Chapter 11: Finance and Billing

Finance and billing practices in the Infant & Toddler Connection of Virginia system support compliance with federal Part C requirements to ensure non-supplanting and use of Part C funds as payor of last resort as well as promoting equity and parity across local systems and enhancing access to early intervention supports and services.

Definitions

1. **Family fee** (or "fee") – Amount required as payment from families for IFSP services based on the accrued charges and co-payments incurred as a result of the services a family receives each month. The family fee may not exceed the monthly cap.
2. **Monthly cap** (or "cap") – The maximum amount, as determined by the Family Cost Share fee scale or fee appeal process, that a family will be required to pay per month for IFSP services regardless of the number, type, frequency or intensity of services a child and family receive.

General

Local Lead Agency Responsibilities:

1. Ensure the following functions are carried out at no cost to families:
    a. Child find requirements;
    b. Eligibility determination;
    c. Assessment (this does not include the ongoing assessment that is integrated into and occurs as a routine part of service delivery);
    d. Service coordination;
    e. Development, review and evaluation of IFSPs; and
    f. Implementation of procedural safeguards.
2. Ensure that the charges for Part C supports and services are consistent regardless of the anticipated payment source.
3. Make every effort during planning and implementation of the interagency system of early intervention supports and services to consider and access all available sources of funds prior to use of state and/or federal Part C funds. Every effort must be made to access private insurance (including private HMOs) and public insurance through the Department of Medical Assistance Services (DMAS) and TRICARE for all Part C supports and services covered by these payors. Other potential resources include, but are not limited to the following:
    a. Private foundations, civic organizations (i.e., Kiwanis, Lions Club, etc.), and faith organizations that have potential supports/resources for children and families in early intervention;
    b. Publicly and privately funded initiatives (i.e., Healthy Families, Comprehensive Health Investment Project of Virginia, Early Head Start, etc.) that may have overlapping services and supports for families;
    c. Public and private agencies/organizations including health/medical, social services, education and mental health agencies; and
    d. Parent organizations.

    Funding for the various steps in the early intervention process (such as intake, determination of eligibility, assessment for service planning, provision of supports and services) varies according to the step in the process and to what is "covered" by the particular funding source. The two *Reimbursement Sources* tables at the end of this chapter show the potential funding sources for each step in the early intervention process.

4. Ensure that, in accordance with the Education Department General Administrative Regulations (EDGAR, §74.24), all income generated by the local Infant & Toddler Connection system is retained by the local Infant & Toddler Connection system. For the purposes of Part C, income includes public and private insurance reimbursement and income from family fees and fundraising.
5. Develop interagency agreements, contracts or memoranda of agreement with as many providers as possible to meet the needs of children with disabilities and their families. These agreements or contracts must specify the responsibilities of each party including the requirement to comply with Part C of the Individuals with Disabilities Education Act, as well as the supports and services that will be provided and how these supports and services will be financed. Local lead agencies must allow families to have access to any certified practitioner in the family's payor network who is working in the local system area, contracting or otherwise arranging for services with the selected provider if needed to allow for exchange of Part C funds.
6. Implement the family cost share practices specified below to ensure documentation that payor of last resort requirements are met and that no child and family are denied supports and services due to an inability to pay. The family cost share practices also specify the process for documenting the family's choices related to use of public or private insurance and payment of family fees.
7. Implement procedures for the use of Part C funds to cover the cost of supports and services pending reimbursement from the agency or entity that has ultimate responsibility for the payment or pending designation of the responsible agency or entity in order to prevent a delay in the timely provision of supports and services.
    a. During a dispute between/among local counterparts of participating agencies regarding financial or other responsibilities, the local lead agency notifies the State Lead Agency of the dispute and uses Part C funds until the dispute is resolved to ensure that no supports and services that a child is entitled to receive are delayed or denied. Upon resolution of the dispute, the agency determined responsible reimburses Part C as follows:
        - If reimbursements are not made by a State participating agency (or its local counterpart) within 45 days of resolution of the dispute, the State Lead Agency contacts the staff involved at the State participating agency of the given program.
        - If not resolved by the respective State agency within 14 days, the matter is referred to the Secretary of Health and Human Resources and/or the Secretary of Education.
    b. Under extraordinary circumstances, Part C funds may be utilized to ensure the provision of services until a monthly cap is determined through the family cost share practices described later in this chapter.

<u>Early Intervention Rates</u>

Standard rates are in place for reimbursement of early intervention services regardless of reimbursement source (though not all reimbursement sources will reimburse for all services listed below – see tables at the end of this chapter). These rates reflect the full cost of providing a unit of early intervention services, including not only salary and benefit costs but also travel and administrative and support costs. In the case of assistant-level practitioners, the rate also accounts for supervision costs. The table below reflects the standard rate for each type of service:

Service	Location	Provider*	Rate (per 15 minute unit)
Eligibility Determination - Travel required to be with family	Any location	RC 1 + audiologists	$37.50/unit
		RC 2 + dietitians	$27.50/unit
Eligibility Determination - No travel to be with family	Any location	RC 1 + audiologists	$22.50/unit
		RC 2 + dietitians	$16.49/unit
Initial Assessment for Service Planning	Natural environment or center	Reimbursement category 1 providers	$37.50/unit
		Reimbursement category 2 providers + dietitians***	$27.50/unit
		Audiologists***	$150/assessment
		Physicians	Negotiated individually at local level
Initial or Annual IFSP Meeting	Natural environment or center	RC 1 + audiologists	$37.50/unit
		RC 2 + dietitians	$27.50/unit
Team Treatment activities (more than one professional providing services during same session for an individual child/family)	Natural environment**	RC 1 + audiologists	$37.50/unit
		RC 2 + dietitians	$27.50/unit
IFSP Review Meeting (child and family present)	Natural environment**	RC 1 + audiologists	$37.50/unit
		RC 2 + dietitians	$27.50/unit
Assessments that are done <u>after</u> the initial Assessment for Service Planning	Natural environment**	RC 1	$37.50/unit
		RC 2 + dietitians	$27.50/unit
		Audiologists	$150/assessment
		Physicians	Negotiated individually at local level
Group (congregate) early intervention services	Natural environment**	RC 1 + audiologists	$25.13/unit
		RC 2 + dietitians	$18.43/unit
Individual early intervention services	Natural environment**	RC 1 + audiologists	$37.50/unit
		RC 2 + dietitians	$27.50/unit
Center-based group (congregate) services	Center	RC 1 + audiologists	$7.43/unit
		RC 2 + dietitians	$5.44/unit
Center-based	Center	RC 1 + audiologists	$22.50/unit

Service	Location	Provider*	Rate (per 15 minute unit)
individual services		RC 2 + dietitians	$16.49/unit
Consultation (child and family not present) - No travel involved	Any location but must be face-to-face	RC 1 + audiologists	$22.50/unit
		RC 2 + dietitians	$16.49/unit
Consultation (child and family not present) - Travel by provider required	Any location but must be face-to-face	RC 1 + audiologists	$37.50/unit
		RC 2 + dietitians	$27.50/unit

* Reimbursement category 1 providers are physical therapists, occupational therapists, speech-language pathologists, nurses (registered nurses or nurse practitioners; providing nursing services or developmental services), physical therapist assistants and occupational therapy assistants. Reimbursement category 2 providers are certified therapeutic recreation specialists, counselors, educators, family and consumer science professionals, family therapists, music therapists, orientation and mobility specialists, psychologists, social workers, early intervention assistants, certified nursing aides and licensed practical nurses.

** Includes center-based services with acceptable justifications AND for which travel by the provider is required. Such situations should be infrequent. Audiology and medical assessments are not required to occur in natural environments.

*** Medically necessary services from audiologists, dietitians, and physicians are reimbursed by Medicaid outside of the Medicaid Early Intervention Program. Providers are required to accept the Medicaid reimbursement as payment in full for these services.

Application of rates:

1. Services are reimbursed for the time spent directly with the child/family.
2. Providers may bill for their entire time spent in an IFSP meeting or assessment.
3. Providers are required to accept Medicaid reimbursement for medically necessary early intervention services as payment in full.
4. When the child is covered by private health insurance or has no insurance, the rate for a delivered service may be paid through multiple payor sources (private insurance, family fees, Part C funds, etc.). These payor sources and billing procedures are discussed below.
5. The entity that bills receives the standard EI rate. If the Local Lead Agency bills for the service, the local lead agency receives the EI rate and pays the employee or contractor who provided the services. Since the standard rates represent the total cost of providing a unit of service, including not only salary and benefit costs but also administrative and support costs such as billing and supervision, local lead agencies can negotiate with contracted providers regarding the portion or amount of the standard EI rate that will be "paid" to the local lead agency for doing the billing. For example, the standard EI rate for PT is $150/hour. If ABC provider delivers 20 hours of PT services and is doing all of their own billing and supervision, then ABC provider will receive the $150 rate multiplied by the number of PT hours provided. If, on the other hand, the local lead agency does all of the billing for ABC provider, then the local lead agency would negotiate with ABC provider to determine how much ABC provider will pay the local lead

agency to do their billing. While the rate remains $150/hour, the amount that the local lead agency will pay ABC provider for PT will be reduced by the amount the provider is paying the local lead agency for billing.

6. A provider will not be reimbursed for participation in consultations or IFSP meetings by phone.
7. For eligibility determination:
    a. While eligibility determination does not have to be a face-to-face meeting, it must be planned ahead of time.
    b. A provider may participate by phone, protected email, videoconference, etc. or a combination of those mechanisms to allow for review of available information and team interaction. Both the time spent for review/preparation and the time for team interaction are reimbursable.
    c. No separate reimbursement is needed or appropriate if the provider participating in eligibility determination is a salaried employee of the local lead agency or if the eligibility determination is combined with the assessment for service planning (and the child is found eligible).
8. An Individualized Education Plan (IEP) meeting is not a medically necessary treatment service and participation by service providers other than service coordinators is not covered by Medicaid/FAMIS. The State Lead Agency considers participation in an IEP meeting to be a teaming activity that cannot be billed by the provider and will not be reimbursed by Part C.

<u>Family Cost Share Practices</u>

Local Lead Agency Responsibilities:

1. Identify the individual(s) who will be responsible for explaining the family cost share practices to families and assisting the family to complete the *Family Cost Share Agreement* form.
2. Ensure that the individual(s) who are responsible for implementing the family cost share practices are trained to:
    a. Explain financial information, including use of Medicaid, TRICARE and private insurance for Part C early intervention services, availability of other resources to support Part C service provision, family fees and monthly caps; and
    b. Collect and record the required financial information from families in a sensitive, confidential and accurate manner.
3. Ensure all families are advised that:
    a. They must be charged the cost of care (i.e., full charge) to comply with federal Medicaid requirements that indicate all services must be charged in like manner; and
    b. A sliding fee scale is available to reduce charges based on family size and income.

    This and other critical aspects of the family cost share practices are explained in *Facts About Family Cost Share*, which is given to all families at the same time they receive *Notice and Consent to Determine Eligibility*.
4. Ensure billing for and collection of all family fees for the local Part C system. The local lead agency may: 1) do all billing and collection of family fees, 2) contract with a single entity to bill for and collect all family fees for the local Part C system, or 3) assign the billing and collection of the family fee to a specific agency/provider for each child.
5. Maintain and report quarterly to the State Lead Agency data on the total amount of family fees collected. Data must be on file at or accessible to the local lead

agency and made available to the State Lead Agency, upon request, to document charges billed, payments received, and the status and follow-up for those families who are required to pay but do not do so.

6. Assist the family in accessing the Part C administrative complaint process, mediation and/or a due process hearing if disagreements regarding family cost share cannot be resolved.
7. Require providers to routinely (at least once a month) confirm with families whether or not their insurance has changed. The provider must notify the local system manager immediately if a child who has or had Medicaid/FAMIS no longer has Medicaid/FAMIS or does not have the Medicaid EI benefit, and notify the service coordinator if the child had TRICARE or private insurance coverage and the child no longer has that coverage.
8. For children with Medicaid/FAMIS, the following specific procedures apply:
    a. Confirm eligibility: The Medicaid Early Intervention Services Manual, Chapter 3, states that eligibility for Medicaid/FAMIS benefits must be confirmed each time a service is rendered. While it is the provider's responsibility to verify Medicaid/FAMIS eligibility prior to every visit, changes in Medicaid/FAMIS eligibility tend to occur at the beginning or end of the month. An effective strategy is to verify Medicaid/FAMIS eligibility the first week of the month and after the 20th of the month. The provider must:
        - Contact the Part C Office if the Medicaid EI benefit is not added within a week; and
        - Retain documentation of all contacts with the Local System Manager and with the Part C Office as these will be used to determine the start date for adding (back) the Medicaid EI benefit.

      Options for verifying a child's Medicaid/FAMIS coverage are discussed in the text box that follows, titled "Medicaid/FAMIS and Medicaid EI Benefit Eligibility Verification."
    b. Ensure the following steps occur if notified by a provider that a child is not showing the Medicaid EI benefit:
        - The local system manager must:
            - Check to be sure that all information is entered correctly in ITOTS;
            - Notify the Part C Office immediately; and
            - Retain documentation of contacts with providers and with the Part C Office as these will be used to determine the start date for adding (back) the Medicaid EI benefit.
        - For a child who no longer has Medicaid/FAMIS coverage, the service coordinator must check with the family to determine if they are in the process of re-applying or if the child no longer meets the Medicaid/FAMIS financial eligibility requirements. Approximately 20% of the Medicaid/FAMIS population loses their benefit for a variety of reasons, including failure to complete the re-application process. If the family is in the process of re-applying, then the service coordinator should:
            - Connect with the local Department of Social Services Office so the child's eligibility worker can assist the

family with completion of the steps necessary to restore the benefit;
    - Contact the family weekly until the coverage is restored and notify the local system manager when the benefits are restored; and
    - Obtain information about the status of the application from the child's eligibility worker (DSS), if needed.
- If the child is no longer financially eligible, the service coordinator must update the *Family Cost Share Agreement* form, and the Medicaid/FAMIS information must be deleted in ITOTS. If Medicaid/FAMIS coverage is later restored, Medicaid/FAMIS must be selected in ITOTS and the 12 digit number re-entered.

9. Checking for Medicaid/FAMIS eligibility for all children in the local system using one of the eligibility mechanisms below may identify children whose families have forgotten to inform the service coordinator that they have Medicaid/FAMIS coverage, which can occur especially when Medicaid is secondary. This is important because DMAS can not be billed retroactively if the timelines for adding the EI benefit are not met, and Part C funds cannot be used for children who have Medicaid or FAMIS coverage.

Medicaid/FAMIS and Medicaid EI Benefit Eligibility Verification:
There are several options for providers to use to verify Medicaid/FAMIS benefits, including the Medicaid Early Intervention benefits.

Eligibility and Claims Status Information
DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderLogin.
Click on Provider Resources, then click on Automated Response System (ARS).

Eligibility Vendors
DMAS has contracts with the following eligibility verification vendors offering Internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. Contact information for each of the vendors is listed below.

Passport Health Communications, Inc. www.passporthealth.com sales@passporthealth.com Telephone: 1-888-661-5657	SIEMENS Medical Solutions – Health Services Foundation Enterprise Systems/HDX www.hdx.com Telephone: 1-610-219-2322	Emdeon www.emdeon.com Telephone: 1-877-363-3666

Medicaid Medical Case Management Programs and Contacts
A list of the contacts for the various Medicaid Managed Care Organizations can be found at: http://www.dmas.virginia.gov/downloads/mcrguides/Chapter_9.pdf. Though early intervention services are "carved out," many of the infants and toddlers enrolled in Medicaid/FAMIS are enrolled in Managed Care. This list can be used by Service Coordinators in order to coordinate children's other services with the Managed Care Organization. In addition, the MCO can assist with questions about the child's Medicaid number and eligibility.

Responsibilities of the Individual(s) Designated to Implement Family Cost Share Practices for the Local Infant & Toddler Connection System:

1. **Conduct financial intake** following eligibility determination and prior to the initial IFSP meeting unless the child has Medicaid/FAMIS (in which case the *Family Cost Share Agreement* form must be completed at the intake visit to ensure timely entry of Medicaid/FAMIS data into ITOTS and, as a result, Medicaid reimbursement for all reimbursable services).
    a. Since the financial intake includes sharing personal financial information, care must be taken when combining eligibility determination and/or assessment for service planning and/or IFSP development to ensure the family has an opportunity for privacy during the financial intake.
        - If there is documentation from the physician of a qualifying diagnosed condition prior to the eligibility determination and the

family wishes to combine the eligibility determination with the assessment for service planning, and potentially the IFSP meeting, then financial intake can be conducted prior to the combined activities.

- Otherwise, when eligibility determination and assessment for service planning are combined, then the financial intake should occur between assessment for service planning and the IFSP meeting. If the family wants the IFSP meeting also to occur on the same date, then the service coordinator needs to be sure the family understands (before consenting to this arrangement) that the financial intake will need to occur that day as well, prior to the IFSP meeting. The family should be made aware that if they wish to discuss these matters privately and if these activities are happening at the family's home, then there will need to be a separate place where the service coordinator and family can go to discuss the financial matters. Provider participants should also be made aware of the need to conduct financial intake during these combined activities since it impacts their time and availability for other activities and services.

b. Under extraordinary circumstances, Part C funds may be utilized to ensure the timely provision of services until a monthly cap is determined through the family cost share practices. Any extenuating circumstances that result in the financial intake not being conducted prior to initiation of IFSP services must be clearly documented. In the event of such extraordinary circumstances, the family must provide income information within 30 calendar days of the parent signing the IFSP if they wish to access the fee scale. At the end of 30 days, if the family has not provided income information, then they have the option to either:
    - Sign the *Family Cost Share Agreement* form indicating that they will pay the full charge or marking the box "Opting to Delay Services" (indicating that they are choosing to delay further services, other than those available at no cost, until they can provide income information). If the family opts to delay services and those services have not yet started, this would be a family reason for a delay in start of services. Part C funds must be reimbursed once the monthly cap is established and payment is received. – OR-
    - Decline early intervention services other than those available at no cost to the family. For additional information about and requirements when a family refuses to pay for early intervention services, please see additional information in #4 and #5 under Fee Appeal Process later in this chapter.

    If the Family Cost Share Agreement form cannot be completed prior to development of the IFSP, the family cost share process still must be fully explained to the family and all related forms shared with the family prior to IFSP development. The family must understand their obligation to provide financial information within 30 days of the date they sign the IFSP and the options available to them at the end of those 30 days. It should also be made clear that the family will be obligated to pay, in accordance with the terms of the agreement form that is signed no later than 30 days after the IFSP, for any services (other than those that must be available at

no cost) delivered prior to the agreement form being signed. This discussion must be documented in a contact note.

c. The financial intake must include providing families with the following:
    - A list of chargeable services as well as services for which there are no charges;
    - Charges and/or fees for the services;
    - Family Cost Share Agreement forms; and
    - A copy of the family cost share fee scale.
d. Financial intake also includes explaining the following:
    - No child and family will be denied services because of an inability to pay. The family cost share practices determine a family's ability to pay.
    - Families will be charged a monthly fee towards the full charge of their IFSP services unless:
        - The child has Medicaid (including FAMIS, FAMIS Plus). For children with FAMIS, Part C funds will be used to pay the family's co-pay for early intervention services listed on the child's IFSP;
        - The family has an income that puts them at $0 on the fee scale; or
        - The child and family receive no services other than those that must be provided at no cost to families.
    - The family fee covers all IFSP services, including assistive technology devices, regardless of the number, type, frequency or intensity of services provided.
    - The family fee may not exceed the total of any applicable co-payments, deductibles, and/or the full early intervention reimbursement rate (if the service is not covered by insurance) for delivered IFSP services in a given month.

Background Information: How the family fee works for assistive technology devices

There is no separate fee to the family for assistive technology devices. The family's responsibility for payment toward the cost of such devices is covered by their use of insurance and/or the family fee just like all other IFSP services. (Note: Resources other than insurance also may be available to assist in the purchase of an assistive technology device. If available, these resources must be accessed prior to the use of Part C funds.)

An assistive technology device is considered a one-time cost that is incurred in the month of purchase. If the full charge for IFSP services other than the assistive technology device is less than the family's monthly cap, the family may pay a higher fee (up to the monthly cap) in the month the assistive technology device is purchased.

Example: Family's monthly cap is $207. The child is receiving PT weekly and their insurance co-pay for each PT visit is $25. Therefore, the family has been paying $100/month. This month, the assistive technology device listed on the child's IFSP was purchased at a cost of $500. Insurance did not reimburse for any of that cost. This month the family will pay not only the $100 they've been paying for PT but also an additional $107 toward the cost of the assistive technology device since this brings them up to their monthly cap of $207.

- Families who will be charged a fee have the opportunity to provide documentation of taxable income that will be used along with family size to determine a monthly cap, or maximum amount, for their family fee, based on the family cost share fee scale. Because it's based on taxable income, the family cost share fee scale automatically takes into consideration normal living expenses, including medical costs associated with the child's disability.
- The monthly cap established by the family cost share fee scale is the same regardless of the number of children the family has enrolled in the Infant & Toddler Connection system at the same time (e.g., if the family's monthly cap is $231 based on the fee scale, then that family pays no more than $231 per month, total, regardless of the number of children in their family who are enrolled).
- If the family chooses not to provide income information then the family has declined to participate in the family cost share process.
    - If the family has health insurance and agree to have it billed for reimbursable IFSP services, then they are required to pay all applicable co-payments and deductibles for those services.
    - If the family does not have health insurance, declines to have their insurance billed or the service is not covered by their health insurance, they must pay the full EI reimbursement rate for IFSP services.

- Parent consent is required in order to bill private insurance for IFSP services. If the family does not provide consent to use their private insurance, the family pays the full EI reimbursement rate for IFSP services unless the family indicates that they believe use of their insurance will result in a financial loss such as a decrease in available lifetime coverage, escalation of premium, or discontinuation of the policy. As long as the necessary financial information is provided, the family cost share fee scale also can be accessed by families:
    - With insurance that does not cover early intervention services; or
    - Who do not have access to a provider in their insurer's network within the local Infant & Toddler Connection system.
- Families that use their insurance as well as accessing the family cost share fee scale are responsible for covering the cost of insurance co-pays and deductibles up to the monthly cap except that the family cost share fee scale may not be used to reduce co-pays and deductibles that are automatically paid through the family's flexible spending account.
    - As long as the family does not have a flexible spending account that automatically pays the provider, Part C funds may be used to cover the remaining balance of the co-pays and deductibles above the family's monthly cap. Deductibles and co-pays are an obligation between the subscriber and the insurer, not the provider and the insurer. The provider agrees to collect the deductible and co-pay from the family, and these cannot be waived. Therefore, the full deductible/co-pay (minus the amount the parent pays that month) is the responsibility of Part C.
    - Families with flexible spending accounts that automatically pay the provider must sign the *Family Cost Share Agreement Addendum Form – Addendum* and must pay the full cost of any co-pays or deductibles until the funds in their flexible spending account have been exhausted. Please note that this requirement to use available flexible spending account funds is not an acceptable reason for a family to deny use of their insurance for Part C services since this will not result in a financial loss to the family (since the family has already set aside these funds in a flexible spending account for medical expenses, using these funds does not constitute a financial loss).

Example: Family Cost Share When Family has Flexible Spending Account that Automatically Pays:

- A family has private insurance and has $1,000 in their health care flexible spending account.
- Based on the family cost share fee scale, the family's monthly cap is $50.
- Their child is receiving Physical Therapy (PT) and Developmental Services.

This family is responsible for all co-pays and deductibles for the PT services until their flexible spending account is exhausted. In addition, the family will pay up to $50 per month toward the cost of Developmental Services. Once their flexible spending account is exhausted, the family will pay no more than $50 per month to cover all services

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- If the family feels the monthly cap calculated on the family cost share fee scale is more than they can afford, they may request to reduce the monthly cap through completion of the Fee Appeal Form. The fee appeal process is detailed later in this section
- In cases where services are anticipated to extend over one year, the family is informed that an annual re-evaluation of their financial circumstances is required.

2. Prior to development of the initial and each annual IFSP, complete the following steps to **determine the family cost share**:
    a. Determine whether the child is covered by Medicaid/FAMIS, TRICARE and/or private health insurance.
        - If so, review coverage opportunities with the family for Part C supports and services.
        - Request written parent consent on the *Family Cost Share Agreement* form to access Medicaid, TRICARE and/or private insurance for reimbursable Part C supports and services.
    b. Determine family size. All related or non-related persons who share income as an economic unit are considered part of a family unit. "Shared income" is income that is pooled or commingled to support the economic unit. "Shared expenses" is not the same as "shared income," and does not define an economic unit.

Examples for Determining Family Size:

- A pregnant woman counts as 2 family members (or more in the case of multiple gestation). A woman's statement that she is pregnant is sufficient, and medical confirmation is not required.
- A college student living away from home but receiving financial support from his family counts as part of the family unit.
- Multiple families who share the rent for an apartment but who do not share or commingle their incomes would not be considered a family unit.
- A child and her mother live with the grandparents. The mother is employed and pays her own expenses. She pays rent to her parents. The child and her mother would be considered a family unit of 2, and only the mother's income would be used to determine the family cost share because payment of rent to grandparents does not constitute pooling of income.
- A child lives with his unmarried father and his father's companion. Both adults are employed. They are both signators on their apartment lease and pay living expenses for food, utilities, etc. out of both incomes. The child, father and the companion would be considered an economic unit of 3 and both adults' incomes would be used in determining the family's cost share.
- A family member who is paying child support for the eligible child is not considered a part of the child's family unit.
- In cases where there is joint custody of the child, the parents must designate which of them is the head of the family (e.g., will the child be considered part of the mother's family unit or the father's family unit). If the head of the family unit is not designated, the parent presenting for services will be considered the head of the family.
- A husband and wife who are separated and are not living together are considered separate units. If a husband and wife are legally separated, but are living together and sharing their income, the two of them become a single economic unit despite their separated status.

When situations arise that do not match exactly with one of those listed above, local systems are encouraged to use the given examples to make their best effort in determining who constitutes the family unit in the specific situation being considered.

c. Determine the family's monthly cap using the family cost share fee scale. Request that the family provide proof of income by presenting (1) a copy or transcript of last year's federal 1040 tax returns; or (2) an estimated taxable income calculated by using the federal 1040 format (i.e., by completing a blank federal 1040 form, either the short form or the long form, from last tax year); or (3) if the family is unable to provide a copy of last year's tax return or estimated taxes in accordance with (1) or (2) above, proof of net monthly income in accordance with steps outlined in the fee appeal process.
    - Taxable income must be taken from the most recent federal 1040 tax return. Taxable income found on the state return may not be used.
    - In situations where family conditions have materially changed since the most recently filed federal 1040 form, the family is required to notify their service coordinator. A revised taxable income will be determined by estimating taxable income using the

- In situations where families have not retained copies of their most recent tax return, families should take two steps: (1) request a transcript of the most recently completed federal 1040 from the IRS (see note below); and (2) estimate their taxable income using the 1040 format and using more current family financial data (i.e., by completing a blank federal 1040 form, either the short form or the long form) for immediate use until the requested information is received. This will prevent a delay in the start of services. NOTE: Families are encouraged to request a transcript from the IRS and not a copy of their most recent tax return. Copies of tax returns cost approximately $23 and can take several weeks to receive. Transcripts are sent at no cost within one to three weeks and can be requested by calling 1-800-829-1040 or accessing a request form (IRS Form 4506T) at www.irs.gov.
- Completion of the federal 1040 form is the responsibility of the family and under no circumstances is it the responsibility of the individual designated by the local system to implement family cost share practices to assist the family in preparing estimated and/or annual income taxes.
- If the family's income level is low enough to make the child eligible for Medicaid or FAMIS, there is no family ability to pay and the monthly cap for the family fee is automatically assessed at zero ($0). A family with income below the level that requires completion of federal income tax returns also has a monthly cap of zero ($0) under the family cost share practices. To determine if a family's income is too low to require a tax return, visit www.irs.gov

3. **Complete the *Family Cost Share Agreement* form**. The *Family Cost Share Agreement* form is designed to clearly identify the specific responsibilities of the parent(s), document the choices parents have made regarding the manner in which they will pay for their services (i.e., use of insurance, full EI rate vs. monthly cap), identify the information used to determine the amount of the monthly cap, and obtain a written agreement from the parent(s) to pay for their early intervention services within their financial ability. Only one *Family Cost Share Agreement* form is needed for each family, regardless of the number of children the family has enrolled in the Infant & Toddler Connection system. If the family wishes to access the family cost share fee scale, then proof of income must be viewed by the individual designated by the local system to implement family cost share practices. Proof of income must be one of the following:
    a. A copy of the family's most recent federal 1040 form (only the page showing taxable income); or
    b. If the federal 1040 form is grossly misrepresentative of the current financial status (e.g., due to birth of new baby, change in employment or marital status, etc.) or is non-existent, an estimate of their taxable income using a blank federal 1040 form with current financial information filled in; or
    c. If no pay stub or income documentation of any kind exists, then a written statement from the employer verifying the net income amount; or

d. If the family's income qualifies them for Medicaid/FAMIS, then documentation of Medicaid/FAMIS eligibility; or
e. If the family states they have no income and no Medicaid/FAMIS and no proof of this is available, then a signed statement by the parent certifying that they have no income.

Visual regard of the income documentation is adequate verification of income, and it is not necessary under federal and state Part C requirements to retain a copy of the document viewed. Signatures on the *Family Cost Share Agreement* form of the parent and the individual reviewing the income documentation confirm that the required income documentation was viewed. Local agency or local system requirements may be different from the state practice that allows visual regard of income and expense documentation. The individual designated to implement the family cost share practices for the local Infant & Toddler Connection system must be aware of and comply with any local requirement to receive and maintain a copy of income and expense documentation. The *Family Cost Share Agreement* form must be maintained in the child's early intervention record or in a separate financial file. If the agreement form is filed in the early intervention record, it is recommended, but not required, that there be a separate section for financial information within the record, particularly for any information stored that documents the family's income or expenses.

4. **Ensure that re-evaluation of the family's cost share occurs at least annually** and whenever the family's financial circumstances change. Make sure the family knows to inform their service coordinator of any significant changes in their financial status, including a change in their insurance coverage, income, or family size, throughout enrollment in services unless the family has chosen to pay all applicable co-pays, deductibles and/or the full EI reimbursement rate (if the service is not covered by insurance) for IFSP services.
    a. Once notified by the family of a change in the family's financial circumstances, the service coordinator facilitates completion of a revised *Family Cost Share Agreement* form that reflects the family's new financial circumstances. The revised *Family Cost Share Agreement* form is signed by the family. If there is a new monthly cap, it becomes effective on the date of signature on the *Family Cost Share Agreement* form.
    b. Any delay in signing the *Family Cost Share Agreement* form annually must be handled the same was as a delay in initially signing the form. Under extraordinary circumstances, Part C funds may be utilized to ensure the continued provision of services until the agreement form is signed. In the event of such extraordinary circumstances, the family must provide income information within 30 calendar days of the parent signing the annual IFSP if they wish to access the fee scale. At the end of 30 days, if the family has not provided income information, then they have the option to either:
        - Sign the *Family Cost Share Agreement* form indicating that they will pay the full charge or marking the box "Opting to Delay Services" (indicating that they are choosing to delay further services, other than those available at no cost, until they can provide income information). If the family opts to delay services and those services have not yet started, this would be a family reason for delay in the start of services. Part C funds must be reimbursed once the fee is established and payment received. – OR-

- Decline early intervention services other than those available at no cost to the family. For additional information about and requirements when a family refuses to pay for early intervention services, please see additional information in #4 and #5 under Fee Appeal Process later in this chapter.

Fee Appeal Process:

1. The intent of the fee appeal process is to provide families with the opportunity for individual consideration of financial circumstances including documentation of extraordinary expenses, such as medical or other expenses related to the child's disability, and to appeal for additional reduction of the monthly cap.
2. There should be no duplication of processes between the family cost share fee scale and the fee appeal process. If a family expresses financial hardship after the monthly cap is established using the family cost share fee scale and accesses the fee appeal process, the monthly cap established through the fee appeal process is the final determination of the family's monthly cap.
3. The following steps are used consistently with all families who access the fee appeal process:
    a. Families are informed of all factors considered in the fee appeal process, including, but not limited to, the following:
        - The basis for the fee appeal is disposable income derived from taxable income or net monthly income less actual expenses;
        - For items on the fee appeal form specifying a fixed average allowable amount (i.e., food, gasoline, clothing), no proof of expenses is needed unless the family's actual expenses exceed the average allowable amount. The fee appeal process specifies the following average allowable amounts:
            - Auto insurance - $75 per month per family
            - Utilities - $310 per month
            - Food - $200 per person per month*
            - Telephone - $70 per month
            - Internet - $20 per month
            - Cable - $65 per month
            - Gasoline - $100 per adult per month
            - Clothing - $35 per person per month

          The average allowable amounts may be exceeded only if the family provides documentation. The family is required to provide documentation of expenses for all items on the fee appeal form where an average allowable amount is not specified. Visual regard of the expense documentation is adequate unless the local agency or local system does not allow this practice.
          (* This average amount includes the cost of groceries as well as the cost of eating some meals at restaurants.)
        - The amount allowed for **recreation/entertainment** is limited to $25 per person per month and may not exceed that amount. This is an automatic deduction of $25 per person.
        - **Credit card payments** may be deducted for families carrying a credit card balance. Use the current minimum monthly payment amount or the documented monthly payment negotiated with the

creditor, through a debt counseling service or court-ordered. This monthly amount does not need to be updated more than annually unless there is a significant change, which substantially impacts the family's ability to pay.

- Child support payments should be included under **Other Debt Payment**. However, if taxable income is being used on the Fee Appeal form, please be certain that child support has not already been deducted on the individual's tax form.
- **Educational expenses** include tuition, books, room and board and may be for any member of the family. Costs for programs like Gymboree classes or recreational programs may not be included as educational expenses.
- **Expenses to maintain the home in a livable condition** include expenses associated with adaptations necessary to make the home accessible and safe for a family member with a disability or to make repairs as a result of a natural disaster, fire or similar damage. Costs associated with a lawn service, weekly housecleaning service or remodeling for a purpose other than maintaining the home in a livable condition (e.g., cosmetic improvements) are not allowed.
- The category of **job-related necessities** includes expenses incurred when the wage earner must purchase job necessities that the employer does not furnish or reimburse, such as tools, equipment, materials or uniforms.
- The following are not allowed as family monthly expenses on the fee appeal form: tithing; contributions to retirement or education savings accounts.
- There is no "other" category under "Monthly Family Expenses." If the family states an expense that does not fit into an existing expense category, contact Bev Crouse (btcrouse@vt.edu or 540-231-0803) who will determine either that the expense fits into a given category, can be added as an "other expense," or cannot be deducted.

Frequently Asked Questions About Allowable Expenses for Fee Appeal:

1. For the elder care deduction, do the parents need to be declared as a dependent on their income tax return to get this deduction? **No**
2. If families have second homes or vacation homes, are they an allowable deduction? **Yes**
3. For car repair bills under transportation deductions, are these outstanding bills or does this line item account for past repairs? **Outstanding bills**
4. For medical expenses, do you take into account bills they've already paid and if so how far back or do you just allow routine monthly expense (i.e. doctor visits and prescriptions)? **Take into account expenses from the past 12 months; divide that number by 12 to get a monthly amount to enter on appeal form**
5. The credit card payments category is only used if they carry a balance, right? **A deduction can only be taken if the family carries a credit card balance and not if they pay their bill in full each month.**
6. What if a family is doing unreimbursed medical/child care pretaxed? **If the family has set aside pre-tax dollars in a flexible spending account for medical or child care expenses, then expenses paid with these pre-tax dollars cannot be deducted on the fee appeal form since these dollars have already been deducted in determining the taxable income or net monthly income figure**. **For example, if the family put $1,000 into a medical flexible spending account this year and had $1,000 in medical expenses (all of which were paid through the flexible spending account), then the amount the family can deduct for medical expenses on the Fee Appeal Form is $0.**

b. The monthly cap is calculated by first subtracting expenses from taxable income (or net monthly income) and then taking 5% of that total. For example, if taxable income minus expenses equals $100, then the monthly cap is 5% of $100, which is $5. Five percent (5%) of the disposable income is the amount determined as the monthly cap.
c. The *Fee Appeal Form* is completed and signed, and the family must provide documentation of their expenses as required by the *Fee Appeal Form*.
    - If using taxable income, the family will have already provided documentation of their taxable income in order to complete the *Family Cost Share Agreement* form. No further documentation of income is required. Divide the family's taxable income by 12 and enter that amount on the "Monthly Family Income" line at the top of the *Fee Appeal Form*.
    - If using net monthly income, then enter this amount (based on pay stubs or written statement certifying income) on the "Monthly Family Income" line at the top of the *Fee Appeal Form.*
    - In situations where the family's taxable or net monthly income puts them at $0 on the family cost share fee scale, no documentation of expenses is required (because the family would already be at $0 and showing further expenses would have no effect on the monthly cap amount).
d. Information on the monthly cap resulting from the fee appeal process is transferred to the *Family Cost Share Agreement* form.

4. A family's inability to pay is different from a family's unwillingness to pay. If a family has been given access to the family cost share fee scale and fee appeal process but is unwilling to pay for services that have been delivered, then providers may proceed with their own agency's process for collecting delinquent accounts.
5. If the family refuses to pay the fee determined through the fee appeal process, then the local system manager and service coordinator are notified. The service coordinator notifies all other service providers and provides a *Parental Prior Notice* form to the family indicating that all services, other than those that must be provided at no cost (e.g., service coordination, assessment, IFSP review) will not start or will end due to parent refusal to pay. The family must receive a copy and explanation of the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined. In explaining the Notice of Child and Family Rights and Safeguards, the service coordinator reviews and explains the complaint procedures.
6. Parents have the right to access the administrative complaint, mediation and/or due process procedures if they disagree with assigned fees or other decisions related to family cost share.

<u>Billing Procedures</u>

General:

1. In order to be reimbursed, services must be provided in accordance with the IFSP. The frequency and intensity for a service cannot exceed that listed on the IFSP over a one month period unless the provider is making up missed sessions from another month.
2. With the exception of physicians, audiologists and registered dietitians, only certified early intervention providers and agencies who employ certified early intervention providers can bill for early intervention services.
3. Billing for early intervention services occurs at the local level. Each provider must have a mechanism to bill for services, either by:
    a. Being employed by or contracted with an agency (including a local lead agency) that does the billing or contracts out the billing function; or
    b. Doing their own billing.
3. Providers must have a National Provider Identifier, NPI, or Atypical Provider Identifier, API, for billing (group number if employed by an agency that is doing the billing, or an individual number if an independent practitioner). The National Provider Identifier is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard, a unique identification number for covered health care providers. An Atypical Provider is an individual or business that bills DMAS for services rendered but does not meet the definition of a healthcare provider according to the NPI Final Rule 45CFR 160.103.

Medicaid/FAMIS:
Medicaid Early Intervention Services Program

1. Under the Medicaid Early Intervention Services Program, providers bill DMAS (for children with Medicaid or FAMIS coverage) using a CMS 1500 form, electronic billing or Direct Data Entry and the codes listed in the Medicaid Early Intervention Services Program Reimbursement Information table at the end of this chapter.
2. Medically necessary audiology, nutrition, medical services and assistive technology devices are reimbursed by Medicaid outside of the Medicaid Early Intervention Services Program and require different codes.
3. In order to be reimbursed by Medicaid for early intervention services:
    a. Providers must be EI Certified;
    b. Providers must enroll with the Department of Medical Assistance Services (DMAS) as an early intervention provider, even if already enrolled as a rehab provider. Follow the instructions on the DMAS website (www.dmas.virginia.gov) to enroll as an early intervention provider;
    c. Services must be provided to children who are determined eligible for Part C services and who are receiving early intervention services, which may include an assessment for service planning, through the Infant & Toddler Connection system. Please see "Initial Data Entry for Enrollment in Medicaid EI Benefit" and "Maintaining Enrollment in Medicaid EI Benefit" text boxes on the next two pages for specific information on the ITOTS information required for Part C eligible children who have Medicaid/FAMIS); and
    d. Services must be covered services and, with the exception of the assessment for service planning, approved by a physician, physician's assistant or nurse practitioner (for specific requirements associated physician signature, please see the "Completing the IFSP Form" section of Chapter 7).

    For additional information about early intervention services through the Medicaid Early Intervention Services Program, visit the DMAS website (see link above), click on the link to provider manuals, and then select Medicaid Early Intervention Services.
4. No service that is planned solely for the parent is reimbursable by Medicaid. However, if the child falls asleep during an intervention session, it is okay to provide teaching/coaching to the caregiver and to bill for this service. This situation should be infrequent and well-documented; and the length of the session will generally be shorter than planned since the provider and caregiver are not able to practice the strategies with the child.
5. Rounding the minutes of service provided up or down is not allowed. In cases where the provider does not complete one unit (15 minutes) of billing time, the provider may bill for a range of dates within a month (and the units provided in two or three sessions) that best captures the billable time. For instance, the provider delivers 55 minutes on 10/1, 50 minutes on 10/8, 40 minutes on 10/15, and 65 minutes on 10/22. The provider has delivered a total of 210 minutes of service and could bill this as 210/15 = 14 units for dates of service 10/1 – 10/22.
6. For children with Medicaid/FAMIS and commercial insurance coverage, providers must bill the commercial insurance first except in the following circumstances:
    a. If a family has declined access to their private health/medical insurance for covered early intervention services because they believe use of their insurance will result in a financial loss such as a decrease in available lifetime coverage, escalation of premium, or discontinuation of the policy,

then the following steps may be taken to secure Medicaid reimbursement without billing the commercial insurance first:

- Check "yes" for box 11-D on the CMS 1500 form; and
- Complete and sign a *Notification to the Department of Medical Assistance Services: Family Declining to Bill Private Insurance* form and attach it to the claim form.

b. Edits (requirements to submit proof of billing commercial insurance if the client has Medicaid/FAMIS as secondary) have been removed for the following billing codes: T1023 and T1023 UI; T1024 and T1024 U1; T1027 and T1027 U1; and T1015 and T1015 U1. This means providers do not have to go through the additional paperwork step of providing an explanation for why commercial insurance is not being billed or is not paying for developmental services and for assessments.

Medicaid Early Intervention Targeted Case Management (EI TCM)

1. EI TCM providers bill DMAS (for children with Medicaid fee for service, MCO or FAMIS coverage) using a CMS 1500 form, electronic billing or Direct Data Entry and the billing code T2022.
2. In order to be reimbursed monthly by Medicaid for service coordination:
   a. The service coordinator must be certified as an Early Intervention Case Manager;
   b. The agency providing service coordination must be enrolled with the Department of Medical Assistance Services (DMAS) as an early intervention provider with specialty type 119. Follow the instructions on the DMAS website (www.dmas.virginia.gov) to enroll. The Local Lead Agency determines which agency(ies) within the local system will provide and bill for early intervention service coordination;
   c. Service coordination must be delivered in accordance with a signed Initial Early Intervention Service Coordination Plan or a signed Individualized Family Service Plan (IFSP);
      - In order to bill DMAS for service coordination starting at intake, an Initial Early Intervention Service Coordination Plan must be completed, signed and dated at Intake.
      - The Initial Early Intervention Service Coordination Plan ends when the child is found ineligible for Part C, the IFSP is signed, or 90 calendar days from the date of intake, whichever comes first, with billing not to exceed three calendar months.
      - The month in which a child is determined to be ineligible or no longer eligible is the last month that service coordination can be billed.
   d. During the month being billed, at least one of the allowable activities listed in the text box on the next page must be provided by the service coordinator with the child, the family, service providers, or other organizations on behalf of the child/family. The contact must be relevant to the child/family needs and the Initial Early Intervention Service Coordination Plan or Individualized Family Service Plan (IFSP). The service may not duplicate any other Medicaid service;
   e. The contact or communication must be documented completely and correctly, as outlined in the contact note requirements in Chapter 9;
   f. At a minimum, a phone, or email, or a face-to-face contact with the family must occur every three calendar months, or there must be documented

attempts of such contacts. Three-calendar months does not mean every 90 days, nor does it mean quarterly. The contacts must begin no later than the next month after the month that the initial IFSP is signed, and the 3-calendar-month period restarts after each contact (i.e., if the service coordinator contacts the family on October 7 and November 10, then the next contact must be made no later than the last day of February).

- The family's preferred method of contact must be documented (see Chapter 9 for more information about documentation requirements).
- Text messaging is not an allowable method of direct contact.
- The provider may not bill for a month in which the only activity was attempted contacts with the family, but these attempted contacts within the three calendar month period will prevent the provider from losing all billing during the three calendar month period (e.g., they could bill for another month in that period during which an allowable activity was completed even though their attempts to make the required contact with the family by phone, email or face-to-face every three calendar months were unsuccessful);

g. There must be documented face-to-face interaction between the service coordinator and the family at the development of the initial IFSP and the annual IFSP along with documentation that the service coordinator observed the child during the calendar month that the IFSP meeting was held; and

h. The health status indicator questions must be submitted to the child's physician every six months or an alternate local mechanism (e.g., request and review of well-child records) used to collect the answers to these questions.

3. When a child transitions from one local system to another and both systems provide service coordination during that month, only one of the local systems can bill for EI TCM. If the child is transferred on or before the 15th of the month the receiving local system would bill. If the is child transferred from the 16th of the month to the end of the month, the sending local system would bill.
4. Early Intervention (EI) enrollees must receive EI targeted case management. Since DMAS allows only one case management program to be billed during the same time period, DMAS cannot be billed for ID or MH TCM for EI enrollees.
    a. DMAS does allow an exception for BabyCare case management to be billed simultaneously along with EI targeted case management during the same time period.
    b. Because case management is built into the reimbursement for therapeutic foster care, EI and Therapeutic Foster Care (TFC) case management cannot be billed to DMAS for the same service month. If an EI enrollee is receiving TFC, the EI case manager should review the child's needs and services with the TFC case manager to determine if the child's services are better monitored and coordinated by the EI case manager or the TFC case manager. The two case managers are responsible to make the determination of which TCM is better suited for the child's particular needs and services. If it is determined that Therapeutic Foster Care will be billed, then Part C funds may be used as payor of last resort to cover the costs of Part C service coordination.

EI TCM Allowable Activities for Billing Medicaid

Allowable activities include but are not limited to the following:

1. Coordinating the initial Intake and Assessment of the child and planning services and supports, to include history-taking, gathering information from other sources, and the development of an Individualized Family Service Plan, including initial IFSP, periodic IFSP reviews, and annual IFSPs. This does not include performing medical assessments, but may include referral for such assessment;
2. Coordinating services and supports planning with other agencies and providers;
3. Assisting the child and family directly for the purpose of locating, developing, or obtaining needed services and resources;
4. Enhancing community integration through increasing the child and family's community access and involvement;
5. Making collateral contacts to promote implementation of the Individualized Family Service Plan and allow the child/family to participate in activities in the community. A collateral contact is defined as "Contact with the child's significant others to promote implementation of the service plan and community participation, including family, non-family, health care entities and others related to the implementation and coordination of services;"
6. Monitoring implementation of the Individualized Family Service Plan through regular contacts with service providers, as well as periodic early intervention visits;
7. Providing instruction and counseling that guide the family in problem-solving and decision-making and developing a supportive relationship that promotes implementation of the Individualized Family Service Plan. Counseling in this context is defined as problem-solving activities designed to enhance a child's ability to participate in the everyday routines and activities of the family within natural environments where children live, learn, and play;
8. Submitting to the client's physician (semi annually) the health status indicator questions or using an alternate local mechanism to collect the information necessary to answer these questions. Based upon the results of the questionnaire from the physician, following-up with the family/caregiver to inform and/or assist in obtaining needed medical services;
9. Coordinating the child/family's transition from Part C early intervention services; and
10. Making contacts (face-to-face, phone, email) with the family (see #2g in the section directly above for minimum requirements).

For all children with Medicaid/FAMIS

1. The local system manager (or designee) must provide oversight to ensure Medicaid/FAMIS information is correctly entered into ITOTS in order to begin and maintain enrollment in the Medicaid EI benefit. The following text boxes and the one titled "Medicaid/FAMIS and Medicaid EI Benefit Eligibility Verification" in the Family Cost Share section of this chapter provide further information.

Initial Data Entry for Enrollment in Medicaid EI Benefit:

In order for providers to receive Medicaid reimbursement for Part C early intervention services the following ITOTS data fields must be completed promptly and accurately:

- Medicaid/FAMIS must be selected in the Third Party Coverage section of ITOTS;
- An accurate 12-digit Medicaid number must be entered in the ID field next to Medicaid. The 12-digit number is used by the State Lead Agency to locate the child's record in the Department of Medical Assistance Services (DMAS) database, VaMMIS.
- The Intake Visit Date must be recorded in ITOTS.
- Entering the child's social security number can facilitate locating the child's record in VaMMIS.

Child has Medicaid/FAMIS when the Child is Referred to Part C

- ITOTS data entry must be completed (Medicaid/FAMIS selected, 12-digit Medicaid number and Intake Visit Date entered) within 10 business days of the Intake Visit Date in order to bill for Initial Early Intervention Service Coordination. (An Initial Early Intervention Service Coordination Plan also must be in place in order to bill for this service).
- If the required information is entered in ITOTS more than 10 business days after the Intake Visit Date, then the date the required information is entered in ITOTS will be the start date for the Medicaid Early Intervention benefit.

Child Enrolled in Medicaid/FAMIS after the Child is referred to Part C

- If Medicaid/FAMIS is selected and the 12-digit Medicaid number is entered in ITOTS within 30 calendar days of the Medicaid Disposition Date (the date the decision was made that the child was eligible for Medicaid or FAMIS) and if the child has an Initial Early Intervention Service Coordination Plan in place, then the start date for the Medicaid EI benefit is the same as the Medicaid/FAMIS start date, unless this date precedes the Intake Visit Date. If the Medicaid/FAMIS start date precedes the Intake Visit Date, then the Intake Visit Date will be the start date for the Medicaid EI benefit.
- If Medicaid/FAMIS is selected and the 12-digit Medicaid number is entered more than 30 calendar days after the Medicaid Disposition Date, then the date the required information was entered in ITOTS will be the start date for the Medicaid EI benefit. Neither Medicaid nor Part C reimbursement will be available for the time period that is not covered.

NOTE: Medicaid reimbursement is available only for service coordination (Early Intervention Targeted Case Management) until it is determined that the child is eligible for Part C.

Maintaining Enrollment in Medicaid EI Benefit:

Child's Medicaid Early Intervention Benefit is "Dropped" in the Medicaid VaMMIS System:

- Occasionally, a child's EI benefit in the Medicaid MMIS system may be dropped, which can occur when the child has changes in their Medicaid/FAMIS benefits. If this happens, the local system must notify the Part C office in order for the EI benefit to be added back to the Medicaid VaMMIS system starting the next day from when the benefit had ended.

Child Loses Medicaid/FAMIS Coverage, Then Coverage is Restored:

- The local system must notify the Part C Office within 30 calendar days of the Disposition Date (date the decision was made to restore Medicaid/FAMIS). When the local system meets this timeline, the date the Medicaid/FAMIS is restored will be the start date for restoration of the Medicaid EI benefit.
- If the local system notifies the Part C Office more than 30 calendar days after the Medicaid Disposition Date, then the date the local system notifies the Part C Office will be the start date for the Medicaid EI benefit and reimbursement will not be available through Medicaid or Part C for the time period that is not covered.
- If the child lost Medicaid/FAMIS coverage and the Medicaid/FAMIS information was deleted from ITOTS, the local system must re-enter the Medicaid/FAMIS information in ITOTS within 30 calendar days of the Medicaid Disposition Date.

Child is Transferred from One Local System to Another Local System in Virginia:

- The "sending" local system must complete the discharge data entry, including transferring the record to the new ("receiving") local system prior to the date that the child will be starting services within the new local system.
- When a child transfers from one local system to another, the start date for the Medicaid EI benefit under the new, "receiving" local system must be after the discharge date from the original, "sending" local system.
- There must not be two open records in ITOTS for the same child.

Child Becomes Inactive

- When a child becomes inactive, this must be documented in ITOTS within 10 business days of the inactive date.

Child Becomes Active after Being Inactive

- For children who become active after being inactive, the local system must make the child active again in ITOTS within 10 business days of the date the child became active in order for the Medicaid/FAMIS EI benefit to be added back with the active date as the start date.

If the local system is responsible for Medicaid/FAMIS not being available to reimburse for services (through failure to enter child information in ITOTS on time or to notify the Part C Office if a child has lost Medicaid/FAMIS and then regained it), the funds that can be used to pay for services are local funds or revenue from private insurance, Medicaid/FAMIS, other third party payors, or family fees. If funds from these sources are not adequate to pay for the service(s), then the local system manager must contact his/her Part C Technical Assistance Consultant.

Private Insurance and TRICARE

1. Providers bill third party payors according to the requirements (including billing codes and forms) of the particular payor.
2. Virginia has enacted third party payor regulations that mandate coverage for early intervention services. Insurance companies that are domiciled in Virginia and that are part of the fully insured market must include coverage for physical therapy, occupational therapy, speech-language therapy and assistive technology for infants and toddlers enrolled in the Infant & Toddler Connection of Virginia.
    a. The benefit is capped at $5,000 per year.
    b. The mandate specifies that money paid through this benefit cannot be applied to the insured's lifetime maximum benefit.
    c. Organizations who contract with insurance companies to manage their employee health benefits, but who "self-fund" the benefit are exempt from the mandate.
    d. A similar mandate is included for insurance for state employees.

    Insurance companies based outside of Virginia (even if operating and covering services provided in Virginia) as well as self-insured policies are not covered by the early intervention insurance mandate. For more information on these insurance mandates click on http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+38.2-3418.5 and http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+2.2-2818.
3. Private insurance plans may not be billed for services where no consumer liability can be established (i.e., where services must be provided at no cost to the family).
4. TRICARE is the uniformed services health care program for active duty service members and their families, retired service members and their families, members of the National Guard/Reserve and their families, survivors and other eligible beneficiaries. TRICARE is a public third party payor. As such, TRICARE can be billed for assessments conducted under Part C (whereas, private insurance cannot). To learn more about TRICARE, including information about the managed care support contractor for TRICARE North Region, which includes Virginia, click on www.tricare.mil.
5. Since private insurance companies typically do not reimburse for the increased costs incurred when services are provided in natural environments, Part C funds are used to bring the reimbursement to the provider up to the standard early intervention rate or up to the rate charged by the provider, whichever is less.

Part C Funds

1. In order to receive Part C reimbursement as the payor of last resort (e.g., for services not covered by third party payors or to bring provider reimbursement up to the standard rate), providers must have a contractual relationship with the local Infant & Toddler Connection system.
2. Providers are required to submit a contact log or contact notes to the local lead agency no later than the 21st of each month for the previous month for all services provided, including any service for which reimbursement is sought from Part C funds.
    a. Local lead agencies may decide to require all providers to submit only contact logs or only contact notes or may allow each provider the choice of submitting either the log or notes.

b. When submitting a contact log, the log must include the type of service delivered (e.g., physical therapy, developmental services, OT, etc.), date(s) of service delivery, amount of time service was provided on each date, and signature of the provider or an authorized individual from the provider's agency.
c. When insurance reimbursement is pending for a service, include that service on the log for the month in which the service was delivered and mark it "insurance pending." Once the insurance company has acted, if Part C funds are being requested, then submit that service again on a later log for payment by Part C.

3. Part C funds cannot be used to reimburse a provider for a Medicaid billable service when the child has Medicaid/FAMIS, except when necessary to prevent a delay in the timely start of services. Once Medicaid funds are received they must be used to reimburse the local system for the Part C funds originally paid. For example, suppose a family is in the process of applying for Medicaid/FAMIS when a Part C service begins on March 16. The child's Medicaid/FAMIS eligibility is established on April 1 and coverage is backdated to March 1. If Part C funds were used to pay the provider for the service delivered on March 16, then DMAS must be billed for that service and the local system must be reimbursed for the Part C funds originally used to pay for that service.
4. Sample billing and reimbursement scenarios are provided on the next page to illustrate use of Part C funds as payor of last resort when the family allows their private insurance to be billed for Part C services.

<u>Purchase of Assistive Technology Devices</u>

1. Public procurement policies must be followed when using public funds to pay for all or part of an assistive technology device.
2. If purchased with the family's health insurance (public or private), the equipment belongs to the family and they may keep it when they leave the Infant & Toddler Connection of Virginia system.
3. If federal or state Part C funds are used to pay for more than 50% of an assistive technology device and the device is valued at $5,000 or more, then the assistive technology device belongs to the local Infant & Toddler Connection system and must be treated as follows when the child leaves the system:
    a. The assistive technology device is returned to the local Infant & Toddler Connection system, re-inventoried and used for other children on a loaner or a trial basis.
    b. If the child is transitioning to preschool special education services under Part B through the local school division, then the local school system may receive the assistive technology device and utilize it as long as the child needs it. Once the child no longer needs the device, it is returned to the local Infant & Toddler Connection system.
    c. If the child is transitioning to a program other than preschool special education services under Part B, then the receiving program may purchase the assistive technology device with appropriate depreciation consideration.
4. Assistive technology devices that are expendable, personal use items (e.g., bath forms, ear molds) are for the personal use of the specific child and are not reclaimed.
5. The Local Lead Agency must maintain a comprehensive, up-to-date inventory of all assistive technology devices purchased with federal or state Part C funds

paying more than 50% of the cost and valued at $5,000 or more. This inventory will cite the device, appropriate serial numbers, location of the device, and anticipated disposition of the device including timeline.

6. Please see the text box titled “When considering the purchase of an Assistive Technology Device” in “The Initial IFSP Meeting” section of Chapter 7 for information about what is considered an assistive technology device under Part C.

Sample Billing/Reimbursement Scenarios:

Family Cost Share Agreement Form Says:	Charges and Reimbursement
1. Private insurance (w/permission to bill) Full fee	Provider Charge: $180 Insurance Co-Pay: $20 Insurance Deductible: $500 Insurance Allows: $95 Amount applied to deductible: $0 Part C Standard Rate: $150 Insurance Pays: $95 Family Pays: $20 Part C Pays: $35
2. Private insurance (w/permission to bill) Fee Cap = $0	Provider Charge: $180 Insurance Co-Pay: $25 Insurance Deductible: $1,000 Insurance Allows: $90 Amount applied to deductible: $0 Part C Standard Rate: $150 Insurance Pays: $90 Family Pays: $0 Part C Pays: $60
3. Private insurance (w/permission to bill) Family has PPO allowing balance billing Fee Cap = $0	Provider Charge: $180 Insurance Co-Pay: $0 Insurance Deductible: $1,000 Insurance Allows: $80.50 Amount applied to deductible: $80.50 Part C Standard Rate: $150 Insurance Pays: $0 Family Pays: $0 Part C Pays: $150
4. Private insurance (w/permission to bill) Fee Cap = $0	Provider Charge: $180 Insurance Co-Pay: $25 Insurance Deductible: $1,000 Insurance Allows: $180 Amount applied to deductible: $180 (co-pay amount included in deductible) Part C Standard Rate: $150 Insurance Pays: $0 Family Pays: $0 Part C Pays: $180*

* Deductibles and co-payments cannot be bound by the contract rate that the Part C system has with a private agency for direct services that are not covered by insurance since the insurance reimbursement rates and co-payment and deductible amounts are determined and set by the insurer. Deductibles and co-payments are an obligation between the subscriber (family) and the insurer, not the provider and the insurer. The provider agrees to collect the deductible and co-payment from the family. These cannot be waived. Therefore, the full deductible and co-payment (minus the amount the parent pays that month) is the responsibility of Part C.

Reimbursement Sources and Medicaid EI Codes for Components of the Early Intervention Process for Children with Medicaid or FAMIS Coverage

Step			Initial EI TCM	Medicaid EI TCM	Medicaid EI	Medicaid EI Codes	Other Medicaid	Other Funds*	Part C – POLR
Referral Steps								X	X
Intake			X	X		T2022		X**	X**
Developmental Screening			X	X		T2022		X**	X**
Hearing and Vision Screening			X	X		T2022		X**	X**
Eligibility Determination	**SC**		X	X		T2022		X**	X**
	EIP							X	X
Assessment for Eligibility	**SC**		X	X		T2022		X**	X**
	EIP– Combined w/ASP and Child found eligible	**PT, OT, SLP, N**			X	T1023 U1			
		Other EIP			X	T1023			
	EIP – Separate from ASP or Child found not eligible							X	X
Assessment for Service Planning	**SC**			X		T2022		X**	X**
	EIP	**PT, OT, SLP, N**			X	T1023 U1			
		Others			X	T1023			
IFSP Development	**SC**			X		T2022		X**	X**
	EIP: PT, PTA, OT, OTA, SLP, N				X	T1023 U1			
	EIP: Other EIP and EIS				X	T1023			
Provide Individual EI Services in Natural Environments	**EIP: PT, PTA, OT, OTA, SLP, N**				X	G0151 U1 G0152 U1 G0153 U1 G0154 U1			
	EIP: ECE, etc				X	T1027 & T1027 U1			
	Other Disc: AUD, Diet., etc.						X	X	X
	EIS: EIA, Nurse Aide				X	T1027 & T1027 U1			
Provide Group EI Services in Natural Environments	**EIP: PT, PTA, OT, OTA, SLP, N**				X	G0151,G0152, G0153,G0154			
	EIP: ECE, etc				X	T1027			
	Other Disc: AUD, Diet., etc.						X	X	X
	EIS: EIA, Nurse Aide				X	T1027			
Provide Individual EI Services Center	**EIP: PT, PTA, OT, OTA, SLP, N**				X	T1026 U1			
	EIP: ECE, etc				X	T1015 U1			
	Other Disc: AUD, Diet., etc.						X	X	X
	EIS: EIA, Nurse Aide				X	T1015 U1			
Provide Group EI Services in Center Setting	**EIP: PT, PTA, OT, OTA, SLP, N**				X				
	EIP: ECE, etc				X	T1015			
	Other Disc: AUD, Diet., etc.						X	X	X
	EIS: EIA, Nurse Aide				X	T1015			
IFSP Review	**EIP: PT, PTA, OT, OTA,**				X	T1024 U1			

Step		Initial EI TCM	Medicaid EI TCM	Medicaid EI	Medicaid EI Codes	Other Medicaid	Other Funds*	Part C – POLR
Meeting: Child and family present	**SLP, N**							
	EIP: Others and EIS			X	T1024			
Consultation: without child/family	**EIP and EIS**						X	X

PLEASE NOTE that Federal Regulations and Virginia Policies and Procedures require that ….*no services that a child is entitled to receive are delayed or denied because of disputes between agencies regarding financial or other responsibilities.*

Key:

*****	State and local non-Part C funds, grants, donations, etc.
******	For children receiving therapeutic foster care
POLR	Payor of Last Resort
AUD	Audiologist
Diet	Dietitian
ECE	Early Childhood Educator
EIP	Early Intervention Professional (PT, OT, ECSE, etc.)
EIS	Early Intervention Specialist (PT Assistant, OT Assistant, Early Intervention Assistant, Nurse Aide)
Others	Early Intervention Professionals other than OT, PT, SLP and Registered Nurses and Nurse Practitioners
SC	Service Coordinators
TCM	Targeted Case Management

Reimbursement Sources for Components of the Early Intervention Process for Children with Tricare, Private Insurance or No Third Party Payor Source

Step			TRICARE	Private Insurance	Other Funds*	Part C - POLR
Referral Steps					X	X
Intake					X	X
Developmental Screening					X	X
Hearing and Vision Screening					X	X
Eligibility Determination	**SC**				X	X
	EIP				X	X
Assessment for Eligibility	**SC**				X	X
	EIP– Child found eligible	**PT, OT, SLP, N**	X		X	X
		Other EIP			X	X
	EIP – Child found not eligible		X		X	X
Assessment for Service Planning	**SC**				X	X
	EIP	**PT, OT, SLP, N**	X		X	X
		Other EIP			X	X
IFSP Development	**SC**				X	X
	EIP: PT, PTA, OT, OTA, SLP, N				X	X
	EIP: Others and EIS				X	X
Provide Individual EI Services in Natural Environments	**EIP: PT, PTA, OT, OTA, SLP, N**		X	X	X	X
	EIP: ECE, etc				X	X
	Other Disc: AUD, Diet., etc.		X**	X**	X	X
	EIS: EIA, Nurse Aide				X	X
Provide Group EI Services in Natural Environments	**EIP: PT, PTA, OT, OTA, SLP, N**		X	X	X	X
	EIP: ECE, etc				X	X
	EIS: EIA, Nurse Aide				X	X
Provide Individual EI Services Center	**EIP: PT, PTA, OT, OTA, SLP, N**		X	X	X	X
	EIP: ECE, etc				X	X
	Other Disc: AUD, Diet., etc.		X**	X**	X	X
	EIS: EIA, Nurse Aide				X	X
Provide Group EI Services in Center Setting	**EIP: PT, PTA, OT, OTA, SLP, N**		X	X	X	X
	EIP: ECE, etc				X	X
	EIS: EIA, Nurse Aide				X	X
IFSP Review Meeting: Child and family present	**EIP: PT, PTA, OT, OTA, SLP, N**				X	X
	Other EIP and EIS				X	X
Consultation: without child/family	**EIP and EIS**				X	X

Key: ***** State and local non-Part C funds, grants, donations, etc.
**** Reimbursement depends on the child's third party payor policy**
POLR Payor of Last Resort **AUD** Audiologist **Diet** Dietitian **SC** Service Coordinators
ECE Early Childhood Educator **EIP** Early Intervention Professional (PT, OT, ECSE, etc.)
EIS Early Intervention Specialist (PT Assistant, OT Assistant, Early Intervention Assistant, Nurse Aide)
Other EIP: Early Intervention Professionals other than OT, PT, SLP and Registered Nurses and Nurse Practitioners

Medicaid Early Intervention Services Program
Reimbursement Information

Code	Rate	Who bills	When is This Used	Location	Limits
T2022	120.00/mo	Service Coordinator	• Service coordination	N/A	1 charge/child/month
T1023	27.50/unit	Reimbursement Category 2 Providers	• Initial Assessment for Service Planning • Development of IFSP • Annual IFSP	NE or Center-based	24 units/day and 36 units/year
T1023 U1	37.50/unit	Reimbursement Category 1 Providers			
T1024	27.50/unit	Reimbursement Category 2 Providers	• Team Treatment activities (more than one professional providing services during same session for an individual child/family • IFSP Review Meetings (must be in person) • Assessments that are done <u>after</u> the initial Assessment for Service Planning	Natural Environments*	The maximum daily units/per child/ per (service) code/ per individual practitioner is **6 units** with a maximum of **18 units** (for any combination of codes) per day per child for all agency/providers combined. [The 18 units can be a combination from 2 or more agencies/providers or can be all from one agency as long as no individual practitioner exceeds the 6 units/individual practitioner/per day limit]
T1024 U1	37.50/unit	Reimbursement Category 1 Providers			
T1027	18.43/unit	Reimbursement Category 2 Providers	• Developmental Services and other early intervention services provided for more than one child by one Early Intervention Certified Specialist (congregate), except PTA or OTA	Natural Environments*	
T1027 U1	27.50/unit		• Developmental Services and other early intervention services provided for one child by one Early Intervention Certified Specialist, except PTA or OTA		
T1026	7.43/unit	Reimbursement Category 1 Providers	• Center-based group early intervention services	Center-based	
T1026 U1	22.50/unit		• Center-based individual early intervention services	Center-based	
T1015	5.44/unit	Reimbursement Category 2 Providers	• Center-based group early intervention services	Center-based	
T1015U1	16.49/unit		• Center-based individual early intervention services	Center-based	
G0151	25.13/unit	Physical Therapists, PTAs (RC 1)	• Congregate PT	Natural Environments*	
G0151 U1	37.50/unit		• Individual PT		
G0152	25.13/unit	Occupational Therapists, OTAs (RC 1)	• Congregate OT	Natural Environments*	
G0152 U1	37.50/unit		• Individual OT		
G0153	25.13/unit	Speech Language Therapists (RC 1)	• Congregate SLP	Natural Environments*	
G0153 U1	37.50/unit		• Individual SLP		
G0154	25.13/unit	RN or RNP (RC 1)	• Congregate Nursing Services	Natural Environments*	
G0154 U1	37.50/unit		• Individual Nursing Services		

* May include rare situations where services are provided in a center with acceptable justifications <u>AND</u> for which travel by the provider is required. See Infant & Toddler Connection of Virginia Practice Manual for information.