EARLY INTERVENTION
PUBLIC AND PRIVATE INSURANCE USE DETERMINATION

Please monitor the EI website at www.dhs.state.il.us/ei for changes to Early Intervention Insurance Use Determination procedures.

EARLY INTERVENTION SERVICE COORDINATION
PUBLIC AND PRIVATE INSURANCE USE DETERMINATION

POLICY

1. Families whose children are enrolled under private insurance plans are required to use their child's benefits to assist in meeting the costs of covered Early Intervention services and devices unless an insurance exemption has been approved.

2. The family, in conjunction with the CFC, and in cooperation with their insurance company and the service provider, will determine insurance benefits. The provider shall contact the insurance carrier for verification of benefits and should send the verification in the form of a denied claim or statement of non-coverage under the insurance plan to the CBO as part of the billing process. One or more of the following items must be obtained by the CFC as documentation if the service is not covered:

   - Applicable pages from the plan that clearly state that the service is not covered;
   - Notes from conversation(s), with the name(s) of the insurance company contact, phone number(s) and date(s) of contact, by CFC Manager and/or service coordinator confirming denial of the service; and/or
   - Written response or denial from insurance company

3. All Early Intervention service providers are required to bill private insurance prior to billing the CBO unless an exemption has been approved. The only exceptions are Developmental Therapists, Interpreters, Deaf Mentors, and Physicians providing only medical diagnostics, Transporters, and Parent Liaisons.

4. Families may request exemption from private insurance for one or more services if such use would put the family at material risk of losing their coverage as specified on the Insurance Exemption Request form.

   a) Private insurance plan/policy covering the child was purchased individually by a head of household not eligible for group medical insurance.

   b) Child's private insurance plan/policy has lifetime cap for one or more types of early intervention services which could be exhausted during the IFSP period based on the estimated cost of the Early Intervention services.

5. Service coordinators are required to enter private insurance information on Cornerstone for covered EI eligible children.

6. Service coordinators are required to enter Medicaid or KidCare (State Child Health Insurance Program or other public insurance plan) recipient identification numbers on Cornerstone for covered EI eligible children.

7. Regional intake entities are required to apply to the Illinois Department of Public Aid to become KidCare Applicant agents.

8. Families determined eligible through use of the Screening Device are required to apply for benefits through Medicaid/KidCare in order to enroll and remain eligible for Early Intervention services.

9. As payer of last resort, all other resources must be maximized to cover the costs of Early Intervention services prior to utilizing state and federal appropriations for Early Intervention services.

PROCEDURES

Determining Other Eligibility

1.0 Complete the *Screening Device* to determine eligibility for KidCare/Medicaid and University of Illinois Division of Specialized Care for Children (DSCC) services. If indicated, complete and submit a KidCare application and/or make a referral to DSCC. As part of the referral to DSCC and with proper authorization (documented with the *Consent for Release of Information* form), send to the DSCC local office a copy of the completed Screening *Device* and the following Cornerstone screens/reports: *Participant Enrollment Information, Assessment History*, and *Insurance*. File the completed, signed screening form in the child's file.

Documenting Insurance Coverage

2.0 Assist family in completion of the *Insurance Affidavit, Assignment and Release* form.

2.1 If the child has private health insurance enter insurance information on Cornerstone.

2.2 If the child has insurance coverage through Medicaid/KidCare or the Medicaid managed care program, enter the correct code into Cornerstone (refer to the Cornerstone Manual if necessary).

2.2 If the child has public insurance through Medicaid/KidCare, and private health insurance or insurance through the Medicaid managed care program enter the correct code into Cornerstone (refer to the Cornerstone Manual if necessary).

2.4 If the child does not have private or public insurance, enter correct code into Cornerstone (refer to the Cornerstone Manual if necessary).

Determining if Insurance will be Billed

3.0 Determine if insurance may be used to pay for Early Intervention services and equipment or if any Statutory Waivers or Exemptions apply for that particular child. All information obtained on the family's policy must be forwarded to the service provider.

3.1 Insurance use is NOT required if any of the following are true:

3.1.1 Insurance provider is not available to receive the referral and begin services immediately (within 15 business days).
3.1.2 Insurance provider is not enrolled and fully credentialed as a provider in the Early Intervention system.
3.1.3 Insurance company will not cover the services in the manner required in the IFSP.
3.1.4 Family would have to travel more than an additional 15 miles or an additional 30 minutes to the insurance provider as compared to travel to a different enrolled and credentialed provider.
3.1.5 The family's insurance carrier has no approved providers that are enrolled and credentialed in the Early Intervention system *or* they allow for billing (even at a reduced rate) for Early Intervention services by non-insurance providers.

3.2 Statutory Insurance Waiver Certification
During service coordination activities, it may be determined that one of the situations in

section 3.1 does exist and that issuing an insurance waiver may be appropriate. The service coordinator should:

1. Determine which waiver type applies.
2. Obtain written verification of the waiver type from the insurance company.
   2a. If written verification is not attainable, obtain verbal verification and document the verification according to the guidelines of the At-A-Glance policy grid.*
3. Complete an insurance waiver.
4. Immediately forward a copy of the completed waiver form to the CBO.
5. Immediately forward a copy of the completed waiver form to the provider.
6. Attach all documentation to the original waiver and maintain in the child's file.

**Note: Insurance waivers ONLY, may be documented verbally if NO written documentation is attainable.*

3.3 To apply for an Insurance Use Exemption, provide the family with a copy of the *Insurance Exemption Request* form and explain the two types of exemption that can be requested:

a) Private/Non-Group Plan;
b) Lifetime Cap on some or all IFSP services

*These exemption requests require the signature of the CFC manager to confirm the appropriateness of the request and thoroughness of the submitted documentation and are the **only** type that should be sent directly to the Bureau of Early Intervention.

3.4.1 Upon request of the family, assist them in completing the form and submit it and all attachments and documentation to the Insurance Exemption Request Coordinator at DHS. DHS will make a decision within 10 business days of receiving all required information.

3.4.2 Update SV 07 Insurance field to indicate "Pending Exempt" for the authorized services for which an Insurance Use Exemption is be applied for on the same day the request is submitted to DHS. Do not use this code until the exemption request has been sent to DHS.

3.4.3 Upon receipt of a decision from DHS, update the SV 07 Insurance field immediately.

3.4.4 If the private insurance plan/policy covering the child is not part of a group medical insurance plan, and an exemption has been approved enter the code for "*Insurance Exempt/Individual Plan*".

3.4.5 If an exemption has been approved for all IFSP services because a child's private insurance plan/policy has an overall lifetime cap which could be exhausted during the IFSP period due to the billing of early intervention services, enter the code for "Insurance Exempt/Cap on All".

3.4.6 If an exemption has been approved for one or more IFSP services because a child's private insurance plan/policy has a lifetime cap for one or more types of early intervention services which could be exhausted during the IFSP period due to the billing of early intervention services, enter the code "Insurance Exempt/Cap on Some" on the SV 07 screen related to the authorizations for those services.

3.4.7 If the Insurance Use Exemption has been denied, update the SV 07 Insurance field to reflect, "Bill Insurance First" and notify all service providers of the new insurance billing status. Claims submitted to the Central Billing Office more than 7 (seven)-calendar days after the date of the denial will be placed in a pending status if they do not have an insurance Explanation of Benefits attached.

Determining the Appropriate Insurance Billing Indicator in Cornerstone

4.0 *There is an insurance billing indicator (commonly referred to as the "Insurance* Flag") for each Cornerstone generated authorization. The person generating the authorization must check the appropriate insurance billing procedure for the provider performing each service. The insurance billing indicator will print on the authorization that is shared with the authorized provider.

4.1 The PA 35 screen will display a general billing indicator that may be different than the specific per service indicator. The general indicator should not be confused with the specific per authorization indicators generated per authorization.

Determining the Provider

5.0 Give the family a list of credentialed, enrolled Early Intervention providers in the geographic area. The list should include which insurance networks each provider participates in. If the providers that are approved by the family's insurance network are not known to the CFC or the family, the CFC will assist the family in obtaining a list of approved providers from the insurance carrier and verifying if any of those providers are credentialed and enrolled in the Early Intervention system.

5.1 <u>If HMO</u>: The service coordinator will provide the family a list of approved providers, specifically identifying those providers who are approved by that family's HMO and are enrolled in the Early Intervention system. The family should be informed that, under certain circumstances, an HMO may make payments to a provider not in its HMO network. Determination of benefits is established in cooperation between the family, insurance company, and the provider. A determination of payment to a provider not in the HMO network is made with the same parties. If an HMO will not approve payment to an out-of-network provider, the family will be required to accept services from an HMO provider in accordance with all applicable Early Intervention rules and statutes.

5.2 <u>If PPO or POS</u>: The service coordinator will provide the family a list of approved providers, specifically identifying those providers who are approved by that family's PPO and are enrolled in the Early Intervention system. The Service Coordinator will also advise the family that any of those listed enrolled Early Intervention providers would most likely be able to access the insurance but an actual determination of benefits would be established in cooperation between the family, insurance company and the provider.

6.0 Print and attach the following and distribute to IFSP team members and family as part of the IFSP:

- Cornerstone *Insurance Report*,
- Family's insurance card, if applicable,
- *Insurance Affidavit, Assignment, and Release* form.
- Insurance Use Exemption Request form, if applicable

*Service providers are **not** to bill private insurance until they have received this information from the CFC *and not before* the effective date shown on the Cornerstone *Insurance Report*. If private insurance exemption is approved for some or all services, attach a copy of the DHS exemption approval letter to the Cornerstone *Insurance Report* before distributing to providers and families.

7.0 Tell families and providers that they must inform their service coordinator immediately if the child's Medicaid/KidCare or private insurance coverage changes. Failure to

do so may result in the provider's inability to receive payment form the insurance company or the CBO and may create a liability on the part of the family.

PROVIDER RESPONSIBILITIES

The early intervention provider must verify that IFSP services are a covered benefit under insurance plan. There may be multiple plans. For example, vision related services might be covered in a separate policy.

a) Review Insurance Plan or Policy Booklet.

Ask the family to provide a copy of the policy or plan. Review the plan, noting references to IFSP services, requirements for services and exclusions. See list (c) below. A service may be listed in the *Benefits Summary*, but it is necessary to go to the specific section for that benefit to determine coverage. The benefit may be under its own heading, 'Speech Therapy' or may be included in a section, such as 'Outpatient Rehabilitation Services'. For further information, also review the *Exclusions Section*. There may be references in these sections to 'restorative' therapy, i.e., that which restores a previous function. There may be other subjective restrictions such as the requirement that significant improvement may be expected within two months of initiating therapy.

b) Contact Insurance Company.

If more information is needed, it may be necessary to contact the insurance provider. Call the number on family's insurance card. If there is no number available, reference the Insurance Provider Phone Directory on the Early Intervention web site to obtain a general number for the insurance company. When the insurance company is reached, ask to be connected with *Benefits Verification*. Identify yourself, say you are representing a customer and would like to verify coverage of the particular Early Intervention service(s). If permitted, be prepared to provide policy holder's identifying information. If the insurance company will not release information, assist policy holder in obtaining the information below by making the call during a home or office visit or by placing a conference call with the family and the insurance provider.

c) Submit documentation to the CBO.

Collect the following documentation from the family, if applicable, and submit the appropriate Statutory Waiver to the covered service providers for submission to the CBO:

- Applicable pages from plan; and/or
- Written response/denial from insurance company.

DEFINITIONS

Enrolled Provider
A provider that is credentialed and enrolled in the Early Intervention System to provider direct service to children.

Approved Provider
A provider that is authorized to provide services and bill an insurance company as part of their network of providers.

Commercial Health Insurance Plans (also referred to as Private Plans)

a) Health Maintenance Organization—HMO
An HMO relies heavily on their network of providers and will typically require documentation and a standardized process to cover providers outside the network.

b) Preferred Provider Organization—PPO
A PPO contracts with a network of preferred providers, but will reimburse at a lower rate for out-of-network providers.

c) Point-of-Service—POS
A POS plan combines an HMO and PPO. A provider may subscribe to one or both plans. Because of the PPO component, out-of-network providers may be used. When requesting a list of network providers make certain both HMO and PPO providers are being included.

d) Private Insurance—Group (may also be HMO, PPO or POS)
Group insurance is usually offered through an employer. The employer may purchase a policy from an insurance company or may administer its own (self-insured) plan. Group health insurance may also be offered through other organizations or special-interest groups. Coverage varies with each plan.

e) Private Insurance—Individual (may also be HMO, PPO or POS)
Health insurance is purchased out-of-pocket directly from an insurance company to cover one of more members of a family. Coverage varies widely with each plan. This type of plan is eligible for an Insurance Exemption.

Government - Sponsored Health Plans (Also referred to as Public Plans)

a) Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)
Civilian Health and Medical Program of the Veterans Administration (CHAMPVA)
These are federal programs to cover health expenses of the dependents of military personnel and veterans. They are secondary to commercial health plans. Military medical-care providers are to be used if available. Prior authorization may be required for use of civilian providers. Administered by TriCare.

b) MEDICAID—KidCare Assist
Medicaid is a federally assisted program to help with medical expenses of eligible low-income families. It is administrated through the Illinois Department of Public Aid.

c) KidCare Share, Premium or Rebate
Children whose families are not eligible for Medicaid (KidCare Assist) due to income may be eligible for these low-income programs. KidCare Share and Premium require the insured to render co-payment for services. KidCare Premium also requires payment of a premium. Through KidCare Rebate, IDPA reimburses the policyholder for the cost of health insurance.

d) Illinois Comprehensive Health Insurance Plan—CHIP
CHIP is a state-subsidized program for Illinois residents who cannot otherwise purchase major medical insurance due to a pre-existing condition or disability. It is administered by Blue Cross/Blue Shield of Illinois.

e) Division of Specialized Care for Children—DSCC
DSCC offers low or no-cost diagnostic and medical services for children with certain eligible medical conditions that can be improved through treatment.

At-A-Glance Insurance Guidelines				
SCENARIO	**ACCEPTABLE DOCUMENTATION**	**ACTION REQUIRED BY:**	**PAYER**	**COMMENTS**
Service **NOT** a covered benefit	1. Pages from policy, and/or 2. Written statement from insurer, and/or 3. Notes from conversations including name of contact, date, phone number.	**CFC**: Supplies waiver to CBO and provider for submission to CBO with claims.	CBO	
Insurance Required Evaluation by Their Approved Provider	1. Written statement from insurer, ***and/or*** 2. Notes from conversations including name of contact, date, phone number.	**CFC**: Supplies waiver to CBO and provider for submission to CBO with claims.	1. INSURANCE (second eval) 2. CBO pays if insurance determination of coverage exceeds 15 business days.	1. Only when the insurance refuses to accept the evaluation already performed by an EI provider to determine eligibility. 2. CBO pays for dates of service prior to Pre-Cert, but only when claims are submitted with an attached approval or denial from insurer. 3. Insurance pays for dates of service after the Cert has been approved.
Insurance Requires Medical Diagnosis	1. Pages from policy. ***and/or*** 2. Written statement from insurer. ***and/or*** 3. Notes from conversations including name of contact, date, phone number.	**CFC**: Supplies waiver to CBO and provider for submission to CBO with claims.	CBO	Insurance company requires a diagnosis other than “developmental delay” in order to pay for services.

At-A-Glance Insurance Guidelines				
SCENARIO	**ACCEPTABLE DOCUMENTATION**	**ACTION REQUIRED BY:**	**PAYER**	**COMMENTS**
Medical Necessity	1. Pages from policy and/or 2. Written statement from insurer and/or 3. Notes from conversations including name of contact, date, phone number	**Provider**: Submits documentation in accordance with insurance company's requirements.	1. INSURANCE 2. CBO	1. If insurer denies payment after review of the submitted material, provider submits EOB and claim to CBO. 2. If provider fails to supply required information, claims will not be paid by CBO because this represents a failure to comply with insurance company requirements. (Refers to the child's need for IFSP services, NOT an attempt to establish a diagnosis or link a medical model to EI services.)
Referral Required	1. Pages from policy, ***and/or*** 2. Written statement from insurer, ***and/or*** 3. Notes from conversations including name of insurance company contact, date, phone number.	**CFC:** Works with family, provider and primary care physician to obtain referral.	1. INSURANCE 2. CBO	If the doctor refuses to offer referral or will only refer to a provider unable to meet the mandates of the IFSP, the CFC will verify and provide statutory waiver.
Pre-Auth/Pre-Cert Required	1. Insurance company specific.	**Provider**: Submits documentation in accordance with insurance company's requirements.	1. CBO 2. INSURANCE	1. CBO pays for dates of service prior to Pre-Cert, but only when claims are submitted with an attached approval or denial from insurer. 2. Insurance pays for dates of service after the Cert has been approved.

At-A-Glance Insurance Guidelines				
SCENARIO	**ACCEPTABLE DOCUMENTATION**	**ACTION REQUIRED BY:**	**PAYER**	**COMMENTS**
Requires Network Provider that is NOT EI Credentialed	1. Pages from policy, ***and/or*** 2. Written statement from insurer, ***and/or*** 3. Notes from conversations including name of contact, date, phone number.	**CFC**: Supplies waiver to CBO and provider for submission to CBO with claims.	CBO	
Out of Network Rate Available	N/A	**CFC**: Issues auths for the provider.	INSURANCE	
Provider credentialing Requirements different than EI	1. Pages from policy, and/or 2. Written statement from insurer, and/or 3. Notes from conversations including name of contact, date, phone number.	**CFC**: Supplies waiver to CBO and provider for submission to CBO with claims.	CBO	If the insurance company requires credentials other than those established by EI, if none of the insurer's providers are also EI credentialed, CBO pays.

At-A-Glance Insurance Guidelines				
SCENARIO	**ACCEPTABLE DOCUMENTATION**	**ACTION REQUIRED BY:**	**PAYER**	**COMMENTS**
Insurance company Limits # of Visits	1. Final EOB documenting visits exhausted. 2. Written statement from insurer. 3. Notes from conversations including name of insurance company contact, date, phone number.	**Provider**: Submits documentation to CBO along with claims.	CBO	• After insurance company has paid for the pre-established number of visits, CBO should be billed for IFSP services. • Provider may follow insurer's guidelines for requesting approval for additional visits beyond initial limit.
Maximum Payable	1. EOB denying payment based on annual maximum payable met 2. Written statement from insurer 3. Notes from conversations including name of insurance company contact, date, phone number.	**Provider**: Submits documentation to CBO along with claims.	CBO	• After insurance company has paid up to their pre-established maximum amount payable, CBO should be billed for IFSP services • Provider may follow insurer's guidelines for requesting approval for additional visits beyond initial limit.
Insurance Deductible Applies	1. EOB denying payment for failure to pay deductible	**Provider**: Submits documentation to CBO along with claims.	CBO	Provider bills insurance company, if denied then submits the EOB with the claim to CBO.

At-A-Glance Insurance Guidelines				
SCENARIO	**ACCEPTABLE DOCUMENTATION**	**ACTION REQUIRED BY:**	**PAYER**	**COMMENTS**
Waiver or Exemption issued based on primary insurance status	1. Waiver approval from CFC. 2. Exemption approval from DHS.	**Provider**: Submits documentation (if applicable) to CBO along with claims.	CBO	Insurance waivers and exemptions apply to insurance use in general. Secondary insurance not billed if waiver or exemption has been granted for primary insurance.
Insurance Co-pay applies	N/A	**Provider**: Submits documentation to CBO along with claims.	INSURANCE	Liability is transferred to the State of Illinois; CO-PAY IS NOT COLLECTED