



Early Intervention Billing

October 2023

Common Acronyms

- **CMS**- Centers for Medicare and Medicaid Services
- **DHMC**- Denver Health Medicaid Choice
- **DOB**- Date of Birth
- **DOS**- Date of Service
- **EICO**- Early Intervention Colorado
- **EOB**- Explanation of Benefits
- **HCPF**- Department of Health Care Policy and Financing (Medicaid)
- **HIA**- Health Insurance Authorization From
- **IFSP**- Individual Family Service Plan
- **PAR**- Prior Authorization Request
- **SC**- Service Coordination
- **SGF**- State General Fund



Payment Structure

- For scenarios where RMHS is the responsible biller, providers are reimbursed based on a contracted rate and the duration of each direct services session
 - The 8-minute rule determines the number of units a provider can bill
 - Indirect work such as coordination of care and report writing are considered included in the contracted rate
- Provider contact notes act as the billing invoice
- Billing must be submitted at least monthly, by the 3rd business day
- Billing can be submitted on a more frequent basis, such as weekly
- State fiscal year-end deadlines dictate a hard billing cutoff each year. After which, funding is no longer available
 - The state fiscal year runs from July 1st-June 30th
- Payment is issued via check within 30 days of accurate and timely submission
 - Any charges billed in a week by the Revenue Cycle Department will be issued via check by the RMHS Finance department the following week, typically on Fridays

Minutes Range	Units
8-22	1
23-37	2
38-52	3
53-67	4
68-82	5
83-97	6
98-112	7
113-127	8
128-142	9
143-157	10
158-172	11
173-187	12

Hours Range	Units
.13-.37	1
.38-.62	2
.63-.87	3
.88-1.12	4
1.13-1.37	5
1.38-1.62	6
1.63-1.87	7
1.88-2.12	8
2.13-2.37	9
2.38-2.62	10
2.63-2.87	11
2.88-3.12	12

Progress Notes

- Provider progress notes act as the billing invoice
- Providers are encouraged, but not required, to use the RMHS note template
- Progress notes must be thorough and are subject to audit and potential recoupment if documentation is missing, lacking, or incorrect
- Progress notes are part of the child's medical record and must meet CMS guidelines
- Providers are responsible for appropriately coding their services
- Progress notes must be typed and be in English
- Only one child's services can be listed on one note



Early Intervention Program Progress Note

Client Name: Enter text.	Client Date of Birth: Enter a date.
Provider's Name: Enter text.	Provider's Company Name: Enter text.
Service Location: Choose an item.	Telehealth Modality: Choose an item.
ICD-10 Diagnosis: Enter text.	Date of Service: Enter a date.
EI Service: Choose an item.	Provider Verified Insurance: <input type="checkbox"/>
Note Type: Choose an item.	

Billing Information:

Select a Service Code or Type a CPT Code	Units	Duration
Choose an item.	Enter text.	Start Time: Enter text. End Time: Enter text. Total Minutes: Enter text.

Session Information:

Any updates from family, subjective notes about client's demeanor:

Enter text.

Outcome(s)/session plan:

Enter text.

Observations/progress toward IFSP goal(s):

Enter text.

Recommendations/strategies:

Enter text.

Provider Signature: Enter text.

Date: Enter a date.

Supervising Staff Signature (If Applicable): Enter text.

Date: Enter a date.

Supervising Staff Printed Name (If Applicable): Enter text.



Progress Note Tips

- RMHS billers process thousands of notes each month. The more consistent that note formats are between providers/agencies, the more quickly and accurately billers can process them
- Billers should not have to search for/scroll to find the required billing information
- If not using the RMHS template, the note should be as clean and as easy to decipher as possible
- Keep all billing info clearly distinguishable at the top of the note
- It is recommended to notate if a file has multiple pages or dates of service
- RMHS recommended file naming convention
 - Agency Name_date sent to RMHS_child name and date of service
 - ABC Provider_07.01.23_Minnie Mouse_6.30.23

Progress Note Requirements

- Provider's first and last name
- Provider's agency name
- Child's full legal name as written on the IFSP
- Child's date of birth
- The ICD-10 diagnosis, if applicable
 - A diagnosis is required if a provider is invoicing for a service that has a CPT code
- IFSP service that is being performed
- An indication of who is responsible for billing each service (Provider or RMHS)
- Date of service
- Place of service (e.g., Home, Community, Daycare)
- CPT code(s) or service codes
- The units for each CPT code
- Total session duration
- A narrative including any progress toward the stated goals on the IFSP, the start and end time of that activity, as well as current techniques and activities used to help the child achieve outcomes (SOAP format)
- Each progress note must be signed and dated

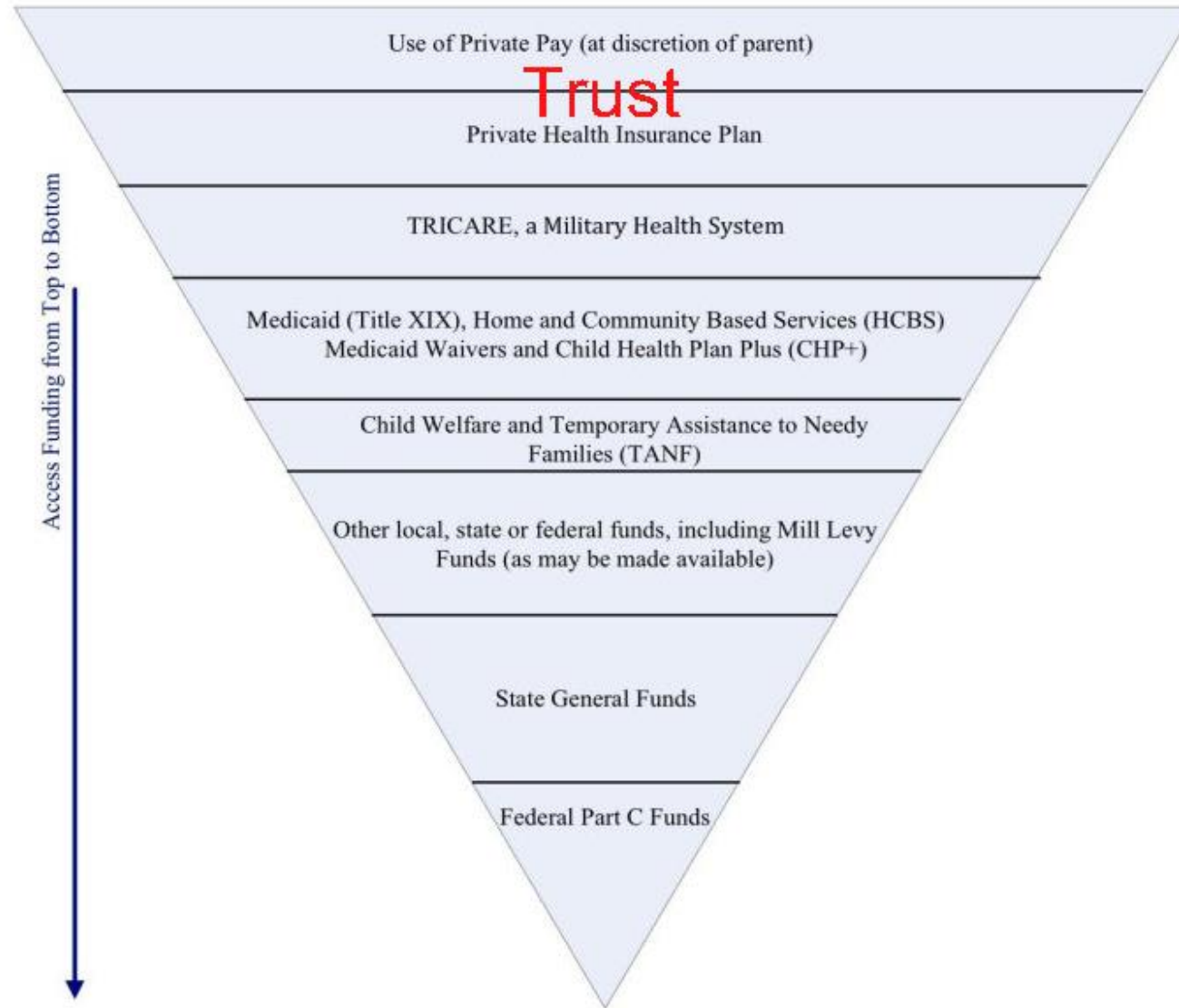
Invoice Submission

- Progress notes must be submitted in a non-editable PDF format and sent encrypted to Invoices@rmhumanservices.org
 - Using the “Print to PDF” function will make a PDF or Word document non-editable
- RMHS highly recommends using our internal system, Mimecast for invoice submission
 - A secure email can be requested to gain access to Mimecast
- The function of the Invoices inbox is only to save files to work queues based on program and submission date
 - Questions should not be sent to this inbox

The Funding Hierarchy

- Early Intervention services must follow the funding hierarchy, with State General Funds being the payer of last resort
- Services that are billable to private insurance/Medicaid must be billed to the appropriate funding source
- In practice, this primarily impacts OT, PT, ST, and sometimes Audiology services
- CMS billing guidelines must be followed when billing insurance/Medicaid

COORDINATED SYSTEM OF PAYMENT: FUNDING HIERARCHY



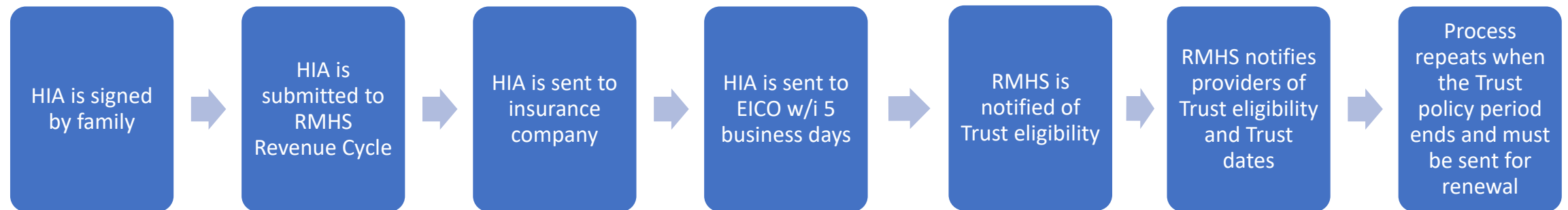
Verifying Insurance

- Providers are responsible for verifying insurance at the onset of services and prior to each visit
- Private insurance can typically be verified by checking in with the family
 - “I know it feels silly to ask you every week, but I just need to verify that you still have Anthem coverage?”
- Public insurance policies must be verified in the HCPF portal at least once a month as children can “flip” coverage frequently
 - RMHS cannot provide reimbursement if a PAR is not obtained due to coverage flipping

Early Intervention Trust

- Providers cannot send claims to Trust eligible policies and should invoice RMHS
- CO-DOI listed on the insurance card is an indicator, but not a guarantee, of Trust eligibility
- Temporary Exemptions can be granted while Trust is being determined
- Some policies are always Trust eligible
 - Kaiser CHP+
 - Denver Health CHP+
 - Denver Health Private Plans
- Trust plans are not guaranteed to renew

Early Intervention Trust



Private Insurance

- Providers are responsible for billing non-Trust eligible policies
- Patient responsibility and valid insurance denials should be sent to RMHS for reimbursement
- Providers must submit the Explanation of Benefits (EOB) and corresponding contact note to RMHS for reimbursement
- RMHS can pay up to your contracted rate for patient responsibility. This includes if the insurance company allows a higher amount than your contracted rate
 - Ex: \$300 deductible, RMHS can pay full contracted rate based on duration
 - Ex: Insurance paid \$100 and there is a \$25 co-pay, RMHS can pay \$25

Balance Billing

- Balance billing is the practice of charging more than an insurance company's allowable rate
- Balance billing is only permissible if the provider does not have a signed contract with that insurance company
- Providers may invoice RMHS for balance billing by clearly notating on the billing “Out of Network Balance Billing for \$xx”
 - Ex: Insurance allows and pays \$70, providers who are out of network may balance bill up to RMHS contracted rate

Medicaid & CO Access CHP+

- Providers are responsible for obtaining prior authorization, collecting EVV, and submitting claims
- Providers must understand authorization and billing guidelines
- Denials will not be accepted by RMHS
- If a child loses eligibility, State General Funds can be used for services
 - Providers should continue to verify eligibility
 - Providers may be responsible for billing Medicaid/CHP+ and reimbursing RMHS if coverage is retroactively reinstated

Denver Health Medicaid

- Providers who can contract with Denver Health are responsible for obtaining prior authorization and billing DHMC
 - Denials can only be accepted if DHMC denies an auth due to medical necessity. Documentation of the auth denial can be submitted for an Exemption request
- Providers who cannot contract with DHMC are responsible for sending Prior Authorization Request (PAR) forms and billing to RMHS for reimbursement
 - Home health providers who do not have a contract with DH should not pickup DHMC referrals from RMHS
- PAR forms must be sent to Eligibility@rmhumanservices.org at the onset of services and if the child's plan of care changes
 - All CPT codes that may be billed must be included, including evaluation codes

Prior Authorization Request

Patient Name: Jane Doe
DOB: 3/15/18
Member ID: P123456
ICD-10 Diagnosis: (No Descriptions) R62.0
Place of Service: Home
Provider Name: John Doe
Service Requested: Speech Therapy

Please complete this form in its entirety and send in a HIPAA secure format to Eligibility@Rmhumanservices.org prior to rendering services.

Start Date	End Date	CPT Code	Modifiers	Units/Visit	Frequency (Weekly, Monthly, Etc.)	Total # of Units
11/13/2019	11/12/2020	92507	GN, TL	1	Weekly	52
11/13/2019	11/12/2020	92523	GN, TL	1	Biannually	2

Modifiers:

Speech Therapy	GN
Occupational Therapy	GO
Physical Therapy	GP
Early Intervention Add-On	TL
Telehealth Add-On	GT
Habilitative Add-On (RMHS Internal CC Providers Only)	96
Rehabilitative Add-On (RMHS Internal CC Providers Only)	97

Declination of Insurance

- Families reserve the right to decline the use of their private insurance in EI
- Families may also decline the transmission of personal identifying information (PII) to Medicaid under the EI program
- If insurance is declined, the next available funding source must be used- this is typically SGF funds where RMHS is the responsible biller
 - Legally, private insurance must be billed prior to secondary funding (Medicaid or occasionally a second private policy). Therefore, if a primary policy is declined, the secondary policy cannot be billed and SGF dollars will be used
 - If a secondary policy is declined, the primary policy can still be billed

Declination of Insurance- HSA's & HRA's

- The most common reason a family will sign a declination is if the policy has a Health Savings Account (HSA) or Health Reimbursement Account (HRA)
- These policies often automatically withdraw payments from the family's account, which should not occur in EI
- If an HSA/HRA payment is received, the provider should contact the insurance company to determine how to return the funds to the account and notify the SC that a declination is needed

Private Insurance Exemptions

- Providers can request to bypass private insurance with **documentation** that services will not be covered/funded
- Exemptions cannot be granted when there is secondary public insurance (Med, DHMC, CHP+)
- Non-Covered Services
 - The IFSP service is not covered under the child's insurance plan, for the child's diagnosis, are not found to be medically necessary, or have exceeded the plan's therapy limits
- No Out of Network Benefits
 - The provider is not in network with the child's insurance and the plan does not cover services rendered by a non-network clinician
- High Deductible Health Plans
 - The child's deductible is greater than \$2,500 or the family is not likely to meet their deductible.
 - Justification for scenarios where the family is not likely to be included must be included on the request form (ex: the child is aging out in two months and the deductible will not be met)
- Unable to Obtain Prior Authorization
 - PAR requirements exceed those of Medicaid and cannot be obtained.
- Untimely Response
 - Providers may invoice RMHS for claims in which no final EOB has been provided after 45 days
 - Providers are responsible for reimbursing RMHS if any payment is eventually received from the insurance company
- Payment is Issued Directly to the Family
 - Some out of state plans will issue payment directly to the family. This can be confirmed when verifying benefits

Please complete this form and send in a HIPAA secure format to Eligibility@rmhumanservices.org prior to invoicing RMHS. Billing will not be processed if an exemption is submitted after invoicing, and resubmission may be needed. Exemptions will only be considered for commercial insurance plans. Exemptions cannot be granted when there is secondary Med/DHMC/CHP+ coverage. Exemptions must be renewed at each annual review, if there is a policy change, or for change in providers. Further details about insurance exemptions can be found in the Provider Manual.

Patient Name: Minnie Mouse Insurance Carrier: Anthem
 DOB: 1/1/2023 Member ID: ABC123456
 Date Form Completed: 9/1/2023 Secondary Coverage: N/a
 Provider Agency: El Services R Us Annual IFSP Date: 12/31/23
 Provider Name(s): Donald Duck Provider Network Status: Out of Network

IFSP Service	Exemption Reason	Requested Start Date	Justification for Retro Start Date
Speech Therapy	Non-Covered Services	7/1/2023	Family was waiting on their insurance card

Insurance Benefit Verification Details: Please verify and record the private insurance benefits that correspond with the exemption reason you are seeking. Benefits should be verified according to your in or out-of-network status. You can use this form as a guide for the type of information to obtain when contacting insurance companies.

Any Additional Details to Justify Request?:

High Deductible Plan
 Individual Amount: Expected to be met?
 Individual Remaining:
 Family Amount:
 Family Remaining:

ST services are only covered in instances of injury/stroke

Unable to Obtain Prior Auth
 Is Prior Authorization Required?:
 Are you Able to Obtain Prior Authorization?:

Required
 Date Benefits Verified: 9/1/2023
 Call Reference Number: 123456
 (Or Attach Online Verification)

No Out of Network Benefits/ Non-Covered Services
 Are Services Covered?: No
Note: Services not covered due to the child's condition/diagnosis would be considered Non-Covered Services. E: Some policies do not cover therapies unless there is an injury/stroke. It may help to ask the insurance company if the child's diagnosis is covered.

Untimely Response
 Date of Submission to Insurance:

Payment Issued to Family
 Who Will Payment be Issued To?:

To Be Completed By RMHS:
 Insurance Exemption: Approved
 Denial Reason:
 Insurance Exemption Date Range: 7/1/2023-12/31/2023
 Review Date: 9/5/2023
 Review Staff Initials: LH

000 Miscellaneous Code

- Can be used to invoice RMHS for services typically billable to insurance, but that do not fall under a CPT code
- 000 can be listed as the CPT code but the approved IFSP service must still be listed on the progress note

No Shows

- A no show can be billed if the family cancels within 24 hours of the scheduled visit
- The EI service that was scheduled to occur must be listed on the contact note

Encounter Codes, Bundled Codes & Unbundling Modifiers

- It is RMHS policy to not accept two encounter codes billed together or encounter codes billed with timed codes
 - This policy includes OT/PT evaluation codes
- RMHS will not accept the usage of bundled codes (Ex: 97530 + 97533)
- Providers should select the coding that most accurately reflects the session
- RMHS will only accept the usage of unbundling modifiers (59, X[ESPU]) in extremely rare scenarios. Justification for the use of these modifiers must be well documented
 - This is due to the nature of common fraud, waste, and abuse in the medical industry and high audit risk associated with these modifiers

IFSP Meetings

- If a CPT code is appropriate for the service provided during the meeting, then insurance/Medicaid can be billed
- If a CPT code is not appropriate, RMHS can be invoiced
- The specific IFSP type can be used as the service code
 - Initial Assessment
 - Periodic Review (this includes Abbreviated Reviews)
 - Annual Assessment
- Transition Conferences are not a separate IFSP type in the state billing portal. The corresponding IFSP type should be listed (usually an IFSP Review)

Transteam Attendance

- A maximum of 8 units are billable per month
- The contracted rate for Transteaming is lower than a direct service
- The provider's name, agency, DOS, meeting duration, and units must be listed on the invoice
- Providers can only bill Transteam attendance when they are part of an approved team

SLP Medicaid Stipend

- A progress note showing the outpatient CPT encounter code that was billed to Medicaid (Ex: 92507, 92526) must be submitted listing an additional 1-unit charge line for “ST Stipend”
- Per EICO, the stipend is not billable when:
 - Revenue codes are billed (Home Health providers)
 - Two CPT codes are billed together
 - An evaluation code is billed (Ex: 92523)
 - The visit was less than 53 minutes (4 units)
 - Any scenario in which RMHS is the responsible biller and the RMHS contracted rate is being paid
 - If “ST Stipend” is not listed on the contact note o
 - For any service other than Speech Therapy on the IFSP

Common Billing Hiccups

- A Medicaid auth is already active with another provider
 - A change in provider form can be completed, signed by the family, and submitted to Kepro
 - If the family does not know the previous provider, they must call member services
- Documentation for auths
 - The child's IFSP is the only documentation that needs to be submitted to Kepro for EI services
- One provider seeing siblings concurrently
 - Billing can only be submitted for direct time spent with each child
 - Service times cannot overlap
 - Ex: Twins are seen over the same hour. The first thirty minutes are spent with one child and the last thirty minutes are spent with the second. Two invoices must be submitted, one for each child and each for two units. The provider is not paid twice for the same hour of time.
- Takebacks
 - A takeback may be issued if a billing error or audit issue is discovered. RMHS may issue a takeback at any time if an error is discovered. Payment from RMHS should be reconciled and any identified payment errors should be sent to Billingquestions@rmhumanservices.org within thirty days of receipt
 - Takebacks will be issued as a credit from the provider's next check. If the provider will not be receiving future payment from RMHS, the provider is expected to issue a refund payment to RMHS

Common Billing Hiccups

- Issues with forms
 - RMHS forms should be downloaded from the website and should not be completed in a web browser
- Issues with Mimecast
 - Accounts will lock for 15 minutes if multiple incorrect passwords are entered
 - Providers can only email RMHS employees/inboxes from Mimecast
 - Providers can request for RMHS staff to initiate an email with other outside parties included
 - Email addresses have to be clicked on when typed to actually send an email

Billing Resources

- Independent contractors are responsible for understanding billing guidelines and are expected to be able to follow the funding hierarchy accordingly
- RMHS can only offer limited assistance to subcontractors on private insurance and Medicaid billing
- RMHS does not endorse any specific training materials or billing programs, but some general ideas of resources to learn about billing as a private practice/independent contractor include:
 - YouTube Videos
 - Many billers/coders have created video series to teach how to code, how to bill, how to read EOB's, etc.
 - HCPF Website
 - Provider specific billing manuals, billing basics training, guide to verifying eligibility, EVV resources, etc.
 - Subscribe to HCPF provider bulletins
 - Kepro
 - Auth trainings, provider manual, etc.
 - Professional Affiliation Guidance
 - ASHA, APTA, AOTA

Billing Resources

- Private insurance portals
 - Most insurance companies have their own portals that providers can register for, usually even out-of-network providers
 - Can use portals to verify benefits submit and submit claim
- Keep it organized!
 - Determine the best method to track client information and insurance coverage, make sure progress notes have been submitted, reconcile payments, etc.
 - Consider using spreadsheets, folder organization systems, accounting software, EHR systems, claims clearing houses, etc.
- Extenuating circumstances
 - RMHS is contracted with the state to responsibly utilize SGF dollars and follow the funding hierarchy. Any scenario that bypasses the funding hierarchy must be documented
 - Providers may request the use of SGF funds if extenuating circumstances are clearly documented. Extenuating circumstances do not include failure to follow billing/authorization guidelines or timelines
 - Examples of potential documentation: authorization denials, claim denials, call reference numbers with insurance/HCPF, email correspondences, written timelines of events, etc.



Get Started

Colorado Case Management Changes

Search Site

- Home
- About
- Our Services
- Denver Mill Levy Services
- Single Entry Point
- News
- Career Opportunities
- Providers**



Providers
Early Intervention Providers
Play and Learn Library
Program Approved Service Agencies
Single Entry Point Providers
FAQ - Providers
Página del plan de apoyo de Mill Levy
START
Presentación de Denver START
Social Media

Early Intervention Providers

Welcome to the RMHS Early Intervention Providers (independent contractors and agencies) resources page! On this page you will find resources for the Early Intervention program including manuals, templates, forms, and training materials.

If you are a caregiver interested in learning more about Early Intervention, please visit the family side of our website here: [Early Intervention | Denver | Rocky Mountain Human Services](#)

Mimecast Secure Message Portal

EI Provider and Invoice Manual

Play and Learn Library

Mimecast User Guide

- **EXIT:** This form is also utilized to notify RMHS that you have a provider leaving your practice. Please remember to send this in if an EI Provider leaves your agency!

Forms

Please Note: Full functionality of these forms may not be supported by your web browser. Please download the document to your computer for use.

- [Progress Note - 2023](#)
- [Prior Authorization Request](#)
- [Private Insurance Exemption Request](#)
- [Assistive Tech Request](#)

EI Provider Newsletters

- [August 2023](#)
- [June 2023](#)
- [March 2023](#)
- [February 2023](#)
- [December 2022](#)

Videos

Use the links below to access to our Vimeo for past office hours and recorded trainings and also archived presentations:

- [Early Intervention on Vimeo](#)
- [Archived presentations](#)