, a Medicaid PA is more appropriate than a CIS EI PA. For more information on this, please refer to the Medicaid Manual beginning in section 4.5. The CIS State team is not able to help with the details of this process, for

support please reach out to your Gainwell Provider Representative.

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 Gainwell 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.

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: _____

VERMONT
DEPARTMENT FOR CHILDREN AND FAMILIES

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							☐ 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.

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:

1. DTL	2. A/D/I	3. START DATE/ STOP DATE (5)	4. REVENUE CODE / PROCEDURE / NDC / DIAGNOSIS (6)	5. Units (7)	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

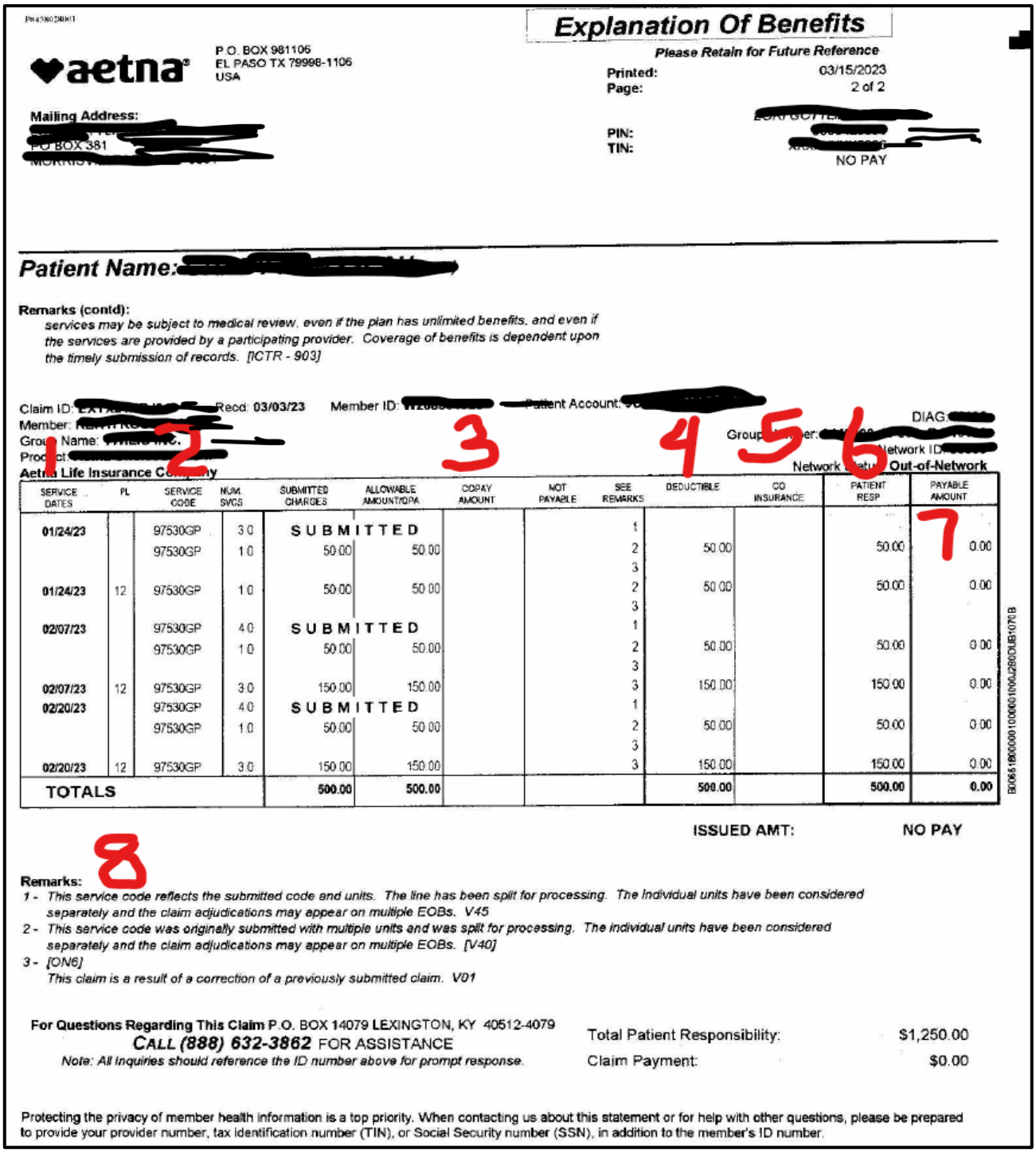
Parent Signature: _____ Date: _____

- 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

VERMONT
DEPARTMENT FOR CHILDREN AND FAMILIES
CHILD DEVELOPMENT DIVISION

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**

B0661800000100000100902860DUB1070 B

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: 09/06/[redacted] RA NUM: [redacted] PAGE NUM: 5

RECIPIENT NAME MID ICN HVER PT ACCT/RX # FRQ DRG Code DRGWeight
BILLED AMT ALLOWED AMT OI AMT 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)

D E N I E D C L A I M S

CLAIM TYPE: HCFA1500

[redacted] 4020242[redacted] 00 [redacted] 0.0000

001 00 02/05/24 02/05/24 S5111 1.000 50.00 0.00 0.00 0.00 0.00 0.00
0418/29 50.00 | 1158/B12 0.00 |
002 00 02/14/24 02/14/24 S5111 1.000 50.00 0.00 0.00 0.00 0.00 0.00
0418/29 50.00 | 1158/B12 0.00 |
CLAIM TOTALS: 100.00 0.00 0.00 0.00 0.00 0.00

[redacted] 4020242[redacted] 00 [redacted] 0.0000

001 00 04/01/24 04/01/24 T1023 GN 1.000 350.00 0.00 0.00 0.00 0.00 0.00
0063/198 350.00 | 1158/B12 0.00 |
CLAIM TOTALS: 350.00 0.00 0.00 0.00 0.00 0.00

[redacted] 4020242[redacted] 00 [redacted] 0.0000

001 00 08/27/24 08/27/24 99366 95 1.000 100.00 0.00 0.00 0.00 0.00 0.00
0063/198 0.00 | 1158/B12 0.00 | 1969/197 0.00 |
CLAIM TOTALS: 100.00 0.00 0.00 0.00 0.00 0.00

TOTALS FOR CLAIM TYPE: HCFA1500 4 CLAIMS(S) 550.00 0.00 0.00 0.00 0.00 0.00
DENIED CLAIM TOTALS: 4 CLAIMS(S) 550.00 0.00 0.00 0.00 0.00 0.00

In the top screenshot, the summary information is organized. Any denial code reasons will be listed on the left-hand side under 'Messages Header'.

The bottom screenshot is of the last page of the EOB. This includes the summary information about how much has been approved and lists the denial codes and their reasons.

In this example, the denial reason codes are highlighted.

PROV: [redacted] NPI: [redacted] VERMONT MEDICAID REMITTANCE ADVICE LTC AND PROFESSIONAL RA DATE: 09/06/2024 RA NUM: [redacted] PAGE NUM: 6

EARNINGS DATA

	CURRENT	YEAR-TO-DATE
NUM OF CLAIMS PROCESSED	7	[redacted]
CLAIMS PAID AMOUNT	36.00	
SYSTEM PAYOUT AMOUNT	0.00	
MANUAL PAYOUT AMOUNT	0.00	
RECOUP AMOUNT WITHHELD	0.00	
PAYMENT AMOUNT	36.00	
CREDIT ITEMS	0.00	
NET ADJUSTMENT AMOUNT	0.00	
NET 1099 ADJUSTMENTS	0.00	
COVERED DAYS INCLUDING NURSERY		
NET EARNINGS	36.00	

** $36.00 WAS DEPOSITED INTO ACCOUNT NUMBER [redacted] ON 09/05/2024

EOB MESSAGE CODES

0063 THIS SERVICE REQUIRES PRIOR AUTHORIZATION
0093 PAYMENT REDUCED TO MAXIMUM ALLOWABLE AMOUNT.
0418 CLAIM PAST TIMELY FILING LIMITATION
1158 SERVICE PROCESSED BY THE FITP PROGRAM.
1969 SERVICE NOT COVERED OR REQUIRES A PA/VOUCHER

**REGULAR 835 CLAIM ADJUSTMENT REASON MSG. CODES*

197 PRECERTIFICATION/AUTHORIZATION/NOTIFICATION/PRE-TREATMENT ABSENT.
198 PRECERTIFICATION/AUTHORIZATION/AUTHORIZATION/PRE-TREATMENT EXCEEDED.
29 THE TIME LIMIT FOR FILING HAS EXPIRED.
45 CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
B12 SERVICES NOT DOCUMENTED IN PATIENTS MEDICAL RECORDS.

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