



## Early Intervention Targeted Case Management Post Implementation Questions and Answers November 7, 2011; **Updated December 9, 2011**

### Billing/Allowable Activities

**Question:** Are we required to bill commercial insurance for TCM (even if we've been told by the insurance rep that it's not covered) as we do Medicaid? If we do bill commercial insurance and get a denial, because that service is not covered, do we have to continue billing for it?

**Answer:** T2022 claims require an attachment documenting that the primary payor would not pay in situations where the child has other insurance in addition to Medicaid or FAMIS. Please refer to Chapter V of the DMAS Early Intervention Services Provider Manual or call the Provider Helpline at 800-552-8627 for additional information. **Please note that this is a correction to the answer provided previously.**

**Question:** I have a child in EI who also has a case manager through VA Premier. I am not sure if the services are being reimbursed by Medicaid. Can I bill for EI TCM for this child?

**Answer:** Virginia Premier is a Medicaid managed care organization. Early Intervention services are carved out of the managed care programs. The Early Intervention system is responsible for (and can bill for) case management (service coordination) for all children with Medicaid or FAMIS coverage regardless of whether the children are enrolled in a managed care organization.

**Question:** Is preauthorization (through Keypro) required in order to bill for EI TCM?

**Answer:** Preauthorization is not required in order to bill for EI TCM. In order to be reimbursed for EI TCM, the child must have the EI benefit in VAMMIS. (The EI benefit is added to the child's record in VAMMIS when the local system enters the child's Medicaid/FAMIS information and intake date in ITOTS).

**Question:** I thought that it didn't matter if a child was on a waiver, they could still receive EI TCM. Does that apply to the Tech waiver?

**Answer:** Yes, a child can be in a waiver, including Tech Waiver, and in EI.

**Question:** A certified CM on our team had a home visit with a parent, yesterday, and explained the fact sheet related to the new TCM procedures. Do we count that as a direct contact for the month and bill for it?

**Answer:** As long as the discussion is documented and the documentation (contact note) meets the requirements (e.g., includes the service coordination goals that were addressed in the communication with the family), this would meet both the family contact requirement and the billable activity requirement.

**Question:** Is discharge paperwork (ITOTS data entry/agency paperwork) considered an allowable activity?

**Answer:** No

**Question:** Do we bill Medicaid under TCM for talking with a family about rescheduling or scheduling an appt.?

**Answer:** Yes, assisting the child and family directly for the purpose of locating, developing, or obtaining needed services and resources are allowable activities.

**Question:** Since we were told in the EI TCM webinars that the first family contact had to occur by December, 2011, what if we do not have a contact in October or November. Can we still bill for EI TCM?

**Answer:** Yes, you can bill IF there was an “allowable activity” during the month that you are billing.

**Question:** What is the requirement for when a face to face must occur when the child is not present at the IFSP meeting? Is it within the same month or within 30 days before or after the IFSP?

**Answer:** The Service Coordinator must document observation of the child during the month that the IFSP is held in order to bill for EITCM during that month.

**Question:** If the annual IFSP is signed when the child is not present, and then the face to face with the child occurs in the following calendar month, how does this impact billing?

**Answer:** The service coordinator must document observation of the child in the month that the IFSP meeting occurs in order to bill for EI TCM for that month. The observation of the child can occur before or after the IFSP meeting as long as the observation occurs in the same month as the IFSP meeting. In the situation described above, EI TCM could not be billed for the month that the IFSP meeting occurred, but could be billed the following month.

**Question:** When children who currently are receiving MH TCM outside of the early intervention system (such as through Healthy Families) are referred to EI, can that agency continue to bill for MH TCM until (if) the child is found eligible for EI, or do they have to stop providing and billing for MH TCM so EI can bill for EI TCM?

**Answer:** MH TCM should continue (including billing for MH TCM by the MH TCM provider) during the period that EI Eligibility is being determined. If the child is found eligible for Part C, at that point, MH TCM should end and EI TCM should start. Other funds must be used to cover the cost of intake through eligibility determination in such situations.

**Question:** Can billing for EI TCM begin while a child is still in the hospital?

**Answer:** Reimbursement is not available from DMAS for EI TCM while a child is in the hospital. Other funds must be used to cover the costs of service coordination in such situations.

**Question:** If we do an intake in September and want to bill for initial EI TCM in October (not ongoing), will we have to go back and enter the intake date in order for the EI benefit to activate? I'm trying to figure out how to handle the children we have in process now for whom we are not collecting the intake date on the ITOTS form, not to mention that the date won't be entered within 10 days.

**Answer:** It is possible that there will be children who have/had intakes in September who do not have IFSPs by the end of October. As long as you implemented an initial EI Service Coordination Plan and enter the intake date into ITOTS when ITOTS 1.9 is available, you will be able to bill for October. We will not apply the 10 business day rule until ITOTS is fully functional.

**Question:** Does Medicaid cover interpretation and translation services?

**Answer:** Interpretation (spoken word) and translation (printed word) are covered by the plans for their services. The fee-for-service does not have interpretation and translation covered, with a few exceptions such as accessing transportation broker services and Smiles for Children dental program. Plans are not responsible for carved-out services. With interpretation and

translation, the federal guidance is that any entity receiving federal funds and involved with services to non-English speaking persons is to provide meaningful access to services.

**Question:** On the first visit to a child a certified CM/CCC-SLP completes the beginning of the intake process (Reviews Rights, completes notice and consent for eligibility determination, etc.) and completes a thorough developmental screening. An EI Service Coordination Plan was completed at the beginning of the visit. The child is found ineligible at that same visit. She does not complete the financial part of the intake process as the child will not be moving forward along the service pathway. Can we bill Medicaid for this visit?

**Answer:** In order to bill for EI TCM, the Initial EI Service Coordination Plan must be signed by the parent AND the financial agreement form must be signed by the parent. [Please note that the scenario given in this question, with one EI Professional finding the child ineligible at the intake visit, could only happen if there was also a written report from another discipline that provided enough information to be used in eligibility determination (see Practice Manual, Chapter 5, #2b under Planning and Preparation for Eligibility Determination)].

**Question:** Can you bill if you do an intake (or at least meet with a family, go over rights, etc., discuss the program, system, etc) and then before you complete the screening, the family declines to proceed?

**Answer:** In order to bill, there must be a signed Initial Early Intervention Service Coordination Plan and a signed financial agreement form in place. If the family declines after signing the Initial Early Intervention Service Coordination Plan and the financial agreement form, then you can bill for EI TCM. If they decline prior to signing the Initial Early Intervention Service Coordination Plan, you cannot bill.

**Question:** I understand that Case Management cannot be billed for a month when the only Service Coordination activity is unsuccessful attempts to contact the family. What about a situation where the provider contacts the Service Coordinator to report that the family has missed sessions and they are unable to reach the family. In this situation can Case Management be billed even if the Service Coordinator is not able to reach the family?

**Answer:** You are correct that EI TCM cannot be billed if the only activity was unsuccessful attempts to contact the family. The situation described above is a different scenario because it includes communication with the provider (monitoring implementation of the IFSP, an allowable activity), thus EI TCM could be billed.

**Question:** Is it an allowable Service Coordinator contact if the Service Coordinator leaves a phone message with the family and the family leaves a detailed phone message with the Service Coordinator but they do not actually talk together.

**Answer:** Yes, this is an "allowable" activity because the communication loop has been closed.

## Claims information

**Question:** Now that we are able to bill for EI TCM, are there any claims issues we should know about?

**Answer:** Yes. If a targeted case management claim (T2022) is received for a child whose EI benefit has not yet been added or has been dropped in the Medicaid VaMMIS system, the claim will be denied with a "pend" error reason (0148). The claim will be reprocessed, and then denied after review by DMAS staff. [The usual error message for such situations is 0774 (child not enrolled in early intervention)]. Once the child's enrollment is corrected, providers will need to resubmit the denied targeted case management claims for payment. This will be addressed in future VaMMIS updates.

**Question:** Has the edit for the Team Treatment code T1024 been fixed?

**Answer:** Yes, T1024 claims are being reprocessed automatically if they were submitted separately from other claims. Claims for this code that were submitted along with claims for other services will not be automatically re-processed, so providers will need to re-submit such claims.

**Question:** In the 11/14/2011 Webinar, you indicated that the Diagnosis Codes V710.9 and 799.9 could be used for billing EI TCM. Are these codes required? Are these the only codes that can be used?

**Answer:** These codes were suggested in response to a question about what codes could be used initially when there is not a known diagnosis for the child. They are not required, nor are they the only codes that can be used. For questions about which codes are or are not reimbursable, please contact the Help Line at 800-552-8627.

**Question:** Does it matter whether we put in a single day or a date range in the field for service dates on the Medicaid reimbursement claim for EI TCM?

**Answer:** Either a single date or a date range (such as 10/01/2011 to 10/31/2011) is acceptable. Please note that the single date or the first date of a range must be AFTER the start date for the EI benefit in VAMMIS.

**Question:** What are we supposed to put for number of units for EI TCM?

**Answer:** One unit of case management can be billed per child per month.

## Family Contacts

**Question:** What if we contact families more frequently than every three months and the means of communication varies? Do we have to document the family's preference for the every three month contacts? How will Quality Management Reviews look at this?

**Answer:** Document the family's preference for any contacts without specifically isolating a preference for the every three month contact. The requirement for checking with families about their preference is independent of the frequency of the contact. QMR will look to see:

1. Was there a contact at least every three months
2. Is that contact in the mode the family said they preferred (so the reviewer would look to see documentation of parent's preferred method of contact).

Families may specify different mechanisms for different times or purposes (for example, "call me each month to check in, but I'd really like for you to go with me to my daughter's neurology appointment next month."). Service Coordinators should document what the parent tells them, including if they don't have a preference for the type of contact.

**Question:** When we ask a family how they most prefer contact for their every three month direct contacts and they say they prefer to have an option of email, phone and direct because different things come up at different times, is it O.K. to list all three? If a family is forced to pick one (let's say they pick face to face, for example) and something comes up during a phone conversation, are we then not to bill for it as a direct service? We have many families who use all three forms of communication regularly.

**Answer:** It is ok to document that the family doesn't have a specific preference or that the family prefers different methods depending on the purpose of the contact. The key is documentation of the family's response about their preference and consistency of the mode(s) of contact with the family's documented preference or preferences (when they do state a preference).

## Physician Certification

**Question:** The DMAS Early Intervention Services Program Manual says that physician certification is required for EI TCM. Is that correct?

**Answer:** No, this is an error which will be corrected in the next revision of the DMAS manual. Physician certification is **NOT** required in order to bill for EI TCM.

**Question:** How much should we push if a family does not want to take their child to the doctor? Should we transport the family to the child's physician visit?

**Answer:** The role of the early intervention Service Coordinator is to provide information about the value and importance of well baby visits, so that they can make informed decisions about physician services for their child. The decision remains with the family. If the family needs assistance with transportation, then the Service Coordinator would assist in working out transportation arrangements. It is not the role of the service coordinator to transport the child and family to the visit.

**Question:** Can we be reimbursed for EI TCM if the child is not seen by a physician?

**Answer:** Reimbursement for EI TCM requires communication with the child's physician. However, if a family makes an informed decision that they do not want their child to be seen by a physician (or nurse practitioner or physician assistant), you can still bill for EI TCM as long as there is clear documentation of discussions with the family about the benefits of medical care for the child and of the family's decision. Please note that you will not be able to bill for early intervention services (such as Occupational Therapy, Developmental Services, etc.) without a physician certification. In such instances, Part C can be billed for the services as payor of last resort as long as there is sufficient documentation about conversations with the family about the value of medical follow up.

**Question:** What if the child's physician refuses to complete the Health Status Indicator form and/or sign the Physician Certification because they have not seen the child recently or at all?

**Answer:** The Service Coordinator must work with the family to identify and resolve barriers to making and keeping physician appointments. If the reason that the family has not kept the appointment is because they have made a conscious, informed decision that they do not want physician care for their child, then this must be documented. In such cases, you can still bill for EI TCM as long as there is clear documentation of discussions with the family about the benefits of medical care for the child and of the family's decision. Please note that you will not be able to bill for early intervention services (such as Occupational Therapy, Developmental Services, etc.) without a physician certification. In this situation, Part C can be billed for the services as payor of last resort as long as there is sufficient documentation about conversations with the family about the value of medical follow up.

**Question:** Do we have to use the revised combined Physician Certification/Health Status Indicator form or can we develop our own form?

**Answer:** You can develop your own form as long as you include the exact wording for the Health Status Indicator questions.

**Question:** Can we continue to use the physician certification letter without the Health Status Indicators included on the same form?

**Answer:** Yes. If you do not use the combined form, you will need to use another mechanism for communication about the Health Status Indicator questions.

**Question:** Is a confirmation required that the physician received the letter requesting answers to the Health Status Indicator questions?

**Answer:** There is not a requirement to obtain confirmation that the letter requesting the HSI info was received. There is a requirement to document when and how the questions were sent to the physicians.

## **Documentation Requirements**

**Question:** I know the Service Coordinator is to indicate the specific Service Coordination goal that each contact note is addressing. However, is this also a requirement for contact notes that are written prior to the development of the IFSP and the Service Coordination goals? If so, how are we to do this?

**Answer:** Reference the goal listed on the Initial Early Intervention Service Coordination Plan that is being addressed

**Question:** In the contact note checklist, it states that the Service Coordination goal that is being addressed is written on the Service Coordination progress notes. Do they have to write the goal number for EVERY Service Coordination activity or just the activity that counts for the billable activity?

**Answer:** Documentation requirements for service coordination contact notes apply regardless of the payment source, the method of contact, or whether or not the service is billable. Please note that numbering the goals, then using the number in the contact note is one OPTION, but not the only option for documenting the goal being addressed. See page 7 in Chapter 9 of the Infant & Toddler Connection of Virginia Practice Manual for additional options for Service Coordination contact notes.

**Question:** How do we document a service coordination activity that doesn't relate specifically to the outcomes on the Service Coordination outcome page of the IFSP? (E.g. a family that wants information about community programs, such as YMCA and Mothers morning out, etc.)

**Answer:** The examples provided in the question are related to a Service Coordination short-term goal on the IFSP. The 2<sup>nd</sup> pre-printed short-term goal on page 4 of the IFSP states: *provide support and assistance to your family in addressing issues or concerns that emerge over time.*

**Question:** Can service coordination activities that occur over several days be documented on one note?

**Answer:** It is recommended that documentation be completed immediately following the activity. Although you are not prohibited from combining multiple contacts on one note, separate documentation will often be necessary for each activity that is done with or on behalf of the child/family in order to meet the requirement that documentation be completed no more than 5 business days from the date of the contact. If more than one contact is listed on the same note, then it must be clear what happened on each date and the amount of time that was spent on the activity on each date.

## **Collaborating with Other Agencies that Provide Case Management**

**Question:** In accordance with guidance provided by the Department of Behavioral Services, children birth to three who are receiving targeted case management services through other local programs (such as CHIP, Project Link, etc.) are being referred to the local early intervention system. However, in a number of cases, families have not returned calls from the local early intervention system and/or have not been home when the Part C Service Coordinator arrives for

a scheduled home visit. At what point is it acceptable for the early intervention system to determine that they are unable to contact the family.

**Answer:** If you are having difficulty contacting the family, the Part C Service Coordinator should partner with the child's Case Manager to make a joint visit with the family during which the Part C Service Coordinator can provide information about early intervention including next steps (intake and determination of eligibility).

**Question:** If a child who is receiving MH TCM is found eligible for Part C partway through the month, which program bills for TCM for that month, the MH TCM program or the EI TCM program?

**Answer:** If the child is found eligible for Part C on or before the 15th of the month the Part C system would bill for EI TCM. If the child is found eligible for Part C from the 16th of the month to the end of the month, MH TCM would be billed for that month.

**Question:** Can a child birth to three continue to receive MH TCM if the family declines EI services?

**Answer:** If the child is eligible for MH TCM and the family declines EI services, then the child can continue to receive MH TCM and MH TCM can be billed. Please note that:

- 1) EI services should be explained to the family by an Early Intervention Service Coordinator or other Early Intervention personnel (intake coordinator, etc.); and
- 2) The MH TCM program is expected to assure that the child is indeed eligible for MH TCM. Since the EI TCM program was designed specifically for children birth to three, it is the most appropriate case management program for this population.

## ITOTS Data Entry Requirements

**Question:** What is the relationship between the EI TCM and the EI Benefit? I was under the impression when we were developing this EI TCM that there was really no connection. So, I made the assumption that, as far as billing the EI TCM, we did not need to worry about the EI Benefit.

**Answer:** The purpose of adding the intake date to ITOTS is to provide the date the Part C Office needs in order to add the EI benefit for the child in VAMMIS. The Part C Office uses the intake date as the start date for the EI benefit. If a child does not go on to be eligible, the local system must enter an exit date in ITOTS (new for children who don't have an IFSP). This exit date is the date that will be used to end the EI benefit in VAMMIS. Both of these dates populate the Medicaid/FAMIS Enrollment/Discharge screen for children who have Medicaid/FAMIS and the 12 digit Medicaid number entered in ITOTS.

**Question:** When we start putting intake dates in ITOTS, what date do we use for transfers?

**Answer:** For children already found eligible in Virginia who are transferred to your local system from another system, the referral date to your system will be the start date for the Medicaid EI benefit. Filling in the intake date in this situation is optional. Please note that you do need to record an intake date (date the Service Coordinator meets with the family and develops the Initial Early Intervention Service Coordination Plan which the family signs) in the following situation:

- the transfer is from out of state
- the child was previously seen in another local system, but discharged because he/she no longer met eligibility requirements
- the child had been seen in another local system, but there have been at least 6 months since discharge

**Question:** Please clarify the requirements for referral dates and intake dates for children who are transferred from other Virginia Infant & Toddler Connection Systems?

- 1) For children who have had an intake in another local Part C system, but for whom eligibility has not yet been determined:
  - The referral date is the date the child is referred to your system, but no sooner than the day after the child exits the previous system.
  - Since eligibility has not yet been determined, you need to have an intake visit (which could be combined with the Eligibility determination if you have information from the prior system) and that intake date will be the date used as the start date for the Medicaid EI benefit (for children with Medicaid)
- 2) For children who have been determined eligible by another Virginia Part C system, but have not yet had an ASP and/or IFSP
  - The referral date is the date the child is referred to your system, but no sooner than the day after the child exits the previous system.
  - Recording an intake date is optional because the referral date will be the date used as the start date for the EI benefit
  - The eligibility date is the date eligibility was determined by the prior system
- 3) For children who transfer from another local system who have already had an IFSP developed:
  - The referral date is the date the child is referred to your system, but no sooner than the day after the child exits the previous system.
  - Recording an intake date is optional because the referral date will be the date used as the start date for the EI benefit
  - The eligibility date is the date eligibility was determined by the prior system
  - The IFSP date is the IFSP date from the prior system

**Question:** If we enter the Medicaid number in ITOTS at the time of referral, do we still need to put the intake date in ITOTS within 10 days?

**Answer:** Yes. You must enter the Medicaid/FAMIS number AND the intake date within 10 business days of the intake date in order for the intake date to be used as the start date for the EI benefit.

### **Practitioner Certification**

**Question:** Who should providers contact for assistance when they cannot access the practitioner certification database?

**Answer:** David Mills at [david.mills@dbhds.virginia.gov](mailto:david.mills@dbhds.virginia.gov) or 804-371-6593.