Private Insurance Reimbursement Update Tips for Providers on Billing June 2013

In Virginia, there is an Early Intervention Mandate that requires insurers to cover services up to $5,000 per insured or member per policy or calendar year. Not all insurers are subject to this mandate, so it is important to check each policy for coverage.

Early Intervention is a benefit of an insurance policy. There is no medical code for Early Intervention. The local system will be billing for OT, PT, and/or SLP medical services under this Benefit. Developmental Services are not covered by private insurance.

The Infant and Toddler Connection of Virginia does not have a contractual relationship with private insurance companies. Therefore, it is the responsibility of each local system or contracted provider to pursue obtaining a "participating provider" agreement with each individual insurance company.

Each Therapist needs an NPI (National Provider Identifier – https://nppes.cms.hhs.gov) number and must be registered in CAQH (www.caqh.org), the database system used by Insurance Companies to credential providers.

Establishing Medical Necessity

The Code of Virginia states ….."early intervention services means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services for dependents from birth to age three who are certified by the DBHDS as eligible for services under part C of the IDEA.

Documentation to establish Medical Necessity for services is essential for reimbursement of therapy services. This can be done through the IFSP. The Doctor/Hospital referral and Part C Eligibility Form are two pieces of supporting documentation, but may not be sufficient to guarantee payment. The IFSP Evaluation data is becoming increasingly important.

Changes in Reimbursed Codes

Aetna and Anthem are no longer covering any of the 315 codes, 317-319 codes, lack of coordination (781.3), lack of normal physiological development (783.4), or delayed milestones (783.42), or the apraxia code (784.61) plus many others for **children in plans that exclude developmental delay**. These codes are valid but these insurers have changed their policy about paying for these codes. DMAS does recognize and cover these codes.

Early Intervention provider billing departments may inquire about a family's coverage for Early Intervention services when they call to pre-authorize (required for UHC and Aetna). If pre-authorization is not required, a Service Coordinator can suggest families call and inquire about their EI coverage. Sometimes this coverage is considered an "exclusion" to a typical benefits package and may need to be pursued beyond the average service representative to the Medical Management Department of the Insurance Company. The insured's Employer Representative may also be able to assist in finding out this information.

Private insurance companies are not obligated to pay the established EI rate of $150.00. They will negotiate a contract rate that is consistent with the “Usual & Customary fee” based on a 15 minute unit of PT, OT, or SLP service in your region of the State. Families may negotiate a better rate through their policy benefit package. Local systems cannot negotiate for families.