MASSACHUSETTS
DEPARTMENT OF PUBLIC HEALTH

EARLY INTERVENTION
SERVICE DELIVERY REPORTING REQUIREMENTS
AND REIMBURSEMENT FOR SERVICES

Massachusetts Department of Public Health
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Early Intervention
Service Delivery Reporting Requirements
And Reimbursement for Services

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I. INTRODUCTION

The Early Intervention Service Delivery Reporting Requirements and Reimbursement for Services is a document for Early Intervention providers who provide direct care services to enrolled Early Intervention children and their families. This manual provides information on Massachusetts Department of Public Health's billable EI services, payment sources, service delivery requirements, DPH's processing of service delivery records, and reconciliation processing.

Information about EI Autism services can be found in appendix VI and VII.

A. What is Early Intervention (EI)?

Early Intervention in Massachusetts is a statewide, integrated, developmental service available to families of children between birth and three years of age. Children may be eligible for EI if they have developmental difficulties due to identified disabilities, or if typical development is at risk due to certain birth or environmental circumstances.

EI provides family-centered services that facilitate the developmental progress of eligible children. EI helps children acquire the skills they will need to continue to grow into happy and healthy members of the community.

Referrals to Early Intervention are made directly to programs that have been certified by the Massachusetts Department of Public Health. Services are designed to meet the developmental needs of each child as well as the needs of the family related to enhancing the child's development. Services are coordinated in collaboration with families, using an Individualized Family Service Plan (IFSP) and are culturally and linguistically appropriate.

Early intervention services are provided by a professional team within each EI program that are made up of developmental specialists, physical therapists, occupational therapists, speech language pathologists, social workers, nurses, psychologists, and other specialty service providers and are provided in accordance with functional outcomes identified in the child's IFSP. Services on an IFSP may include home visits, center-based visits, community child groups, EI-only child groups, and assessments.

All professional staff providing direct service to children and families, employed directly or indirectly by an Early Intervention program (including salaried, contract/fee for services, or consultant/subcontract) are certified (or provisionally certified) as Early Intervention Specialists by the Massachusetts Department of Public Health prior to billing for Early Intervention services.

B. Role of the Massachusetts Department of Public Health

The Massachusetts Department of Public Health was designated as the lead agency under MA General Law (MGL) chapter 111G (1993) to administer Early Intervention services as defined under Part C of the Individuals with Disabilities Education Act (IDEA). The Department has responsibility to establish Early Intervention operational standards, certify programs and staff working in a professional capacity, provide general supervision and monitoring for compliance with the state standards and federal regulations and coordinate state and federal funding for the reimbursement of Early Intervention services.

C. Payers of Early Intervention Services

Early Intervention services are paid for by commercial health insurers, MassHealth and the Department of Public Health. DPH pays for costs that are appropriately denied by an insurer. However, providers must be able to fully justify the appropriateness of claims being submitted to the Department.

II. SOURCES OF PAYMENT FOR EI SERVICES

DEFINITIONS for Sources of Payment for EI Services

Centers for Medicare and Medicaid	*The federal agency that oversees the state administration of Medicaid.*
Client	*Recipient of service(s) provided by an Early Intervention program and includes a child, his or her parent(s) and/or siblings.*
Co-payment	*A form of cost sharing that requires a member to pay a fixed amount when a service is received.*
Deductible	*A fixed dollar amount during a benefit period that a member pays before the insurer starts to make payments for covered services.*
Exclusive Provider Organization (EPO)	*A more restrictive PPO under which members must use providers from the specific network.*
Fully Insured Plan	*A plan where the employer contracts with another organization to assume responsibility for those enrolled to administer claims and administrative costs. Employers purchase health insurance coverage for their employees and the insurer assumes the financial risk. Insured plans in Massachusetts are subject to state law and are overseen in Massachusetts by the Division of Insurance.*
General Laws	*General Laws are statutes promulgated by the Legislature and published as the Massachusetts General Laws.*
Health and Human Services (HHS)	*The federal government department that has overall responsibility for implementing HIPAA.*
Health Maintenance Organization (HMO)	*A health care system that assumes the financial risk associated with providing comprehensive care in a specific geographic area.*
Insurance Benefit Coverage	*Insurance coverage is based upon the insurer's definition of medical necessity and the benefits offered by the plan. MassHealth has accepted DPH's definition that if a child is deemed to be clinically eligible, they are eligible for coverage.*
Medicaid	*A public insurance program for low income individuals that is administered jointly by federal and state governments. It is overseen by the federal government but administered by the individual states.*
Medical Necessity	*A service that is appropriate for the treatment of a specific individual. Definitions and guidelines vary by health plan.*
Point of Service Plan (POS)	*POS plans resemble HMOs for in-network services. A POS is open-ended and considered to be an HMO/PPO hybrid*
Preferred Provider Organization (PPO)	*An indemnity plan where coverage is provided to participants through a network of selected health care providers.*

Provider	*A provider, also known as the vendor, is an approved organization with which the state contracts with and conducts business. A provider or vendor may manage many Early Intervention programs as well as other contracts with DPH.*
Self-Insured Plans	*A plan offered by employers who directly assume the major cost of health insurance for their employees. Some self-insured employers contract with insurance carriers for claims processing and administrative services. Employers may offer both self-insured and fully insured plans to their employees.* *In self-insured plans (also called self-funded plans), instead of purchasing health insurance coverage employers pay for their health care costs directly usually using a health insurer to administer benefits, enrollment and billing. Large companies frequently self insure for a variety of reasons. Self-insured plans are not subject to state law but are overseen at the federal level. Federal laws exempt self-insured plans from state mandates.*
Support Documentation	*EI providers must be able to document due diligence in their attempts to resolve non-covered claims before submitting them to DPH. Examples of support documentation justifying DPH payment of claims to be included with the Explanation of Benefits (EOB), Explanation of Payments (EOP) or Statement of Accounts for corresponding dates of service include: MassHealth EVS(Eligibility Verification System) printout, insurer eligibility print outs, correspondence from insurers, verbal confirmation from an insurer with a corresponding trace/tracking/verification number, employer non-covered account or group number , electronic non-covered reports from insurers, appeals, etc. Support documentation must justify why claims have been submitted to DPH and specify efforts to address all avenues of reimbursement with other payers prior to submitting the claims to DPH. Support documentation showing that third party billing rules have been followed must also be made available to DPH for review upon request.*

A. General Information

A payer source is an organization or insurer that covers the cost of services delivered to Early Intervention clients. Early Intervention services provided by certified professionals, in accordance with the EI Operational Standards, are the only services for direct provision. Indirect costs incurred in providing direct services, such as no shows, cancellations, or transportation costs to and from visits to families, are not reimbursable to private insurance, MassHealth or DPH. Services are paid for by third party insurers, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), MassHealth and MassHealth MCOs. The Massachusetts Department of Public Health (DPH) is the payer of last resort. DPH covers the cost of EI services for children who are uninsured and costs that are

appropriately denied by an insurer. Providers must be able to fully justify the appropriateness of claims being submitted to DPH.

B. MassHealth

1. General Information

MassHealth is the name used in Massachusetts for Medicaid and is a public health insurance program for eligible low and medium income Massachusetts residents. To be eligible for MassHealth you must live in Massachusetts and meet general eligibility requirements. These requirements differ from one MassHealth product to the next and eligibility can depend upon age, family situation, immigration status or health care needs.

MassHealth includes several coverage types with different rules under each coverage type. Coverage types applicable to EI include MassHealth Standard (comprehensive health insurance), CommonHealth, and Family Assistance.
MassHealth clients must choose either a primary care clinician or a MassHealth MCO managed care plan. MassHealth contracts with Health Maintenance Organizations (HMO), known as Managed Care Organizations (MCO) to cover a MassHealth client's services. Under CMR 440.00, HMOs must uphold MassHealth rules regarding eligibility determination and definition of medical necessity for MassHealth clients receiving services under an MCO organization. There are currently five MCO Managed Care plans for MassHealth members who choose this option:

- Boston Medical Center Health Plan (BMC)
- Fallon Community Health Plan (FCHP)
- Health New England (HNE)
- Neighborhood Health Plan (NHP)
- Network Health

MassHealth also has product options which function as a secondary payer (i.e. Family Assist) and will pay claims up to an allowed amount. The private insurer is the primary insurance with MassHealth acting as the secondary. The MassHealth products that do not include the EI benefit include the following:

- MassHealth: Basic *(Discontinued 12/31/13)*
- MassHealth: CarePlus
- MassHealth: Children's Medical Security Plan
- MassHealth: CommCare *(Discontinued 12/31/13)*
- MassHealth: Essential *(Discontinued 12/31/13)*
- MassHealth: HSN *(Health Safety Net)*
- MassHealth: HSN-Partial

2. MassHealth Products

MassHealth Product	Description	EI Coverage
Basic *(Discontinued 12/2013)*	This program provides limited coverage based on eligibility and health care needs for a range of services. It does not cover Early Intervention services.	No
Children's Medical Security Plan	The Children's Medical Security Plan provides primary and preventive medical coverage to children who are not eligible for other MassHealth coverage types. It is a basic health insurance program offered by EOHHS for Massachusetts children run by MassHealth.	No
CommonHealth	MassHealth CommonHealth offers complete health care benefits similar to MassHealth Standard including coverage for families and children who are not eligible for MassHealth Standard because their income is too high.	Yes, in full
Commonwealth Care *(Discontinued 12/2013)*	Commonwealth Care is a health insurance program for low and moderate income state residents who do not have health insurance. Coverage is provided through the Commonwealth Insurance Connector Authority funded by the state. Commonwealth Care is for adults alone; children of families receiving Commonwealth Care are eligible for MassHealth.	No
Essential *(Discontinued 12/2013)*	This program provides limited coverage based on eligibility and health care needs for a range of services. It does not cover Early Intervention services.	No
Family Assistance	MassHealth Family Assistance provides health insurance coverage to families and children who are not eligible for MassHealth Standard or MassHealth Common Health and includes most of the services of MassHealth Standard. It has two forms of benefit assistance: (a) Premium Assistance where MassHealth pays part of the insurance premium for private health insurance through qualified employers (members get whatever health care benefits the private health plan offers) and, (b) Direct medical benefits coverage (if the child does not have health insurance benefits), where the member receives MassHealth benefits by enrolling in a health plan.	Partial EI coverage
Health Safety Net- HSN (and HSN Partial) programs	Health Safety Net- HSN (and HSN Partial) programs are for Massachusetts residents who are not eligible for health insurance or can't afford to buy it. The Health Safety Net replaced the Uncompensated Care Pool in October 2007.	No

MassHealth Product	Description	EI Coverage
MCO Managed Care Plans	MassHealth offers comprehensive coverage to members who elect to enroll in an MCO option and can choose one of the following five plans: BMC, Fallon Community Health Plan, Health New England, Neighborhood Health Plan, and Network Health. These plans provide coverage for specific services areas.	Yes, in full
Standard	MassHealth Standard is a comprehensive health insurance that includes preventive and medical services.	Yes, in full

C. Massachusetts Third Party Insurers

Massachusetts General Laws (MGL) chapter 721 mandates that all Massachusetts third party insurers, including HMOs and PPOs, must cover the cost of EI services as part of their basic benefits package if fully insured. However, out-of-state health plans and self-insured employer group plans are not required to follow Massachusetts state mandates. DPH pays for costs that are appropriately denied by one of these insurers.

D. Massachusetts Department of Public Health

The Massachusetts Department of Public Health is the payer of claims for non-insured children and is the payer of last resort for all EI services of insured children and their families. Early Intervention programs must demonstrate through documentation that all attempts at securing reimbursement from insurers for families have been exhausted prior to submitting claims to DPH. Appropriate support documentation justifying DPH payment of these claims include appeals, an EOB/EOP for corresponding dates of service (depending upon payer and adjustment reason codes), insurer eligibility print outs, correspondence from insurers, verbal confirmation from an insurer with a corresponding trace/tracking/verification number, etc.

All records, invoices related documents, and equivalent electronic transmissions submitted to the Department of Public Health shall be under the pains and penalties of perjury as true, correct and accurate as attested by the Executive Director or Chief Financial Officer of the Agency.

III. THE DEPARTMENT OF PUBLIC HEALTH AS THE PAYER OF LAST RESORT

DEFINITIONS for the Department of Public Health as the Payer of Last Resort

Administrative Services Only (ASO)	*An arrangement in which an employer contracts with a third party for claims processing and billing. The employer bears the risk for claims.*
Claim Adjustment Reason Codes	*A national administrative code set that identifies the reason for differences between the original billed charge and payment.*
Client	*Recipient of service(s) provided by an Early Intervention program and include a child, his or her parent(s) and/or siblings.*
Coinsurance	*A form of cost sharing that requires the member to pay a stated percentage of expenses after the deductible amount.*
Co-Payment	*A form of cost sharing that requires a member to pay a fixed amount when a service is received.*
Co-Treatment	*A co-treatment service or visit which involves two or more EI Specialists, the enrolled child, the enrolled child's parent, or both. Reimbursement for one co-treatment is allowed per month for an enrolled child. Co-treatment visits are usually for the purpose of consultation and coordination regarding treatment planning and approaches to treatment. They are billed on the basis of working hours with a maximum reimbursement of two hours per professional discipline or EI Specialist. Reimbursement for a co-treatment is limited to four working hours per session.*
Deductible	*A fixed dollar amount during a benefit period that a member pays before the insurer starts to make payments for covered services.*
Electronic HIPAA Transactions	*HIPAA electronic transactions are predefined and include specific code and information. If an agency or EI program transmits claims electronically to insurers it must be done in the prescribed HIPAA format and codes. The following provides the most common HIPAA transactions to be used by EI programs for information inquiries and claim submission to insurers:* ***270: Health Care Eligibility & Benefit Inquiry transaction*** *An electronic transaction initiated by an EI program to an insurer for the purpose of acquiring information on a client such as insurance eligibility.* ***271: Health Care Eligibility & Benefit Response transaction*** *An electronic transaction from an insurer to an EI program in response to an X12 270 providing information on the client.* ***276: Health Care Claims Status Inquiry transaction*** *An electronic transaction initiated by an EI program to an insurer for the purpose of inquiring about the status of a claim.*

	277: Health Care Claim Status Response transaction *An electronic transaction from an insurer to an EI program in response to an X12 276.* ***835: Health Care Claim Payment & Remittance Advice transaction*** *Remittance response from an insurer to an EI program* ***837: Health Care Claim or Encounter transaction*** *Claim submission from an EI program to an insurer.* ***997: Functional Acknowledgement*** *A confirmation of an electronic HIPAA submission.*
Electronic SDR Transactions	*An electronic transaction from an EI program's to DPH that includes charges to DPH as well as service delivery reporting of all services regarless of payer, and payer transfer records. The SDR electronic file is transmitted to DPH via the DPH EI TVP website. See Appendix I for further information.*
Employee Retirement Income Security Act (ERISA)	*Broad reaching federal laws that establish the rights of participants regarding health insurance.*
Filing Limits	*An insurer's timeframe for the submission of claims.* • *Initial Filing Limit Days - the number of days elapsed between the date of service (and EOB date if another insurer is involved) and the receipt by a plan.* • *Request for additional information - a first time claim submission that is denied for additional information i.e. unlisted procedure code, documentation not supporting code.*
First Dollar Mandate	*A Massachusetts legislative mandate that prohibits fully insured health plans from charging for a co-payment, coinsurance or deductible for EI services rendered by an EI provider.*
Fiscal Year	*A fiscal year is a period of 12 consecutive months used as an accounting period for revenue and expense reporting. The fiscal year for the state of Massachusetts starts July 1st and ends June 30th.*
Flexible Spending Account (FSA) Arrangements	*Accounts administered by employers that provide a way for employees to set aside pretax dollars to pay for a predetermined amount for premiums or medical expenses not covered by the plan.*
Fully Insured Plan	*A plan where the employer contracts with another organization to assume responsibility for those enrolled to administer claims and administrative costs. Employers purchase health insurance coverage for their employees and the insurer assumes the financial risk. Insured plans in Massachusetts are subject to state law and are overseen in Massachusetts by the Division of Insurance.*

General Laws	*General Laws are statutes promulgated by the Legislature and published as the Massachusetts General Laws.*
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	*Health Insurance Portability and Accountability Act of 1996 which mandates the use of standards for the electronic exchange of health care data; specifies what medical and administrative code sets to be used within those standards; requires the use of national identification systems for health care patients, providers, payers (or plans), and employers; and specifies the types of measures required to protect the security and privacy of personally identifiable health care information.*
Health Reimbursement Arrangement (HRA)	*Employer funded accounts used to pay certain out-of-pocket expenses.*
Health Savings Account (HSA)	*An employee owed account (as defined by the IRS) used to pay out-of-pocket expense. Typically members must be enrolled in a high-deductible plan.*
Mandated Benefits	*Services that fully funded plans are required by the state to offer as benefits to their members. Specific benefits vary by state. Self-insured plans are exempt.*
Medical Necessity	*A service that is appropriate for the treatment of a specific individual. Definitions and guidelines vary by health plan.*
Medical Savings Account (MSA)	*Savings accounts designed to allow employees and individuals to contribute pretax dollars to be used to cover out-of-pocket expenses. Typically MSAs are combined with a high deductible plan.*
Network	*A group of providers who contract with a managed care organization to provide services.*
PV(Payment Voucher) Reference Number	*A DPH number or ID that identifies claim records approved for payment. It consists of 11 characters composed of a three-character provider-specific code, the date the payment voucher was generated (YYMMDD), and a two-character fiscal year budget account reference. It is included on each approved claim record on the remittance file with the summation of these records included on the PV document.* *The PV reference number is slightly different from the PV number found on the MassFinance website. The MassFinance PV number includes a preceding number identifying the fiscal year. The MassFinance PV number is assigned by the state comptroller's office and references a check issued to a provider.*
Recipient Eligibility Verification System (EVS and WEB EVS)	*The EVS system is a method to verify MassHealth client eligibility information and to obtain authorizations. WEB EVS is the internet version of this application.*

Request for Reimbursement/ Waiver	*A written request for a clinical waiver or reimbursement for payment submitted to DPH by an Early Intervention program for services which exceed the guidelines specified within the EI Operational Standards. The Massachusetts Department of Public Health retains the authority to approve or deny the request.*
Self-Insured Plans	*A plan offered by employers who directly assume the major cost of health insurance for their employees. Some self-insured employers contract with insurance carriers for claims processing and administrative services. Employers may offer both self-insured and fully insured plans to their employees.* *In self-insured plans (also called self-funded plans), instead of purchasing health insurance coverage employers pay for their health care costs directly usually using a health insurer to administer benefits, enrollment and billing. Large companies frequently self insure for a variety of reasons. Self-insured plans are not subject to state law but are overseen at the federal level. Federal laws exempt self-insured plans from state mandates.*
Supplemental Claims	*For Early Intervention services, supplemental claims are those claims submitted to DPH after the close of the state fiscal year (i.e.; August 31). Early Intervention programs have until March 10th of the following year to research and submit claims for services.*

A. General Procedures and Document Acquisition Needed Prior to Billing DPH

The Department of Public Health is the payer of last resort for Early Intervention services only after providers have demonstrated due diligence in pursuing all avenues of reimbursement. Providers must follow established procedures and/or billing rules as defined by MassHealth, MCOs and third party payers before submitting non-covered claims to DPH.

Procedures and billing rules defined by third parties (including efforts to resolve denied claims) must be followed prior to submission of claims to DPH for payment. The Department expects that providers make all possible efforts to secure reimbursement of these services from the appropriate insurer providing benefits to the family and child in Early Intervention.

1. Verification of Insurer Eligibility

EI providers must be able to document due diligence in their efforts to verify insurance eligibility. MassHealth and the MCOs all require that member eligibility be verified prior to service provision to ensure that appropriate billing information is submitted. For all other insurers, providers must maintain documentation that demonstrates a program's attempts to verify eligibility on an ongoing basis to ensure that the family's insurance status has not changed. It is expected that providers verify insurance eligibility, at a minimum, quarterly (every three months). The insurance eligibility and other support documentation must be made available to DPH for review upon request.

2. Documentation for Non-Covered Services (see also: *C. Services and Partial Payments Paid by DPH* and *D. Support Documentation* sections below)

EI providers must be able to document due diligence in their attempts to resolve non-covered claims before submitting them to DPH. Support documentation showing that MassHealth or insurer billing rules have been followed must also be made available to DPH for review upon request.

2.1. Examples of support documentation to be included with the Explanation of Benefits (EOB), Explanation of Payments (EOP) or Statement of Accounts for corresponding dates of service include:

- Appeals
- Electronic eligibility 271 HIPAA transaction response
- Correspondence from insurers
- Insurer specific website eligibility verification
- Verbal confirmation from an insurer with a corresponding trace/tracking/verification number

Charges to DPH cannot be submitted for payment as a denial from a third party if they are in a "pended" status by the third party insurer.

2.2. Commercially-insured Children

If the initial claim submission to an insurer establishes **definitively** that services are not covered then subsequent claims can be submitted directly to DPH. Providers do not have to submit subsequent claims to an insurer in order to obtain additional denials prior to submitting service charges to DPH. This applies to commercially insured children primarily for denials of "benefit not covered" (reason code 096 for EI services); it does not apply to MassHealth or MCO services.

This does not change any other procedural expectations as established by DPH billing rules and claims submission requirements. The initial denial from an insurer may pend and will require a review by DPH of an insurer's EOP/EOB (Explanation of Payment/Explanation of Benefit) along with any other appropriate support documentation.

Additionally, providers are expected to verify benefits and coverage for services, at a minimum, quarterly in order to ensure that benefits or the family's insurance status has not changed.

In general, providers must make all reasonable efforts to secure reimbursement for services from the appropriate insurer and be able to fully justify the appropriateness of claims submitted to DPH. If anything changes under a family's insurance (e.g., benefit coverage change) then providers must document due diligence of all denials.

B. Commercial Payer Sources that do not Cover EI Services

1. Verification of EI Benefit Coverage

It is important to identify if a plan is fully or self-insured. It is equally important to find out whether or not the plan covers EI. Procedures have been set up by the main Massachusetts insurers for providers to have access to this type of information. More detailed information that gives further insurance guidance can be found in *Appendix 5, Insurance Guidance*.

2. Self-Insured Employer Groups

Employers who directly assume the major cost of health insurance for their employees may offer either or both self-insured and fully insured plans. In self-insured plans (also called self-funded plans) an employer, instead of purchasing health insurance coverage, pays for their health care costs directly, usually using a health insurer for administering benefits, enrollment and billing. Large companies frequently self insure for a variety of reasons.

Self-insured plans are overseen at the federal level and do not have to cover state mandated benefits such as Early Intervention (EI). However many self-insured plans (and out of state health plans) do try to mirror the fully insured plans offered. An employee may not know if they are covered under a fully or self-insured plan.

Fully insured plans are employer-purchased health insurance coverage for employees where the insurer assumes the financial risk. Fully insured plans are subject to state law and are overseen in Massachusetts by the Division of Insurance. Payment for EI services is based upon benefits, eligibility, medical necessity and contractual agreements of the plan with the employer.

3. Process for Identifying Self-Insured Plans offered by the Major MA Insurers

3.1. Aetna Health

Aetna clients must be identified as having either a fully or self-insured plan and then identify if the self-insured plan does or does not cover EI. Providers must show that they have followed guidance provided by Aetna and include a reference/tracking number for any denied claims prior to submission of charges to DPH

3.2. Blue Cross /Blue Shield

BC/BS of Massachusetts generates and sends to DPH a quarterly listing of clients having National and Blue Card plans that do not cover EI. These listings are included in the department's insurance table and used to expedite monthly claims processing. Providers can request their own listing for their agency by contacting BC/BS of MA.

3.3. Cigna Health

There is a two-step process that must be followed prior to submission of charges to DPH when Cigna denies claims. First, the provider must identify if the Cigna plan is a fully or self-insured plan. Next, contact the Cigna insurance contact *(see Appendix 5, Insurance Guidance)* to confirm if the plan does or does not cover EI services.

3.4. United Health Care of New England

United Health Care provides a listing of Employer Group Numbers that do not offer EI as a benefit. This listing is updated routinely and sent to EI programs. DPH uses this information to match against support documentation sent by providers in order to confirm that charges to DPH are appropriate.

4. Options under an Insurer Plan (HSA, HRA, FSA, MSA, etc.)

During the eligibility verification providers should attempt to identify if a family has an insurance plan with an option such as HSA (Health Savings Account plan), HRA (Health Reimbursement Account), FSA (Flexible Spending Account), HRA (Health Reimbursement Arrangement) or MSA (Medical Savings Account), etc. If possible, this information should be obtained prior to the first face-to-face meeting with the family. Otherwise, providers should obtain this information from the family at the first visit.

Massachusetts law mandating insurers to pay co-pays, co-insurance and deductibles do not apply to these types of insurer options. The subscriber should contact their employee benefits office (and possibly their insurer's member services office) to ensure that co-pays, co-insurance and deductibles are not automatically deducted from these accounts and to ensure that there are no other issues related to these options.

C. Services and Partial Payments Paid by DPH

1. Benefit Not Covered

Insurers may not pay for EI services for a variety of reasons such as:

- Self-insured plans
- Out-of-state plans that do not cover EI as a benefit
- The plan's definition of medical necessity does not allow for EI coverage
- Etc.

Documentation that is kept on file at the EI program for these claims must include all follow-up and remittance responses from the insurer. If a plan does not cover EI as a benefit then one of the following reason codes should be used:

Reason codes to be used:

- 96 (non-covered charge)
- 109 (claim not covered by this payer)

If there are multiple adjustments reason codes remitted from the insurer then submit the most appropriate reason code to DPH based on what has been remitted.

2. Insured but not Eligible

If the coverage by a plan is not in effect for a specific time or the child is covered under MassHealth but is deemed ineligible for payment of services then one of the following reason codes should be used and should correspond to the Adjustment Reason Code provided in the remittance from the insurer:

Reason codes to be used:

- 141 (Claim spans periods of ineligibility)
- 177 (Recipient is ineligible on this date of service)

The child is considered insured during this time period and the reason code submitted to DPH must be based on the insurer's Adjustment Reason Code. Therefore, the primary insurer must be reported to DPH when using the above reason codes.

3. Family is between Insurance Coverage

If the family is between insurance coverage then one of the following reason codes should be used and should correspond to the Adjustment Reason Code provided in the remittance from the insurer:

Reason codes to be used:

- 26 (Expenses incurred prior to coverage)
- 27 (Expenses incurred after coverage terminated)
- 28 (Coverage not in effect at time service was provided)

The child is considered insured during this time period and the reason code submitted to DPH must be based on the insurer's Adjustment Reason Code. Therefore, the primary insurer must be reported to DPH when using the above reason codes.

4. Non-insured Client Claims

All claims of services provided to children who are uninsured and are not MassHealth eligible can be submitted directly to DPH. EI providers must document that, at a minimum, the status of non-insured families is being reviewed every three months and assistance is being given to direct the family to apply for MassHealth. Documentation from MassHealth's EVS system must be included as part of a non-insured child's record.

Reason code to be used:

- D05 (Uninsured code)
  This reason code should only be used when a family has verified in writing that they are uninsured. Appropriate use of the D05 (uninsured) reason code is imperative in order for DPH to ensure the proper use of federal funds set aside for these individuals.

The EI program must submit a letter stating that the family is uninsured or a signed document by the family stating this to:

Steve McCourt
MA Department of Public Health
250 Washington Street, 5th flt
Boston, MA 02108

5. Cap Limits for Insurers

Massachusetts General Laws eliminated the maximum and aggregate benefit amounts imposed by commercial and health maintenance organizations for mandated Early Intervention services for fully insured plans. Therefore, the cap limit is no longer valid for fully insured plans. MassHealth and the MassHealth MCOs have never had a cap threshold for EI services. Self-insured employer groups have the option to either abide or not abide by the state mandate. Therefore, an adjustment reason code from one of these plans may be "Benefit maximum for this time period has been reached" or "Lifetime benefit maximum has been reached". Providers should use the following reason code for these denials.

Reason codes to be used:

- 119 (Benefit maximum has been reached)

6. Co-payments and Deductibles

A co-payment is a form of cost sharing that requires a member to pay a fixed amount when a service is received. Co-payments are specified in the remittance received from insurers. A deductible is a fixed dollar amount (during a benefit period) that a member pays before the insurer starts to make payments for covered services. Once paid, the insurer is responsible for payments for covered benefits.

Massachusetts General Laws prohibit fully insured health plans from charging co-payments, co-insurance, and deductible charges for Early Intervention services. Self-insured employer groups have the option to abide or not abide by this mandate. This policy does not apply to Health Savings Account Plans (HSAs) governed by the Federal Internal Revenue Code due to the fact that the HSA plan would lose tax exempt status by prohibiting the co-payments, co-insurance or deductibles.

Reason codes to be used

- 01 (Deductible amount)
- 02 (Co-insurance)
- 03 (Co-payment amount)

7. Parental Refusal to Access Insurance

Families have the option not to use their health insurance for the payment of all their EI services. In instances where the family does not want EI services billed to their insurer, the EI program must obtain a signed statement by the subscriber stating this and keep it on file. A letter along with a copy of the signed statement should be sent to:

The EI program must submit a letter stating that the family is uninsured or a signed document by the family to DPH (along with the child's DPH client ID) stating the family's decision not to use their insurance for EI services. The letter should be sent to:

Steve McCourt
MA Department of Public Health
250 Washington Street, 5th flt
Boston, MA 02108

Reason code to be used

- D06 (Family refused to access insurance)

D. Support Documentation

1. General

The adjustment reason codes submitted to DPH for payment of denied claims should be based on the guidance in this manual and, as much as possible, match the codes used on the EOB (Explanation of Benefits or Statement of Accounts) or EOP (Explanation of Payments) from the insurer. In many cases the adjustment reason code submitted to DPH will result in a claim record being pended for payment under one of the following error codes:

- 4C (Reason for DPH payment for MassHealth child is unacceptable)
- 5B (Reason for DPH payment is co-payment, co-insurance or deductible)
- 5H (Reason for DPH payment is inconsistent with insurer information)
- 5K (Reason for DPH payment is non-covered benefit but client is not included in DPH override or DPH insurance tables)
- 5P (Reason for DPH payment shows lapse in service or other issue but client is not included in DPH insurance table)

In these cases support documentation is needed in order to receive approval from DPH for payment.

2. Acceptable Documentation from Insurers

Support documentation must justify why claims have been submitted to DPH and specify efforts to address all avenues of reimbursement with other payers prior to submitting the claims to DPH. All support documentation should be submitted to the DPH EI fiscal manager with the EOB (Explanation of Benefits or Statement of Accounts) or EOP (Explanation of Payments). Providers should request a reference/tracking number of follow-up verbal communications with insurers. Appropriate documentation includes:

- Appeals
- Eligibility verification for covered benefit dates
- MassHealth EVS (Eligibility Verification System) printouts
- Insurer specific eligibility verification or HIPAA verification 270/271
- Electronic (i.e., email) or documented verbal confirmation with an insurer that includes trace/reference number
- Correspondence from an insurer specifying Early Intervention or including a reference number
- Employer non-covered account or group number
- Electronic non-covered reports from insurers

It is important that support documentation be attached to a printout of the DPH remittance report to expedite the approval process. It is also important to specify the DPH client ID and fiscal year the support documentation submitted represents. Include the following:

- DPH client ID *(7-character ID)*
- Fiscal year of the service *(DPH separates all claims into fiscal years due to funding allocations)*

The inclusion of the DPH client ID is critical since DPH does not match the support documentation to the client's name. The client ID provided in the support documentation is matched to the client ID in the SDR (Service Delivery Reporting) database in order to identify the services pended for payment. The fiscal year is needed to identify the DPH database having the pended services. This helps to expedite the payment of these services especially for supplemental claims that may be under a tight deadline. Support documentation should be sent to:

Steve McCourt
Department of Public Health
250 Washington St., 5th Floor
Boston, MA 02108

E. Request for Reimbursement/Prior Approval

DPH staff members have limited the review of requests for reimbursement waivers to those that reflect **extraordinary circumstance(s)** inclusive of children receiving services from their local Regional Consultation Program (RCP). Requests for reimbursement are made by EI program personnel and must be requested and approved before the EI program submits billing for the service(s) to DPH. DPH reserves the right to deny payment for services rendered where a request for reimbursement was not requested prior to submission of billing to DPH.

A request is submitted to DPH via SecureMail using the "Request for Reimbursement from Billing Guidelines" form. If a request is approved, an authorization number is assigned and the form is returned to the EI program. An authorization number consists of 7 numbers, is specific to the client and the type of request and is time limited. The approved "Request for Reimbursement from Billing Guidelines" form is to be filed in the client's record and the waiver authorization number is used by the EI provider to bill for the waived service(s) on their service delivery data report. Most requests for reimbursement will pend for one month while DPH reviews the service to ensure that a request has been approved. A payment (identified by the PV reference number) or a non-payment message (located under the O_Status column on the remittance file) will be remitted the following month.

The following provides the reason for the different reimbursement request types that are specific to service delivery and claim submission:

- Co-treatment service more than one time per month
- Excessive service hours *(all appropriate hours should be billed to the insurer; only excessive hours should be billed to DPH)*
- Two of the same professional disciplines providing the same service to the same child on the same day (this includes a co-treatment that occurs with 2 staff of the same discipline).
  - If the same clinician provides the same service multiple times on the same day for the same child a waiver is needed
  - If two or more clinicians having the same professional discipline provide the same service on the same day for the same child a waiver is needed (exceptions: assessments and IFSP home visits)
- Services approved for a child over three years of age
- Services approved for a family prior to a child's birth
- Services approved for a family after the child dies
- Child is enrolled in one EI program and is receiving services from another EI program (all services from secondary EI program must have a waiver)

Appropriate hours of service should be billed to the child's insurer prior to billing DPH when an approval for extra service hours has been granted under a Request for Reimbursement.

<u>Reason codes to be used</u>
D01 – Prior authorization for reimbursement
D02 - Services received at a secondary EI program

Billing Requirement

The authorization number (data field: WAIVERNO) must be included on each claim that has a request for reimbursement. DO NOT enter dashes (-) as part of the waiver authorization number into your billing system.

F. Approval of Pended Claim Records

Support documentation is held for review for one PV processing cycle to ensure that the electronic submission of services from the provider has also been submitted. If services have not been processed through the SDR system when the support documentation is reviewed then there will not be any approvals. Providers will need to re-submit the support documentation for these services.

Providers should review their monthly DPH remittance advice to check the status on all pended services. If the pended service has been reviewed the provider will find the following information on the remittance file for the record:

- *Service was approved for payment by DPH:* the PV data field will include the vendor's PV reference number, the line_status data field will state "ACCEPT" and the O_Status data field will identify the reason for payment.
- *Service was not approved for payment by DPH:* the PV data field will be blank, the line_status will state "PENDED" and the O_Status data field will identify the reason for non-payment.
- *Service is on hold for payment:* the PV data field will be blank, the line_status will state "PENDED" and the O_Status data field will identify the reason for holding off approval. The provider does not need to provide any further information to DPH. DPH will either approve or refuse payment once information is received from insurers.

G. Credits, Corrections and Overpayments

An EI program may end up receiving payment for services from MassHealth or an insurer after DPH's deadline for submission of services for payment. DPH accepts electronic credits via the SDR file through July 10th of the supplemental year. For example, a fiscal year 2014 credit can be transmitted to DPH on the SDR file through July 10, 2015.

When payments from an insurer are received after DPH has closed the fiscal year (for FY14 this would be after July 10, 2015), credit payments should be submitted to DPH in the form of a check. Contact the DPH EI fiscal manager for further detail regarding credit payments after a fiscal year deadline.

IV. SERVICE SPECIFICATIONS

DEFINITIONS for Service Specifications

Approved Program Rates	*The rate per EI service unit approved by the Center for Health Information and Analysis (CHIA). The rates are certified by the Commonwealth and filed with the Secretary of the Commonwealth to govern payment for services as stated under 114.3 CMR 49.00.*
Billable Staff Member	*A billable staff member is an individual in an Early Intervention program who possesses the required credentials and is certified by DPH as an Early Intervention Specialist to render billable Early Intervention services.*
Certified Early Intervention Program	*A certified Early Intervention Program is one that is deemed in compliance with the EI Operational Standards set forth by the Massachusetts Department of Public Health.*
Determination of Eligibility	*Eligibility for Early Intervention is determined by an eligibility evaluation performed by a multidisciplinary team exercising sound clinical opinion, and using a developmental evaluation instrument approved by the Department of Public Health. Eligibility is determined only by certified Early Intervention programs.*
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	*Health Insurance Portability and Accountability Act of 1996 mandates the use of standards for the electronic exchange of health care data; specifies what medical and administrative code sets to be used within those standards; requires the use of national identification systems for health care patients, providers, payers (or plans), and employers; and specifies the types of measures required to protect the security and privacy of personally identifiable health care information.*
Medicaid	*A public insurance program for low income individuals that is administered jointly by federal and state governments. It is overseen by the federal government and administered by the individual states.*
Provider	*A provider, also known as the vendor, is an approved organization with which the state conducts business. A provider or vendor may manage many Early Intervention programs as well as other contracts with DPH.*
Regional EI Specialists	*Regional EI specialists are members of the DPH Early Intervention personnel who work out of the DPH regional offices throughout the state. Their primary responsibilities include (1) providing technical assistance to EI programs within a designated region and (2) monitoring the programs for compliance with the EI Operational Standards and with the federal regulations under Part C of the Individuals with Disabilities Education Act (IDEA).*

Unit of Service	*A service unit is the basis on which a service is reported and reimbursed. A DPH unit of service is one hour of service provided to an enrolled child and/or family member. A MassHealth unit of service is 15 minutes of service provided to an enrolled child, i.e. one DPH unit = 4 MassHealth units.* *Providers may bill units to DPH in fifteen-minute segments within the billing restrictions for each service. Providers may only bill for full fifteen-minute segments; thus a twenty-minute intervention would be billed as a 0.25 unit.*
Vendor	*A vendor, often referred to as a provider, is an approved organization with which the state conducts business. A vendor may manage many Early Intervention programs as well as other contracts with DPH. A specific provider code, based upon a FEIN number, is assigned for each vendor.*
Working Hour	*A work hour is defined as one hour worked. For example, if three professionals work together for one hour to complete an assessment, the assessment is three working hours.*

A. Billable Services

Providers can bill DPH for the following types of services:

Service type	Insurance Procedure Code (data field: DMACODE)	HIPAA Modifier	DPH Code (data field: SERVICE)	DPH Modifier Code (data field: DENNUM)
Home Visit or EI Intake	H2015		A	1, 2 or 3
Center Individual Visit	T1015		B	1 or 2
EI-Only Child Group	96153	U1	N	1
Community Child Group	96153	U2	M	2
Parent Group	T1027		D	
Initial Assessment	T1024		G	
Ongoing Assessment	T1024		H	
CHA Screening	T1023		E	

Information on autism services is located in Appendix VI.

1. Home Visit

Definition
A face-to-face meeting at the client's home or at an approved setting outside of the center-based site, with the client, the client's caregiver, or both, and professional staff member(s) for the purpose of furthering the client's developmental progress.

Service Codes
DPH Service code (data field: SERVICE): A
CMS Service code (data field: DMACODE): H2015
Modifier (data field: DENNUM):

1 - Regular home visit
2 - IFSP home visit
3 - Assessment home visit

The purpose of the CMS Service code modifier is for DPH reporting only. It is not a modifier that needs to be reported to third party. All IFSP Home Visit and assessment Home Visit meetings billed to a third party would be reported to the third party as a regular home visit and reported to DPH with the modifier.

A regular home visit service that is no longer than 2.00 hours (one or two clinicians combined) can be billed after the completion of an assessment (regardless of eligibility) for the purpose of notification of eligibility.

Home Visit Types
REGULAR HOME VISIT

Billing Requirements

- Home visit service hours are *not to exceed two hours per clinician per day*
- There is no DPH restriction on the number of regular home visit hours per day
  Note: Some payers, such as MassHealth, may restrict the number of home visit hours they will pay per day

Note: DPH allows programs to provide a home visit after the determination that the child is ineligible on an initial evaluation in order to go over the eligibility determination and provide parents with recommended next steps.

ASSESSMENT SERVICE PROVIDED AS A HOME VISIT
If all 10 assessment hours have been exhausted since the child's assessment anniversary date, a provider may provide assessment services and bill these services as a home visit. These services must be documented in the child's record as assessment home visits.

Billing Requirements

- Home visit service hours are *not to exceed two hours per visit per clinician per day*
- There is no DPH restriction on the number of assessment home visit hours per day
  Note: Some payers, such as MassHealth, may restrict the number of home visit hours they will pay per day

- If two staff of the same discipline participate in an assessment home visit meeting, a request for reimbursement waiver *does* need to be requested prior to service delivery; otherwise, one of the services will be rejected by DPH as a duplicate.
- A home visit provided for assessment activity should be coded appropriately for DPH reporting purposes by using the correct service modifier code (data field: DENNUM=3).

IFSP SERVICES PROVIDED AS A HOME VISIT

An IFSP meeting must be billed as a home visit or center individual service. An IFSP home visit should be documented in the progress notes as an IFSP meeting. The number of staff to attend this meeting should be decided in consultation with the family and based on the individual needs of the child and family; there is no maximum number of people allowed at this type of meeting.

Billing Requirements

- Home visit service hours are *not to exceed two hours per clinician per day*
- There is no DPH restriction on the number of IFSP home visit hours per day
  Note: Some payers, such as MassHealth, may restrict the number of home visit hours they will pay per day
- An IFSP home visit meeting is not a co-visit.
- If two staff of the same discipline participate in an IFSP home visit meeting, a request for reimbursement waiver does *not* need to be requested prior to service delivery. The service modifier (data field: DENNUM) will prevent these records from being rejected as duplicate claims.
- A home visit provided for IFSP development should be coded appropriately for DPH reporting purposes by using the correct service modifier code (data field: DENNUM=2).

CO-TREATMENT HOME VISIT

A co-treatment visit involves *two or more* EI Specialists, the enrolled child, the enrolled child's parent, or both. Co-treatment visits are usually for the purpose of consultation and coordination regarding treatment planning and approaches to treatment.

It is important to understand that this co-treatment definition is a clinical definition providing guidance to EI programs regarding clinical practice. When billing third party payers home visit billing requirements must be maintained, regardless of the fact that the home visit is a co-treatment.

Billing Requirements

- A co-treatment session is billed as either a home visit or center visit service
- A co-treatment is billed on the basis of working hours with a maximum reimbursement of two hours per EI Specialist
- Reimbursement for a co-treatment home visit is limited to *four working hours per session or visit*
- Reimbursement for one co-treatment is allowed per month for an enrolled child
- Consultative visits by specialty providers under contract with DPH for children with low incidence conditions are not considered co-treatment under these reimbursement guidelines.

MassHealth or Insurer Restrictions

- If a MassHealth child receives more than 4 hours of a regular, IFSP or assessment home visit in one day then submit any excess hours not allowed by MassHealth to DPH* using a reason code of B14 *(Payment denied due to insurer maximum has been exceeded)*
- If an insured child receives more hours of home visit than is allowed by the insurer in one day then submit any excess hours to DPH* using a reason code of B14 *(Payment denied due to insurer maximum has been exceeded*

**Important:* In providing support documentation providers must reference MassHealth and other insurer regulations regarding limitations on the number of hours and sessions allowed per day for home visits.

2. Intake Home Visit

Definition

All non-assessment activity (assessment is defined as the "administration and scoring of the tool") that occurs as part of the intake process and that consists of information sharing and gathering with the family.

Service Codes

DPH Service code (data field: SERVICE): I
CMS Service code (data field: DMACODE): H2015

Billing Requirements:

- Service setting (data field: waiver): H01 (at the child's home)/H02 (outside child's home)
- Maximum hours: 2.00 per client referral per EI program
- Must occur on or prior to assessment activities or any other service type
- Two staff are allowed to provide an Intake service if they do not exceed the 2 hour maximum. Intake services can occur on two days but must occur within two weeks of one another and must occur on or prior to assessment activities.

NOTE: If a program is administering part of the Battelle Developmental Inventory – 2 (i.e. social emotional interview questions), a formal or informal family assessment tool, or gathering information related to risk factors for eligibility the program should bill this activity as "evaluation/assessment" at that initial visit. If both intake activities (sharing of information, establishing a relationship, etc.) and assessment are occurring at the first visit they should breakout the activities for billing purposes.

Programs are reminded that if the Personal-Social portion of the Battelle is started during the first face-to-face visit with the family that this activity must be billed as an assessment and the *Date of Testing* and EIIS *Date Tool First Used* should be this date. Programs have two weeks to complete the Battelle from this date. Additionally, programs should bill assessment time for the administration of other formal or informal assessment tools used in the eligibility determination process.

EI programs have the option to provide an Intake Visit or not at the first face-to-face visit with the family. A program is not required to bill Intake Visit at the initial face to face if they have gathered pre-assessment information from the family over the phone, and provided written notice of the evaluation/assessment activity.

3. Center Individual Visit

Definition

A face-to-face meeting at an Early Intervention program's site (or an approved satellite site), of one client or one client's caregiver, or both, with professional staff member(s) for the purpose of furthering the client's developmental progress.

Center-based individual visits must be provided for a scheduled period of time ranging from 15 minutes to two hours.

Service Codes

DPH Service code (data field: SERVICE): B
CMS Service code (data field: DMACODE): T1015
Modifier (data field: DENNUM):

1 = Regular center-individual service
2 = IFSP meeting

The purpose of the CMS Service code modifier is for DPH reporting only. It is not a modifier that needs to be reported to third party insurers and, in fact, it is not HIPAA compliant. All IFSP Individual Center Visit meetings billed to a third party would be reported to DPH with the modifier.

Center Individual Visit Types

REGULAR CENTER INDIVIDUAL VISIT

Billing Requirements

- A center individual visit is provided for a scheduled period of time ranging from 15 minutes to two hours, *not to exceed two hours per clinician per day*
  Note: Some payers, such as MassHealth, may restrict the number of home visit hours they will pay per day
- Center individual services may be provided in conjunction with child group services if this arrangement is clearly specified on the child's IFSP.
  - Total billing time for a child receiving center-based individual service in conjunction with child-focused group may be provided for a period of time that is one hour or less.
  - The combination of time for the center individual and group service must not exceed the scheduled duration of the group.

IFSP Center Individual Service Meeting

An IFSP meeting must be billed as a home visit or center individual service. An IFSP center individual meeting should be documented in the progress notes as an IFSP meeting. The number of staff to attend this meeting should be decided in consultation with the family and based on the individual needs of the child and family; there is no maximum number of people allowed at this type of meeting.

Billing Requirements

- An IFSP center individual visit meeting is provided for a scheduled period of time ranging from 15 minutes to two hours, *not to exceed two hours per clinician per day*
  Note: Some payers, such as MassHealth, may restrict the number of home visit hours they will pay per day
- An IFSP meeting is not a co-visit.
- If two staff of the same discipline participate in an IFSP center individual visit meeting, a request for reimbursement waiver does *not* need to be requested prior to service delivery. The service modifier (data field: DENNUM=2) will prevent these records from being rejected as duplicate claims.
- A center individual service provided for IFSP development should be coded appropriately for DPH reporting purposes by using the correct service modifier code (data field: DENNUM=2).

Co-Treatment Center Individual Visit

Definition: A child visitor center-based individual visit that involves two professional staff members and the client, the client's caregiver, or both.

A co-treatment visit involves *two or more* EI Specialists, the enrolled child, the enrolled child's parent, or both. Co-treatment visits are usually for the purpose of consultation and coordination regarding treatment planning and approaches to treatment.

It is important to understand that this co-treatment definition is a clinical definition providing guidance to EI programs regarding clinical practice. When billing third party payers home visit billing requirements must be maintained, regardless of the fact that the home visit is a co-treatment.

Billing Requirements

- A co-treatment session is billed as either a home visit or center visit service
- A co-treatment is billed on the basis of working hours with a maximum reimbursement of two hours per EI Specialist
- Reimbursement for a co-treatment visit is limited to *four working hours per session*
- Reimbursement for one co-treatment is allowed per month for an enrolled child
- Consultative visits by specialty providers under contract with DPH for children with low incidence conditions are not considered co-treatment under these reimbursement guidelines.

4. Child Group: Community Child Group

Definition
A face-to-face meeting at a community site, as defined in 101 CMR 349.02, facilitated or co-facilitated by professional staff members (Early Intervention Specialist) and designed to further the client's developmental progress and which must include both children enrolled and not enrolled in Early Intervention.

The purpose of the group is to enhance each child's development, and to provide opportunities for young children to come together. The Community Child Group supports the concept that Early Intervention services are most effective when provided as part of a families' everyday routines and activities. Community Child Groups are provided in locations where young children are welcome and typically spend time. Everyday places may include childcare settings, playgrounds, libraries, community centers, Early Intervention programs, or other neighborhoods and community programs. This Child Group should be specified on the IFSP as a "Community Child Group."

Service codes
DPH Service code (data field: SERVICE): M
CMS Service code (data field: DMACODE): 96153
Modifier (data field: DENNUM): 2

Staff-to-Child Ratio
Parents do not need to be present. If present, a parent is counted as one adult in the staff-to-child ratio. If no parents are present in the room, the child to adult ratio will not exceed two to one for children under eighteen months of age, or three to one for those over eighteen months of age. More staff may be present depending on the needs of the group. Child group sessions may occur in sites other than the regular EI program site (e.g. public buildings, private homes, approved satellite sites, etc).

Billing Requirements
- Child groups are provided for a scheduled period of time ranging from 1 to 2 ½ hours per group, not to exceed a total of 2-1/2 hours per week for an individual child.
- Child groups do not meet more than two times weekly
- A group consists of 2 or more children
- One certified EI staff person bills for each individual child participating in the group
- For children receiving center individual services in conjunction with a child group service, the total billing time may not exceed the scheduled duration of the child group
- Billing for child group services is based on the attendance of each individual child, and not on the scheduled duration of the group (i.e. a child arriving half an hour late for a two-hour group is billed for one and one-half hours of child group).
- An EI program must obtain a request for reimbursement waiver from DPH for the following:
    - Reimbursement if child group exceeds 2-1/2 hours per week
    - Reimbursement if child group meets more than twice a week
    - *NOTE: The first 2.5 child group hours must be billed to the appropriate insurer. Child group services that exceed this can then be billed to DPH.*

5. Child Group: EI-Only Child Group

Definition

A face-to-face meeting of a group of children enrolled in Early Intervention, facilitated or co-facilitated by professional staff members and designed to further the client's developmental progress.

The purpose of the group is to enhance each child's development, and to provide opportunities for young children to come together. The only participants in an EI-only child group are children and families enrolled in EI. When a child participates in an EI-Only Child Group, the child's IFSP must include appropriate clinical justification as to why outcomes cannot be achieved in a natural setting, as well as a plan to move toward group services in a community setting. The justification and the plan need to be reviewed a minimum of every six months through the IFSP process. This Child Group should be specified on the IFSP as "EI-Only Child Group."

Service codes
DPH Service code (data field: SERVICE): N
CMS Service code (data field: DMACODE): 96153
Modifier (data field: DENNUM): 1

Staff-to-Child Ratio
Parents do not need to be present. If present, a parent is counted as one adult in the staff-to-child ratio. If no parents are present in the room, the child to adult ratio will not exceed two to one for children under eighteen months of age, or three to one for those over eighteen months of age. More staff may be present depending on the needs of the group. Child group sessions may occur in sites other than the regular EI program site (e.g. public buildings, private homes, approved satellite sites, etc).

Billing Requirements

- Child groups are provided for a scheduled period of time ranging from 1 to 2 ½ hours per group, not to exceed a total of 2-1/2 hours per week for an individual child.
- Child groups do not meet more than two times weekly
- A group consists of 2 or more children
- One certified EI staff person bills for each individual child participating in the group
- For children receiving center individual services in conjunction with a child group service, the total billing time may not exceed the scheduled duration of the child group
- Billing for child group services is based on the attendance of each individual child, and not on the scheduled duration of the group (i.e. a child arriving half an hour late for a two-hour group is billed for one and one-half hours of child group).
- An EI program must obtain a request for reimbursement waiver from DPH for the following:
    - Reimbursement if child group exceeds 2-1/2 hours per week
    - Reimbursement if child group meets more than twice a week
    - *NOTE: The first 2.5 child group hours must be billed to the appropriate insurer. Child group services that exceed this can then be billed to DPH.*

6. Parent Focused Group

Definition

A face-to-face meeting of a group of clients' parents and persons filling the role of parents (for example, a grandparent, foster parent or guardian, but not a day-care worker) with professional staff members (Early Intervention Specialist), for the purpose of support and guidance.

Time-limited (one or more sessions), topic-specific parent educational groups may be provided as Parent-Focused Groups. These sessions are based on a specific curriculum and have an evaluation component, kept on file at the program.

A group for other members of the enrolled child's family, including siblings, may be offered for not more than twelve sessions in a twelve-month period. These sessions will be based on a specific curriculum that addresses the impact of the developmental needs of the enrolled child or family members.

Service codes
DPH Service code (data field: SERVICE): D
CMS Service code (data field: DMACODE): T1027

Billing Requirements

- A parent group may be reimbursed for once a week for up to one and one-half hours per week. This timeframe is for both parents, not per parent.
- If an EI program schedules a single session educational group (i.e. a speaker comes in to discuss parenting issues) the program is expected to assume the cost of that session.
- An EI program must obtain a request for reimbursement waiver from DPH for the following:
  - Reimbursement if a parent attends a parent group that exceeds 1-1/2 hours
  - Reimbursement if a parent attends more than one parent group (if the combination of the two groups does not exceed 1-1/2 hours a request for reimbursement waiver is still needed)
  - Reimbursement if two parents attend the same parent group (if the combination of the two groups does not exceed 1-1/2 hours a request for reimbursement waiver is still needed)
  - *NOTE: The first 1.5 parent group hours must be billed to the appropriate insurer. Parent group services that exceed this can then be billed to DPH.*
- Sibling groups are billed as parent groups and must meet all parent group requirements

- An EI program must obtain a request for reimbursement waiver from DPH for the following:
  - Reimbursement if parent group exceeds 1-1/2 hours per week
  - Reimbursement if parent group meets more than once a week
  - *NOTE: The first 1.5 parent group hours must be billed to the appropriate insurer. Parent group services that exceed this can then be billed to DPH.*

7. Comprehensive Health Assessment (CHA) Screening

Definition

An initial face-to-face meeting of a client (EIPP-referred child) and client's caregiver with a professional staff member (Early Intervention Specialist) to determine whether the client would be appropriately placed.

Referrals to an EI program for a CHA will be recommended to EIPP families at specified times during the child's first year of life. A child enrolled in EIPP and referred to EI for a CHA will be entered into the EI Client system (EIIS). At this point in time they are considered both an EIPP and EI client. It is expected that this service be billed to the appropriate insurer. If billed to DPH an appropriate reason code must be included.

Service codes
DPH Service code (data field: SERVICE): E
CMS Service code (data field: DMACODE): T1023

Billing Requirements

- Child must be enrolled in EIPP
- A CHA may not exceed 1-½ hours
- Third Party Payer Considerations: It is *IMPORTANT* that the EI vendor check with the child's insurer regarding how many hours of the service should be billed. MassHealth and commercial insurers are mandated to pay for only 1.0 hour of a CHA service. DPH may be billed for the additional ½ hour as a partial pay adjustment. The SDR file must show the 1.5 hours under the original claim transaction *(regardless of whether the insurer was billed 1.0 or 1.5 hours).*
- Only one clinician may bill for a CHA service.
- A child can be referred to EI for a CHA service up to five times between a child's birth and their first birth date. Service guidelines follow:
  - 0 to 2 months of age: maximum of 1 service
  - 4 additional services after 2 months of age to occur at 4, 6, 8 and 12 months of age
- Last CHA: The 12-month CHA can be provided up to and including 30 days after the date of the child's one-year birth date.

8. Assessment

General Definition
A comprehensive evaluation of the child's developmental status and family situation, involving the use of a normed developmental assessment tool and measuring fine and gross motor skills, cognitive ability, communication skills, affect and temperament, self care and feeding skills, socialization, family interactions, and social and economic support systems available to the family.

An assessment consists of on-going procedures used by appropriately qualified personnel throughout the period of a child's eligibility for services to identify (1) the child's unique strengths and needs and the services appropriate to meet those needs; and (2) the resources,

priorities and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs for their child.

An evaluation for the determination of eligibility and an assessment of strengths and needs is performed by a multidisciplinary EI team. An evaluation for the determination of eligibility is performed either every six months or annually (depending on eligibility type).

Initial Assessment

Definition

All assessment/evaluation activities completed up to the Initial IFSP signature date are defined as an initial assessment. If a child has been re-referred or transferred from another EI program and the eligibility timeframe has expired (**the child is not under an active IFSP**) then the assessment/evaluation is considered an initial assessment.

Service Codes

DPH Service code (data field: SERVICE): G
CMS Service code (data field: DMACODE): T1024

Ongoing Assessment

Definition

All assessment/evaluation activities for children with active IFSP's are defined as an ongoing assessment. If a child has been re-referred or transferred from another EI program and the eligibility timeframe **has not expired** than any assessment/evaluation activities are considered ongoing assessment.

Service Codes

DPH Service code (data field: SERVICE): H
CMS Service code (data field: DMACODE): T1024

Assessment Hours

A child has a total of ten hours of assessment hours for billing purposes. Assessment hours are renewed one year from the date of the first billed assessment service. This assessment anniversary date stays the same for the child until he/she reaches the age of three. This holds true for children who leave EI services and return at a later time. The exception to this is for children who leave EI and return at a time beyond the anniversary date or in cases where the next eligibility assessment occurs after the anniversary date. In these cases the assessment anniversary date is reassigned according to when assessment services begin again.

In the case of a child who transfers to another EI program, the receiving program should request the assessment history, including the assessment anniversary date and assessment hours used during the current assessment period.

Note: if the child does not have any assessment hours left then bill assessment services as a home visit. You must meet all home visit requirements when doing this.

Billing Requirements

- Assessment hours are limited to ten hours per year based on the child's anniversary date.

B. Units of Service

1. DPH Units of Service

A service unit is the basis on which Early Intervention services are reported and reimbursed. A full unit of service for DPH reporting is one hour of service provided to an enrolled child and/or family member. The service delivery or billing date is the date that the service was delivered, not accrued and batched together.

Providers may bill units in fifteen-minute segments within the billing restrictions for each service. *Providers may only bill for full fifteen-minute segments; thus a twenty-minute intervention would be billed as a 0.25 unit.*

2. MassHealth Units of Service

A MassHealth unit of service is 15 minutes of service provided to an enrolled child, (one DPH unit of service is equivalent to 4 MassHealth units).

A claim submitted to MassHealth is written in 15-minute units. Reporting the MassHealth claim on the DPH service delivery data file is written in one-hour units. For example, a claim to MassHealth for a 90 minute home visit = 6 MassHealth units. Report this service on the service delivery file transmitted to DPH as 1.50 units.

C. Early Intervention Rates for Services

The Massachusetts Center for Health Information and Analysis (CHIA) establishes EI service unit rates. Public Hearing announcements and rate revisions are sent to all certified providers and interested parties (information about rates and rate setting is available directly from CHIA, 2 Boylston Street, Boston MA 02166).
The approved rate is inclusive of payment for all care and services that are a customary part of any certified EI program, including administration, supervision, travel, transportation, and support services.

All Early Intervention services are billable to all payers at the established rates. The following rates are effective for all services with service dates between January 1, 2014 and February 29, 2016.

Service Type	1.0 Unit	.75 Unit	.50 Unit	.25 Unit
Home Visit	$81.80	$61.35	$40.90	$20.45
Center Individual Visit	68.6	51.45	34.30	17.15
EI Only Child Group	23.88	17.91	11.94	5.97
Community Child Group	31.4	23.55	15.70	7.85
Parent Group	30.68	23.01	15.34	7.67
Assessment (and Evaluation)	109.72	82.29	54.86	27.43
CHA Screening	95.6	71.70	47.80	23.90

The following rates are effective for all services with service dates on or after March 1, 2016.

Service Type	1.0 Unit	.75 Unit	.50 Unit	.25 Unit
Home Visit	$89.40	$67.05	$44.70	$22.35
Center Individual Visit	74.96	56.22	37.48	18.74
EI Only Child Group	26.12	19.59	13.06	6.53
Community Child Group	34.32	25.74	17.16	8.58
Parent Group	33.52	25.14	16.76	8.38
Assessment (and Evaluation)	119.92	89.94	59.96	29.98
CHA Screening	104.48	78.36	52.24	26.12

D. Billable Staff Members

Only Early Intervention professional staff members, who meet the required credentials and are certified by DPH as Early Intervention Specialists can bill for EI services. The minimum credentials for provisional certification as an Early Intervention Specialist are specified in the EI Operational Standards.

The following provides DPH codes for service delivery reporting for each of the professional disciplines:

DPH Code	Professional Discipline
AA	Developmental Specialist (as stated under categories a, b and c of the EI Operational Standards)
BB	Developmental Specialist (as stated under category d of the EI Operational Standards)
CS	Mental Health
NS	Nursing
OA	Occupational Therapy Assistant
OT	Occupational Therapy
PA	Physical Therapy Assistant
PT	Physical Therapy
SW	Social Work
SA	Speech Language Pathology Assistant
SP	Speech and Language Pathology
SS	Specialty Provider

Therapy Assistants

The therapy assistant codes (OA, PA and SA) are for DPH reporting purposes only. Services rendered by a therapist assistant would be billed to a third party under the existing CMS professional discipline code that the assistant position falls under.

- MassHealth does not cover services rendered by speech/language pathology assistants but will reimburse for services provided by occupational therapy assistants and physical therapy assistants. Services delivered to MassHealth clients by speech/language

pathology assistants would be billed directly to DPH using a reason code of 52 (The rendering provider is not eligible to perform the service billed).

- If MassHealth is the secondary insurer services rendered by a speech/language pathology assistant should be billed to the primary insurer with any remaining charges not paid by the primary insurer being billed to DPH with a reason code of 52 (The rendering provider is not eligible to perform the service billed).

- Blue Cross/Blue Shield does not cover services rendered by speech/language pathology, physical therapy or occupational therapy assistants. Services delivered to BC/BS clients by a therapy assistant would be billed directly to DPH using a reason code of 52 (The rendering provider is not eligible to perform the service billed).

<u>Billing Requirements</u>

- Both a licensed professional discipline and a therapy assistant under the same discipline can provide the same type of service for a child on the same day at different times; services will not be considered duplicative for DPH. The exception to this is for an IFSP home visit. A licensed professional discipline and a therapy assistant can attend an IFSP home visit and both can bill for this service.
- A home visit with the therapy assistant and his/her supervisor for the purposes of supervision would be billable only for the licensed therapist providing supervision.
- Therapy Assistants do not perform initial evaluations or ongoing assessments but may provide data and input into the IFSP development. Therefore, they are not permitted to bill for evaluation/assessment activities.

V. DOCUMENTATION OF SERVICE DELIVERY

Services are documented to meet the clinical, billing, and reporting needs of EI programs and the Department of Public Health. Service delivery information is recorded in the client's individual client record at each Early Intervention program. EI Specialists should keep a summary of the service information in a daily log. Third party payer claims and the DPH Service Delivery Reports (SDR), which act as DPH invoices, are prepared from the Daily Logs. The service delivery contains information required for reporting to DPH and includes third party payer information.

DEFINITIONS for Documentation of Service Delivery

Daily Log	*Early Intervention Specialists should maintain a daily log of all client services. This daily log is essentially an attendance record and should relate to the documentation in the individual client record. The daily log indicates the name of the child/family receiving the service, the date of service, the type of service, the signature of the EI Specialist who provided it and the number of units of service provided. The daily log should be maintained at the program site and be readily available for routine monitoring. While providers do not need to submit a copy of the daily log to DPH, it provides service delivery and claim documentation for the billing and reporting of claims.*
Individual Client Records	*Each service delivered to a child, and/or family member must be documented in the individual client record. These records must meet documentation requirements outlined in the EI Operational Standards and are necessary to support units billed to DPH. Individual client records must be available to DPH staff for routine monitoring.*
Service Delivery Report (SDR)	*The Service Delivery Report (SDR) is an automated data file of a program's service delivery records submitted to DPH. The SDR provides DPH with information about patterns of service delivery and payment sources for all third party payers in the state. The SDR is submitted to DPH and used to create a payment voucher. Once DPH creates the payment voucher, the SDR serves as the support documentation for the payment voucher.*

A. Individual Client Records

Each service delivered to a child and/or a family member must be documented in the individual client record along with contact or progress notes. These records must include the date of service, service type, duration, who was present during the service, and the signature of the person delivering the service. This information is necessary to support units billed to DPH. Individual client records must be available to DPH staff for routine monitoring.

B. Daily Log

Each person delivering direct service to a child and/or family must keep a Daily Log or Daily Calendar that relates to the documentation in the individual client record. The daily log record includes the following: name of the child/family receiving the service, date of service, type of service, staff member providing service, number of units of service provided, and insurance information. These logs are turned in daily or at least once a week and information is taken from them to generate claims and service delivery reports. Daily logs should be maintained at the program site and be readily available for routine monitoring. While providers do not need to submit a copy of the daily log to DPH, it is the basis for completing the SDR.

C. Maintenance of Documentation

Any type of documentation of service delivery must be maintained by the EI program for a minimum of seven years. This includes individual client records, the daily log, remittance advises, EVS checks, etc.

VI. SUBMISSION OF CLAIMS TO DPH

Early Intervention programs must justify claim submission to DPH, including documentation that demonstrates due diligence by EI staff at securing insurance for non-insured families. All records, invoices and related documents and equivalent electronic transmissions submitted to the Department of Public Health shall be under the pains and penalties of perjury as true, correct and accurate as attested by the Executive Director or Chief Financial Officer of the Agency**.**

DEFINITIONS for Submission of Claims to DPH

EI TVP Website	*The EI Transaction Validation Program (TVP) website is available to EI programs to be used to upload service delivery report (SDR) files. The website summarizes services and payer transfer charges and generates validation reports.*
EIIS Client Registration Database	*The EIIS client registration database supports the collection and management of data on the infants and toddlers in each EI program. Information collected includes referral, socio-demographics, functional status, medical diagnosis, eligibility criteria, IFSP services and discharge information.*
Fiscal Year	*A fiscal year is a period of 12 consecutive months used as an accounting period for revenue and expense reporting. The fiscal year for the state of Massachusetts starts July 1st and ends June 30th of the following year.*
Invoice	*An invoice is a summation of DPH claims from the Service Delivery Report (SDR) file.*
Payment Voucher	*A payment voucher (PV) is a document that generates a summary and total of payable services received, authorizes the disbursement of funds, and references the appropriate encumbrance against which a payment will be charged.*
Provider	*A provider, also known as the vendor, is an approved organization with which the state conducts business. A provider or vendor may manage many Early Intervention programs as well as other contracts with DPH.*
Supplemental Claims	*For Early Intervention services, supplemental claims are those claims submitted to DPH after the close of the state fiscal year (end of August). Early Intervention programs have until March 10th of the following year to research and submit claims for services.*
Support Documentation	*EI providers must be able to document due diligence in their attempts to resolve non-covered claims before submitting them to DPH. Examples of support documentation justifying DPH payment of claims to be included with the Explanation of Benefits (EOB), Explanation of Payments (EOP) or Statement of Accounts for corresponding dates of service include: MassHealth EVS(Eligibility*

	Verification System) printout, insurer eligibility print outs, correspondence from insurers, verbal confirmation from an insurer with a corresponding trace/tracking/verification number, employer non-covered account or group number , electronic non-covered reports from insurers, appeals, etc. Support documentation must justify why claims have been submitted to DPH and specify efforts to address all avenues of reimbursement with other payers prior to submitting the claims to DPH. Support documentation showing that third party billing rules have been followed must also be made available to DPH for review upon request.

A. Early Intervention Information System (EIIS)

DPH oversees all data transmitted to DPH from EI programs via the EIIS Client Registration system and the EI TVP website as well as request for reimbursement waiver information collected by and received from DPH staff. This data is processed for service validation and payment voucher processing and is used for reporting to state and federal agencies. *In order to report child count and process billing information, DPH depends on accurate and timely submission of client information to the EIIS Client Registration database and the transmission of the service delivery data (SDR) through the EI TVP website.*

1. EIIS Client Registration Database

The EIIS Client Registration database supports the collection and management of data by the EI program during referral, assessment, eligibility determination, IFSP determination, and discharge of clients. Although the client registration database performs functions separate from billing, there are certain key elements in the database required for billing. If he following information is not available in the client database before the submission of any service delivery data, claims will remain unpaid:

- *Client ID:* The EIIS Client Registration software application generates an ID (and/or enables program staff to enter an ID) that MUST also be submitted as part of each record or claim line in the SDR file. DPH matches these ID numbers to the claims reported. Any record that does not match will be suspended (on hold) for payment. If the problem is not resolved by the close of fiscal year submission, the service will remain unpaid.

  New client referrals should be entered into the EIIS client registration application and transmitted to DPH within 10 days of the first date of service. Doing so will avoid unpaid claims.

  Programs and providers should take care to ensure that client ID numbers are entered correctly in both their billing and EIIS client system. Names and client IDs are transmitted to DPH from a program's EIIS client database. However, only client IDs are included on claims and service delivery records submitted to DPH.

The client ID on claims are used by DPH to match with the EI Insurance file and are also used to match claims to all support documentation sent to DPH from providers.

- *Client name, sex, birth date, referral and last service date:* The child's name, sex, birth date, referral and last service date must be complete and accurate in the EIIS Client database. If any of these data elements are missing, services will not be paid and will remain unpaid until the data has been entered. Additionally, if a service date comes before the EIIS referral date or after the EIIS last service date then services will remain unpaid until a correction is made.

- *Referral, Evaluation, IFSP and Discharge Data:* Referral, evaluation, IFSP and discharge data must be complete and accurate. Although there are currently no business rules that prevent claims from being paid if this data is incomplete, future constraints may be implemented on previously submitted and future services that may impede payments to EI providers. This data is critical for determining child count. This and other client data are used in reporting information to the legislature during their deliberations concerning the level of funding that Early Intervention is to receive.

2. Service Delivery Report/Invoice

The Service Delivery Report (SDR) is an electronic file of a program's service delivery records (claims). The SDR file provides DPH with service information and payment sources. Providers *MUST* submit this report to DPH electronically via the Early Intervention TVP website.

Service delivery report data must be generated and submitted in accordance with DPH specifications from the provider's billing system. The current specifications are included in *Appendix I, "EI Service Delivery Data Transmission Specifications."*

B. Claims Submission Deadlines

1. Monthly Submission Deadlines

Programs should submit invoices through the EI TVP website by the 10th of the month. If the 10th falls on a weekend or holiday the deadline becomes the next working day.

2. Fiscal Year Deadlines

The deadline for electronic supplemental claims to be submitted is March 10th of each year. If this deadline cannot be met, providers must submit a written request to the EI fiscal manager for an extension to DPH. Service records submitted after the deadline without Department of Public Health approval will not be considered for payment.

The deadline for the submission of support documentation sent to the EI fiscal manager is May 1st of each year.

Credits to DPH can be submitted until July 10th of each year. After the close of the fiscal year and processing of all credits an credits that providers receive from other payers where DPH has also paid should be included on a check made to the "Commonwealth of Massachusetts" and submitted to the EI fiscal manager.

VII. DPH PROCESSING FOR CLAIM APPROVAL

All SDR files received by DPH from the EI TVP website are inserted into an existing service delivery database at DPH. Your SDR file containing multiple fiscal year data will be split up at DPH according to fiscal year as designated by the date of service on each SDR record.

DEFINITIONS for DPH Processing for Claim Approval

Claim and Line Status	*Claim: one or more records that share the same program code, client ID, record number, and service date. A claim has the potential of containing multiple records or transactions.* *Line status: based on the error codes resulting from either passing or failing DPH business rules, the line status can entail one of the following: ACCEPT (passed all business rules), DENIED, SUSPEND, PENDED, WPEND, or REJECT.* *Claim status: summary of all line statuses within a claim. If all the records within a claim have an ACCEPT line status, the claim status will also read ACCEPT. If one or more of the records within a claim have a PENDED or WPEND line status, the claim status for all claim records will read as PENDED or WPEND. Thus one line status that reads PENDED or WPEND will cause the claims status for all records of that claim to be pended. This is the same for claims with a SUSPEND status.* *Claim records with a REJECT line status are not associated with other records; they are removed from all ACCEPT, DENIED, PENDED, WPEND and SUSPEND records.*
Client	*Recipient of service(s) provided by an Early Intervention program and include a child, his or her parent(s) and/or siblings.*
EI TVP Website	*The EI Transaction Validation Program (TVP) website is available to EI programs to be used to upload Service Delivery Report files. The website summarizes all appropriate claims to DPH and generates validation reports.*
EIIS Client Database	*The EIIS client registration database supports the collection and management of data on the infants and toddlers in each EI program. Information collected includes socio-demographics, functional status, medical diagnosis, eligibility criteria, and discharge status.*
Fiscal Year	*A fiscal year is a period of 12 consecutive months used as an accounting period for revenue and expense reporting. The fiscal year for the state of Massachusetts starts July 1st and ends June 30th.*

Provider	*A provider, also known as the vendor, is an approved organization with which the state conducts business. A provider or vendor may manage many Early Intervention programs as well as other contracts with DPH.*
Support Documentation	*EI providers must be able to document due diligence in their attempts to resolve non-covered claims before submitting them to DPH. Examples of support documentation justifying DPH payment of claims to be included with the Explanation of Benefits (EOB), Explanation of Payments (EOP) or Statement of Accounts for corresponding dates of service include: MassHealth EVS(Eligibility Verification System) printout, insurer eligibility print outs, correspondence from insurers, verbal confirmation from an insurer with a corresponding trace/tracking/verification number, employer non-covered account or group number , electronic non-covered reports from insurers, appeals, etc. Support documentation must justify why claims have been submitted to DPH and specify efforts to address all avenues of reimbursement with other payers prior to submitting the claims to DPH. Support documentation showing that third party billing rules have been followed must also be made available to DPH for review upon request.*
Vendor	*A vendor, often referred to as a provider, is an approved organization with which the state conducts business. A vendor may manage many Early Intervention programs as well as other contracts with DPH. A specific provider code, based upon a FEIN number, is assigned for each vendor.*

A. DPH Business Rules and Error Codes

1. Assigning Error Codes

When service delivery data are imported into the database at DPH, a series of fiscal year specific business rules are processed on them (*See Appendix IV, "Business Rules & Claim Status"* for current business rules in effect). Business rule violations include the following:

- Claim is a duplicate
- Reason for claim is unacceptable or requires additional review
- Client has not been registered in the EIIS client system
- Missing EIIS Client data (name, sex, birthdate)
- Date of service is prior to referral date
- Service date of claim occurs after the child's 3rd birth date
- Service hours exceed DPH standards
- No reimbursement waiver authorization for specified services
- Charge to DPH exceeds the value of the service
- Submission exceed DPH deadline

An error code is assigned to the SDR record identifying the business rule(s) the record did not pass. If the record passed all business rules, the error code data field will state "NO ERROR". Business rules at DPH, along with error codes, are defined in *Appendix I, "EI Service Delivery Data Transmission Specifications"*.

The implementation of some business rules cannot be automated at this time. Some claims may be paid that later must be credited back to DPH. In addition, some types of compliance, such as compliance with third party billing practices, can only be monitored on site. If discrepancies are identified after payment of claims has been made to the EI provider, providers are required to return payments to the Commonwealth either as credits to DPH on an SDR file or as a check to the Commonwealth.

2. Records with Multiple Error Codes

EI providers should review all rejected records and resolve the error code that caused the rejection prior to resolving any other error code that may appear on that record. Secondly, providers should resolve any error code that caused the record to suspend prior to resolving any pended error codes. If a provider submits support documentation for a record that has both suspended and pended this will result in an override to the pended error code but will not resolve the suspend.

B. Claim and Line Status

1. Definition of a Claim

A claim is defined as all lines that share the same EI program code, client ID, record number and service date. A claim has the potential of containing multiple lines.

Examples of claims follow:

Claim 1

Record type	Client	Record #	Sv date	Service	Hours	Charge	Payer
Initial record	99555551	8936457	9/15/14	Home visit	1.00	81.80	BC/BS
Adjmt record	99555551	8936457	9/15/14	Home visit	-1.00	-81.80	BC/BS
Adjmt record	99555551	8936457	9/15/14	Home visit	1.00	81.80	DPH

Claim 1: Initial record - 1 hour home visit billed to BC/BS
Claim 1: Adjustment record - 1 hour home visit denied by BC/BS
Claim 1: Adjustment record - 1 hour home visit billed to DPH

Claim 2

Record type	Client	Record #	Sv date	Service	Hours	Charge	Payer
Initial record	88444441	2333345	9/30/14	Child group	2.00	62.80	Tufts
Adjmt record	88444441	2333345	9/30/14	Child group		20.00	DPH

Claim 2: Initial record - 2 hour child group service billed to Tufts
Claim 2 Adjustment record - Tufts denies co-payment of $20.00

2. Assigning the Line Status

The DPH system runs all records through its business rules and assigns error codes where a line has failed a business rule. Claim and line status are assigned for each record based on whether the record passes or does not pass the business rules at DPH. A line may fail multiple business rules but will only have one line status assigned. Records that are not processed for payment will need further follow-up from either the EI program staff or DPH staff prior to DPH payment.

The following are the possible line statuses (based on error codes):

- Accepted: The claim line has passed all business rules.
- Suspended: SDR records are matched against the EIIS client database submitted to DPH from your EI program to ensure that clients receiving EI services are registered and certain EIIS client data is complete and logical. Most suspended SDR records occur due to the child's EIIS client ID differing from the EI program's practice management or billing system child ID. The claim line will be held, waiting for client data to be corrected and transmitted by the EI program via the EIIS Client Registration database.
- Pended:
  - Error codes 3E, 3F, 6F, 9N, 9P, 9R, 9S, 9V or 9Z: EI providers do not need to submit anything to DPH. DPH personnel will review the claim against the waiver database and override the error code if approved for payment.
  - Error codes 4C, 5B, 5H, 5K or 5P: the EI provider must submit support documentation (i.e., remittance advice, EOBs/EOPs, correspondence with third-party payers, EVS check) to the EI Fiscal Manager at DPH. The EI fiscal manager will review the claim for payment approval and override the error code if approved for payment.
  - If a line has failed business rules that both PEND and SUSPEND it, a line status of PENDED is always assigned.
- Rejected: The record is moved to a rejected database and DPH will not pay the claim line. Once rejected records are removed, the remaining records are processed for payment. The rejected records are not included as part of a claim's history and are ignored in all future claim processing; they do not affect the status of the remaining records in the database. An EI provider must examine each rejected record and its error code prior to deciding if any follow-up activity is needed. Claim records reprocessed in an EI program's practice management or billing system can then be resubmitted to DPH. **It is important to understand that DPH does not overwrite a rejected claim record with a resubmitted claim record.** Therefore, if the resubmitted claim record is rejected again, there will be two rejected records at DPH for the same claim.

- Not Processed: The claim line was rejected prior to being processed through the business rules at DPH. They will have an error code of either 20 or 40. These are rejected records that may be corrected and re-submitted.

3. Assigning the Claim Status

DPH assigns claim status to each record based on the combination of all line statuses within a claim. If the claim has multiple lines and all lines within this claim have a line status of ACCEPT, a claim status of ACCEPT is assigned to all of the records. DPH will approve for payment all DPH claim records whose claim statuses read ACCEPT. Most of these records will include the newly transmitted records. However, a record submitted on a previously transmitted file whose line status has changed from suspended or pended to accept will also be paid. **It is important to understand that the summation of a payment does not necessarily translate back to a particular reporting month and year. It may include records from multiple reporting months.**

If one or more records within a claim have a line status of PENDED or WPEND, all subsequent records received for the claim are assigned a claim status of PENDED or WPEND. The same holds true for SUSPENDED records.

Some examples follow:

Claim 1

Claim status	Line status	Error Code	Record type	Record #	Sv date	Charge	Payer
PENDED	ACCEPT		Initial record	8936457	9/15/14	81.80	BC/BS
PENDED	ACCEPT		Adjmt record	8936457	9/15/14	-81.80	BC/BS
PENDED	PENDED	5K	Adjmt record	8936457	9/15/14	81.80	DPH

The line status is assigned based on whether the line passed all DPH business rules.
The claim status does not allow any other record to be processed.

Claim 2

Claim status	Line status	Error Code	Record type	Record #	Sv date	Charge	Payer
PENDED	ACCEPT		Initial record	2333345	9/30/14	81.80	BC/BS
PENDED	ACCEPT	5P	Adjmt record	2333345	9/30/14	20.00	DPH

The line status is assigned based on whether the line passed all DPH business rules.
The claim status does not allow any other record to be processed.

If a claim has a status of REJECT the claim record is removed from the database so that resubmissions for that claim are processed correctly.

C. Additional DPH Claim Processing

1. **Overrides on Pended Claims in need of Support Documentation** (Error codes 4C, 5B, 5H, 5K, 5P and 5T)

   Documentation justifying DPH payment of claims that have pended due to their reason code should be submitted to the EI fiscal manager as soon as possible after the claim has been submitted electronically to DPH. A decision will be made at DPH, based on the documentation, regarding whether the pended status will be overridden in order for payment to occur. If a pended claim with documentation is not overridden for payment, DPH will not pay the claim. An override approval for a 5B or 5K error will clear all future submissions of claims for that child having the same primary insurance and reason code. Therefore, documentation for the earliest date of service having the 5B or 5K error is all that is needed. A change in status (new insurer or different reason code), of course, would result in a new pended error and additional documentation would be required to clear the error.

2. **Overrides on Pended Claims with a Request for Reimbursement/Waiver** (Error codes 3E, 3F, 6F, 9N, 9P, 9R, 9S, 9V and 9Z)

   Claims with waivers that have pended will be matched against the waiver database at DPH. Approved waivers are client specific, time limited and are assigned an authorization number. This number must be included on appropriate claims on a program's service delivery data file for the duration of the waiver. If a waiver does not exist, the claim records will not be approved.

1. Identifying Claim Records that have been Approved or Denied Payment

If the pended service has been reviewed the provider will find the following information on the remittance file for the record:

- *Service was approved for payment by DPH:* the PV data field will include the vendor's PV reference number, the line_status data field will state "ACCEPT" and the O_Status data field will identify the reason for payment.
- *Service was not approved for payment by DPH:* the PV data field will be blank, the line_status will state "PENDED" or "WPEND" and the O_Status data field will identify the reason for non-payment.
- *Service is on hold for payment:* the PV data field will be blank, the line_status will state "PENDED" and the O_Status data field will identify the reason for holding off approval. The provider does not need to provide any further information to DPH. DPH will either approve or refuse payment once information is received from insurers.

2. DPH Reconcilement of Payments due to SDR Problems

At times, a provider may identify service delivery data that was transmitted to DPH in error. If these data were imported into the SDR database at DPH and claim records were processed for payment approval, DPH cannot delete these records. Instead, a reconciliation record will be created that will credit the payment to DPH. The O_STATUS data field on your remit will provide an explanation for the credit.

DPH may identify that charges were paid to a vendor incorrectly. A reconciliation record will be created by DPH to adjust for this payment.

VIII. CREATION OF UNIT RATE PAYMENT VOUCHERS

DEFINITIONS for Creation of Unit Rate Payment Vouchers

MMARS or New MMARS	*Massachusetts Management, Accounting and Reporting System is the centralized, financial database system that supports the financial functions performed by the Commonwealth of Massachusetts.*
Payment Voucher	*A payment voucher (PV) is a document that generates a summary and total of payable services received, authorizes the disbursement of funds, and references the appropriate encumbrance against which a payment will be charged.*
PV (Payment Voucher) Reference Number	*A PV reference number is an ID that identifies claim records approved for payment. It consists of 11 characters composed of a three-character provider-specific code, the date the payment voucher was generated (YYMMDD), and a two-character fiscal year budget account reference. It is included on each approved claim record on the remittance file with the summation of these records included on the PV document.* *The PV reference number is different from the PV number found on the MassFinance website. The MassFinance PV number includes the fiscal year as the first characters.*
Supplemental Claims	*For Early Intervention services, supplemental claims are those claims submitted to DPH after the close of the state fiscal year (i.e.; August 31). Early Intervention programs have until March 10th of the following year after the close of the state fiscal year to research and submit claims for services.*
Support Documentation	*EI providers must be able to document due diligence in their attempts to resolve non-covered claims before submitting them to DPH. Examples of support documentation justifying DPH payment of claims to be included with the Explanation of Benefits (EOB), Explanation of Payments (EOP) or Statement of Accounts for corresponding dates of service include: MassHealth EVS(Eligibility Verification System) printout, insurer eligibility print outs, correspondence from insurers, verbal confirmation from an insurer with a corresponding trace/tracking/verification number, employer non-covered account or group number , electronic non-covered reports from insurers, appeals, etc. Support documentation must justify why claims have been submitted to DPH and specify efforts to address all avenues of reimbursement with other payers prior to submitting the claims to DPH. Support documentation showing that third party billing rules have been followed must also be made available to DPH for review upon request.*

Vendor Code	*A vendor code is the unique identifier used by MMARS to process payments for a vendor. This code is a 13-digit number, with the first 9 specifying the organization's FEIN number, and the next 3 defining an address for check distribution.*
Vendor Invoice Number	*A vendor invoice number is a system generated ten-digit number assigned by vendor to an invoice document. This field is 30 characters long and is also known as the payment reference number.*

A. State Fiscal Terms

The following provides some of the terms used as part of state fiscal for agency and provider funding.

Accounting Line Number	*A two digit number used in MMARS to reference the accounting line on an encumbrance or payment document.*
Appropriation	*The amount authorized by the Legislature for a specific period against which obligations can be incurred and expenditures made.*
Budget Fiscal Year	*Defines the period in which a fiscal years budget can be expended.*
Electronic Fund Transfer (EFT)	*Direct deposits to a business having a contract with the state for payments from the Commonwealth.*
Encumbrance	*A budget document that commits authorized funds for a specific purpose.*
Expenditure	*An outlay of cash for a specific purpose.*
Fiscal Year	*A period of 12 consecutive months used as an accounting period for revenue and expense reporting. The fiscal year for the state of Massachusetts starts July 1st and ends June 30th of the following year.*
House 1	*The Governor's operating budget recommendations for the next fiscal year.*
Invoice	*A summation of DPH claims from the Service Delivery Report (SDR) file. A summary of charges are generated on the EI TVP website for each upload SDR file.*
Legislative Branch	*The Massachusetts Legislature is a two house body consisting of 40 Senators and 160 Representatives.*
Object Codes	*A code that indicates the specific type of goods or services for which the Commonwealth funds are expected.*
Office of the Comptroller	*The Office of the Comptroller manages the proper accounting revenues and expenditures in the state accounting system (MMARS)*
Retained Revenue	*This type of revenue is classified as funds available for expenditure for the purpose of specific activities.*

State Finance Law	*Includes statutes, regulations, rules and policies for receiving and expending commonwealth fund and reporting these revenues and expenditures.*

B. The Payment Voucher

A payment voucher (PV) is the DPH document that generates a payment for services provided by an EI program and authorizes the disbursement of funds by referencing the appropriate accounting lines from which a payment to the EI program is made. An individual PV can be paid from multiple funding sources and/or accounting lines. PVs are generated on a monthly basis for each EI program with each PV representing a specific calendar reporting year and month. DPH generates payment vouchers according to all data received from a program after the 10th of each month. Therefore, claims from multiple reporting months may be included under a month's PV.

DPH claims for children who do not have insurance or MassHealth coverage (identified by a reason code of D05, uninsured) are processed to a separate payment voucher each month and paid using federal dollars. Uninsured claims paid by federal dollars must adhere to strict criteria. For this reason it is critical that claims for uninsured children are verified as truly uninsured prior to submission to DPH.

The DPH central accounting office submits the PV data to the Comptroller. This data is updated and maintained in the Massachusetts Management Accounting and Reporting System (MMARS). MMARS checks PV data to ensure that a sufficient amount of dollars are in the referenced budget accounts. The Comptroller then forwards a request to the state Treasurer's Office for payment.

C. Assigning the PV Reference Number

All accepted records successfully passing the business rules at DPH are assigned a PV reference number. When DPH processes accepted claims for payment, the system records a PV reference number so that each claim can be traced back to a particular PV. The PV reference number consists of three alpha characters that identify the provider followed by six digits that identify the date (YYMMDD) the claims were validated at DPH. The last digits reference both the fiscal year and the account from which funds are drawn.

For example, fiscal year 2014 and 2015 claims processed for payment on September 13, 2014 for Augusts' monthly payment for a vender with a code of VEN would be marked and remitted with the following payment voucher reference numbers:

Fiscal Year 2014 Supplemental Claims	Fiscal Year 2015 Regular Claims
VEN140913S14	VEN14091315 VEN140913D15

PV Reference Number on MassFinance & EFT Statements
Additional characters stating the fiscal year, "2014" or "2015" are added to the beginning of the PV reference number for payment vouchers submitted to the comptroller for the purpose of being able to identify the appropriate fiscal year within the MMARS system. The "2014" and "2015" is NOT included as part of the PV reference number on your remittance email files. The "2014" and "2015" will be seen as part of your PV reference number within the Mass Finance website and on your EFT statement.

Fiscal Year 2015 Regular Claims: The payment voucher reference number VEN 14 09 13 15 identifies provider, VEN (code for the provider), service delivery fiscal year 2015 claims processed on 9/13/14 for claims of children having insurance coverage. Payment voucher reference number VEN 14 09 13 D15 identifies service delivery claims processed on 9/13/14 for claims of uninsured children.

Fiscal Year 2015 Uninsured Claims: Claims for children identified as uninsured (initial records whose reason code is D05) are processed to a separate PV. The character of "D" is always included as part of the PV reference number identify them as "uninsured" claims.

Fiscal Year 2014 Supplemental Claims: The payment voucher reference number VEN140913S14 identifies provider, VEN (code for the provider), service delivery fiscal year 2014 supplemental claims processed on 9/13/14 for claims of children having insurance coverage.

The following provides a reference for the last characters of all claims for fiscal years 2014 and 2015.

	Last characters of PV Reference #		
Fiscal Year	Regular Claims	Uninsured Claims	Supplemental Claims
2014	14	*NA*	S14
2015	15	D15	S15

D. Creating the Payment Voucher

1. General Information

PVs include all acceptable data at the time that they are processed by DPH. A PV may contain records approved for payment that were reported to DPH during multiple reporting months. For example, if a program submits a September service delivery file, all acceptable September data as well as acceptable July and August data (i.e., data that changed from pended or suspended to accept) will be included in the September PV.

Paper PVs are generated for each EI provider for the Central Accounting Office at DPH. DPH charges for a provider having multiple EI programs are aggregated.

2. Multiple PVs from a Single Website Transmission

DPH separates a single SDR website file transmission into multiple payment vouchers according to (1) fiscal year (based on date of service) and (2) regular vs. uninsured services. DPH claims with a reason code of D05 (uninsured) are processed to a separate payment voucher paid by federal funds.

3. Supplemental Claims

Supplemental claims are claims submitted to DPH after the close of the state's accounts receivable deadline for a fiscal year, typically occurring in mid-August. Early Intervention programs have until the 10th of March of the following year to research and submit claims for services. Initial DPH charges submitted after the March 10th deadline will not be approved for payment processing. Credits to DPH will be processed for all records submitted by July 10th of the same year.

E. Authorization of the Unit Rate Payment Vouchers

Each PV is reviewed by the EI fiscal manager. PVs that are either over or under budget based on that provider's projected monthly budget amounts or identified as an outlier for one or more reasons are pulled for review for the purpose of doing a desk audit. The EI fiscal manager may request support documentation and justification for services included on these PVs from these providers. PVs that have been authorized by the EI Office are signed and submitted to the Central Accounting Office at DPH and then entered into the state comptroller's office database.

F. State Comptroller's Office

The State Comptroller's Office produces the checks that are electronically transferred to a provider's designated bank.

1. The Massachusetts Accounting and Reporting System (MMARS)

Once PV information is accepted by MMARS, the state comptroller's accounting and reporting system, the payment will be processed by the State Treasurer's Office. Payments are made to EI providers by Electronic Funds Transfer (EFT).

2. MassFinance Website – http://massfinance.state.ma.us

MassFinance is an on-line resource under the state comptroller's office for providers to access financial information about their agencies. It provides providers with a resource tool to support the reporting and reconciliation of financial transactions with the Commonwealth of Massachusetts (see *X: Reconciliation Recommendations* section for additional information about this website).

IX. DPH REMITTANCE ADVICE INFORMATION

DEFINITIONS for DPH Remittance Advice Information

Client	*Recipient of service(s) provided by an Early Intervention program and include a child, his or her parent(s) and/or siblings.*
Early Intervention (EI) Program	*A program that has been certified by DPH as showing evidence of having met the EI Operational Standards of the Department of Public Health and that provides services such as therapeutic, educational, developmental and social services for children and their families. Services are provided to children who are between the ages of birth and three (3) years and who are deemed eligible due to established medical, developmental or environmental factors and conditions.*
EI TVP Website	*The EI Transaction Validation Program (TVP) website is available to EI programs to be used to upload Service Delivery Report files. The website summarizes all appropriate claims to DPH and generates an invoice as well as unit, charge, and validation reports.*
Electronic Fund Transfer (EFT)	*It represents how a business can receive direct deposits for payments from the Commonwealth.*
Fiscal Year	*A fiscal year is a period of 12 consecutive months used as an accounting period for revenue and expense reporting. The fiscal year for the state of Massachusetts starts July 1st and ends June 30th.*
Invoice	*An invoice is a summation of DPH claims from the Service Delivery Report (SDR) file. Fiscal year invoice reports are generated on the EI website for each upload SDR file.*
Payment Voucher	*A payment voucher (PV) is a document that generates a summary and total of payable services received, authorizes the disbursement of funds, and references the appropriate encumbrance against which a payment will be charged.*
Provider	*A provider, also known as the vendor, is an approved organization with which the state contracts and conducts business. A provider or vendor may manage many Early Intervention programs as well as other contracts with DPH.*
Supplemental Claims	*For Early Intervention services, supplemental claims are those claims submitted to DPH after the close of the state fiscal year (i.e.; August 31). Early Intervention programs have until March 10th of the following year to research and submit claims for services.*
Vendor	*A vendor, often referred to as a provider, is an approved organization with which the state contracts and conducts business. A vendor may manage many Early Intervention programs as well as other contracts with DPH. A specific provider code, based upon a FEIN number, is assigned for each vendor.*

A. General Information

DPH separates SDR data by fiscal year and generates remittance advice information according to a specified fiscal year. Generally within one day of creating a payment voucher, DPH creates a "remittance email" for providers. The subject of the email provides information about the fiscal year and the most recent reporting month processed for the program. All remittance advice information is included in the email as attachments. The monthly remittance email attachments include the following:

README.DOC	(*Word* document providing information about the remittance email)
PV.DOC	(Payment voucher documentation generated for the entire fiscal year)
9909F15.exe X	(Executable file of newly submitted or modified claim records that have been accepted, pended, or suspended)
9909F15R.exeX	(Executable file of newly submitted claim records that rejected)

If an EI program did not have any records that rejected, the 3604F10R.exe file would not be included as an attachment.

It is best to create a directory or folder on your computer hard drive {C:} or a network drive where all remittance advice files are located. Save all attachments in your remittance emails to this folder. Since the README.doc and PV.doc are cumulative, you can continually replace these two documents with the documents from your latest remittance emails. The .exe files are not cumulative.

The remittance files (.exe files) have been compressed to allow transmission of large files over the Internet. In order to "open" these files save them to a folder. You must rename the file extensions from .exeX to .exe. Then double click on one of the files in *Windows Explorer* (a DOS screen will appear briefly and then disappear). Double clicking this file will uncompress the .dbf file. You will find a 9909F15.dbf file. This is the file you use as your remittance file. You can import this file into your practice management or billing system, if applicable, or read this file in Excel *(In Windows Explorer highlight the file, then right click, then select Open with, then select Excel).*

B. README Document

The README document (formatted in *W*ord) provides information about the other attached documents in the remittance email. It is updated with new information when needed. An EI provider should be familiar with the information that is contained in this document. Each month, the "New Information" section in this document should be reviewed. The README document also provides a list of the business rules at DPH, error codes and the definitions of claim and line status.

C. PV Document

The PV document (formatted in *W*ord) includes copies of the Unit Rate PVs generated for an EI program by DPH for a specific fiscal year. These documents were submitted to the Central

Accounting Office at DPH as backup documentation to the PV. This document always includes a complete fiscal year's accumulation of PVs.
A provider overseeing administrative functions to more than one EI program will need to sum all their EI program PV total amounts. This will be the amount that has been processed on the DPH PV. Important things to remember about PVs:

- Records processed on a PV include all data acceptable at the time DPH processes PVs. For example, if a program submits a September service delivery file, all acceptable September data as well as acceptable July and August data (i.e., data that changed from pended or suspended to accept) will be included in the "September" PV.

- Claim records passing the DPH business rules are processed to three payment vouchers:
    - Current fiscal year: charges for uninsured children (paid with federal dollars)
    - Current fiscal year: charges for all other service records
    - Previous fiscal year: charges processed to a supplemental payment voucher

- A PV reference number consists of a three-character provider code plus the date (YYMMDD) identifying the date the claims were validated at DPH plus the 2-character fiscal year reference. This PV reference number is included on the PV document (PV.doc), the remittance file (e.g., 3609F12.dbf) and the check issued to the vendor.

- The last two characters of the PV reference number for uninsured claims is "D15". All other PV reference numbers for the current fiscal year end in "15". The last three characters of the PV reference number for previous fiscal year supplemental charges are "S15".

Note: The PV reference number on MassFinance and the EFT will differ slightly from the PV reference number that is remitted and included on the PV.doc. The PV reference number on MassFinance and the EFT always begins with a fiscal year reference. For example, the PV reference number of VEN14091315 remitted from DPH is the same as the 2015 VEN14091315 PV reference number on MassFinance.

D. Remittance Advice Files

1. Remittance File Name

The name of the remittance file may provide some information about the content of the file. The first two characters of the file name are the program code, the next two characters identify the last reporting month of claims processed by DPH. The "F" means fiscal year with the last two characters identifying the fiscal year. If an "R" follows the fiscal year characters, the file contains rejected records. An example of remittance file names follows:

9909F15.exe (accepted, pended & suspended claim records)
9909F15R.exe (rejected claim records)

The first file tells you that this file is for program #99. The last reporting month is September. The file contains fiscal year 2015 data. The second file contains rejected records.

2. Content of the Remittance File

Remittance information enables EI providers to know whether they need to correct claims information in order to receive appropriate payments. The remittance files (files with the .dbf extension) consist of the following DPH charges:

- Paid (these records will have a PV reference)
- Unpaid, waiting for action
  - Pended records
  - Suspended records
- Rejected records (will not be re-remitted)

Paid records (having a PV) sent to EI programs in a remit file are not included in future remittance files. The PV reference number on the remittance file can be matched against the PV reference number on the PV document.

The remittance file includes claim record information received by DPH from a provider, such as client ID and charges, and additional data fields generated by DPH. The definitions for these additional fields follow:

- *FY*: the fiscal year that the service was provided to a client (the state fiscal year runs from July 1st through June 30th of the following year)
- *Claim_Status*: status of the combination of all lines within a claim based on DPH business rules (does not appear on Reject Remit file)
- *Line_Status*: status of specific line or record within a claim based on DPH business rules
- *PV*: the payment voucher reference number that identifies claim records passing DPH business rules processed for payment approval (e.g., VEN14091315)
- *Errorcodes*: one or more codes identifying a DPH fiscal rule failure
- *Billing_DPH*: the charge billed to DPH for that record (if $0.00, the record is a third party payer record)
- *DateChange*: the last time a record's error code, claim or line status was changed
- *Claim*: combination of prgcode+client+referral+sdrdate+recordno
- *Deadline*: Once the deadline for supplemental claim submission is past all claims are designated "Yes" if transmitted to DPH by the fiscal year's deadline. Otherwise, if blank, it was transmitted past the deadline.
- *O_Status*: text that provides additional information such as the reason for a charge being paid or denied.

E. Suspended Claim Records

Claims identified with a line status stating "Suspend" are not to be resubmitted to DPH. These records are "on hold", requiring further action from the EI program. See *Appendix IV, "Business Rules & Claim Status"* for procedures to follow for these claim records.

If a suspended claim record problem is resolved by the program the record will appear with a PV reference number.

F. Pended Claim Records

Claims identified with a line status stating "Pended" are not to be re-submitted to DPH. These records are "on hold", requiring support documentation to be sent by the EI program to the EI Fiscal manager. See *Appendix IV, "Business Rules & Claim Status"* for procedures to follow for these claim records.

If a pended record has multiple error codes and one of the error codes includes a suspend or reject error code then the reason for the suspension or rejection must be handled prior to reconciliation of the pended status.

Once support documentation received by the EI Fiscal Manager from the EI program has been reviewed one of two things will occur: (1) the record will be remitted with a PV reference number, or (2) the record will be remitted with a comment in the O_Status column of the remittance file stating the reason for denial.

G. wPended Claim Records

Claims identified with a line status stating "wPended" are not to be re-submitted to DPH. These records are "on hold", requiring further action by DPH staff. See *Appendix IV, "Business Rules & Claim Status"* for procedures to follow for these claim records.

If a wPnded record has multiple error codes and one of the error codes includes a suspend or reject error code then the reason for the suspension or rejection must be handled prior to reconciliation of the wPended status.

DPH staff will verify if the request for reimbursement was approved and that the service occurs within the approved limitations. If the record is approved for payment by DPH the record will be remitted with a PV reference number. If it is not approved then the record will be remitted with a comment in the O_Status column of the remittance file stating the reason for denial.

H. Rejected Claim Records

Claim records that have been rejected for payment by DPH are provided to EI providers in a separate remittance advice information file within the same email. See *Appendix IV, "Business Rules & Claim Status"* for procedures to follow for these claim records.

Rejected claim records may be corrected and resubmitted to DPH. EI providers must research thoroughly the problem with a rejected claim record. Otherwise the resubmitted claim record may end up being rejected again. If a rejected record has a reject error code as well as either a pended or suspended error code, the reason for the rejection must be reconciled first prior to addressing the pended or suspend issues.

If an Early Intervention program is able to resolve a problem with a DPH rejected claim record and makes appropriate corrections within their practice management or billing system, the claim record can be resubmitted. Guidelines for re-submissions follow:

- Re-submissions can be done for any record included in the Reject Remit file emailed to EI programs (records with a REJECT line status).
- If a claim record was rejected with a "3A" or "3T" error code (duplicate record) and the "duplicate" record was, in fact, a second person of the same professional discipline providing services, include this client's waiver authorization number when resubmitting the claim.

Resubmitted records will be processed through the business rules at DPH. If these claim records successfully pass through the business rules they will be processed for payment.

H. Multiple Error Codes

It is important to review all of the error codes that a record contains and resolve the issues appropriately. If a rejected record has either a suspended or pended error code, the reason for the rejection must be reconciled first, prior to addressing the suspended or pended issues. If a record has both a suspended and pended error code then the suspend issue must be addressed first. Review *Appendix IV, Business Rule Error Code Descriptions* for a description of all error codes and what to do to resolve each issue. Resolve rejected error code issues first, then suspended error code issues, and lastly, pended error code issues.

I. Using the Remittance File

Some EI programs are able to upload the DPH remittance files into their own practice management or billing system in order to update claim status on all DPH submitted claims. EI providers who do not have this capability with their billing systems must develop procedures and an expertise in using the DPH remittance files in order to monitor all claim submissions. If the DPH status for each claim record cannot be posted in your billing system it is impossible to reconcile funds accurately.

An EI program in need of a remittance file to include all of a fiscal year's remittance records can request this from DPH at any time.

X. RECONCILIATION RECOMMENDATIONS

DEFINITIONS for Reconciliation Recommendations

Accounting Line Number	*A two digit number used in MMARS to reference the accounting line on an encumbrance or payment document.*
Fiscal Year	*A fiscal year is a period of 12 consecutive months used as an accounting period for revenue and expense reporting. The fiscal year for the state of Massachusetts starts July 1st and ends June 30th.*
Line Amount	*In MMARS, the line amount is the dollar amount paid to a vendor for each individual accounting line on a payment document.*
MMARS or New MMARS	*Massachusetts Management, Accounting and Reporting System (MMARS) is the centralized, financial database system that supports the financial functions performed by the Commonwealth of Massachusetts.*
Office of the Comptroller	*The Office of the Comptroller manages the proper accounting revenues and expenditures in the state accounting system (MMARS).*
Payment Voucher (PV)	*A document that generates a summary and total of payable services received, authorizes the disbursement of funds, and references the appropriate encumbrance against which a payment will be charged.*
Provider	*A provider, also known as the vendor, is an approved organization with which the state conducts business. A provider or vendor may manage many Early Intervention programs as well as other contracts with DPH.*
PV (Payment Voucher) Reference Number	*An ID that identifies claim records approved for payment. It consists of 11 characters composed of a three-character provider-specific code, the date the payment voucher was generated (YYMMDD), and a two-character fiscal year budget account reference. It is included on each approved claim record on the remittance file with the summation of these records included on the PV document.* *The PV reference number is different from the PV number found on the MassFinance website. The MassFinance PV number is assigned by the state comptroller's office and references a check issued to a provider. When these two numbers are, in fact, the same, the provider is able to identify claim records to a check.*
Scheduled Payment Date	*The date that the Commonwealths' accounting system (MMARS) uses to generate a check or EFT.*
TVP Website	*The website used by EI programs to upload Service Delivery Report files. The website summarizes all appropriate claims to DPH generates a validation report.*

A. Maintaining Your Remittance Advice Information Files

Create one or more directories or folders to store your remittance advice information files. You may want to rename files in order to easily identify fiscal year, when the file was received, or the reporting month and year that the file represents. Always keep a copy of the original remittance file to be used as a back-up in a separate folder prior to using the information. If anything happens to the data, you will have the original to copy again.

B. Using the MassFinance Website - http://massfinance.state.ma.us

1. Overview

This website can be used to match payments made by the state comptroller's office to your fiscal reports. Scheduled payments and past payments made to a provider for both the current and previous fiscal years are available. Payments that have not been entered into the MMARS system to date will not appear on this website.

When attempting to match payments with reports, remember the following:

- There may be multiple lines on this website with the same Payment Reference number with funds from each line coming from separate budget sources
- EI providers overseeing administrative functions to more than one EI program will need to sum all their EI PV amounts prior to matching amounts to this website.

2. PV Reference Number

The PV reference number generated at DPH for EI providers can be matched against the Payment Reference number on this website. This PV reference number will appear on the check the provider receives, thus providing a complete audit trail from a program's SDR remitted records to the check received from the State Comptroller's Office.

The PV reference number on MassFinance and the EFT will differ slightly from the PV reference number that is remitted and included on the PV.doc. The PV reference number on MassFinance and the EFT always begins with a fiscal year reference. For example, the PV reference number of VEN11091312 remitted from DPH is the same as the 2012 VEN11091312 PV reference number on MassFinance.

An example of what appears under this website's Payment History for the Any EI program follows:

EARLY INTERVENTION PROGRAM
Payment History
Date Range Searched: From 9/1/2014 To 11/26/2014
Department(s) Searched: DPH
Number of Payment Lines Found: 6

Understanding Payments History

Address ID: AD001---974 ANY STREET ANYTOWN, MA				
Payment Number: **046A5002031**			Payment Date: **9/25/2011**	
Department	Payment Ref. #	Contract Number	Line Amount	Check Amount
DPH - DEPARTMENT OF PUBLIC HEALTH	2015 VEN 150913 15	INTF3601MM3001513103	$97,564.69	$97,564.69
Check Description:	EARLYINT			
		Total Amount	**$97,564.69**	**$97,564.69**
Payment Number: **047A5008043**			Payment Date: **10/10/2011**	
Department	Payment Ref. #	Contract Number	Line Amount	Check Amount
DPH - DEPARTMENT OF PUBLIC HEALTH	2015 VEN 150913 D15	INTF3601MM3001513103	$8,236.47	$8,236.47
		Total Amount	**$8,236.47**	**$8,236.47**
Payment Number: **059A5004146**			Payment Date: **11/9/2011**	
Department	Payment Ref. #	Contract Number	Line Amount	Check Amount
DPH - DEPARTMENT OF PUBLIC HEALTH	2014 VEN 140915 S14		$74,532.24	$74,532.24
		Total Amount	**$74,532.24**	**$74,532.24**
Payment Number: **063A5006156**			Payment Date: **11/17/2011**	
Department	Payment Ref. #	Contract Number	Line Amount	Check Amount
DPH - DEPARTMENT OF PUBLIC HEALTH	2015 VEN 151013 15	INTF3601MM3001513103	$92,005.63	$92,005.63
Check Description:	EARLYINT			
DPH - DEPARTMENT OF PUBLIC HEALTH	2015 VEN 141013 D15	INTF3601MM3001513103	$7,975.69	$7,975.69
		Total Amount	**$99,981.32**	**$99,981.32**
Address ID: AD001---974 ANY STREET ANYTOWN, MA Total:			**$293,571.28**	**$293,571.28**

Data last updated: Wednesday, November 24, 2014

Payment History - Detailed information on completed transactions for current or prior fiscal years to your agency. You can determine the specific date that a payment was issued and access information for any state agency.

Line Amount - The dollar amount paid to a provider for each individual accounting line delineated by the Central Accounting Office at DPH on your PV. There may be multiple lines with the same Payment Reference number with funds from each line coming from separate budget sources or accounting lines**.**

Payment Number - A sequential number assigned by the Office of the State Treasurer, which uniquely identifies a payment.

Payment Reference Number – This number is assigned by DPH and provides agencies with the ability to match payments to PVs as well as SDR remittance files. The Payment Reference number on the website includes the fiscal year and the PV reference number found on all files in your remittance advice email.

Scheduled Payment Dates - The scheduled payment option provides EI providers with the payment status of Payment Vouchers that have been processed in MMARS but for which payment has not been issued. The scheduled payment date is the date when the Office of the State Treasurer receives the payment from the accounting system to generate a check (or EFT).

C. Additional Resources

If you have questions regarding amounts paid, business rule policy, support documentation, third party payer issues or supplemental claims, contact Steve McCourt, the EI Fiscal Manager, at (617) 624-5954 or steve.mccourt@state.ma.us. If you have questions or problems regarding the EI TVP website or remittance files, contact Jean Shimer, the EI Data Manager, at (617) 624-5526 or jean.shimer@state.ma.us.

XI. GENERAL DEFINITIONS

Accounting Line Number	*A two digit number used in MMARS to reference the accounting line on an encumbrance or payment document.*
Administrative Services Only (ASO)	*An arrangement in which an employer contracts with a third party for claims processing and billing. The employer bears the risk for claims.*
Appeal	*A formal request made to a payer to reconsider a decision regarding the denial of a claim.*
Appropriation	*The amount authorized by the Legislature for a specific period against which obligations can be incurred and expenditures made.*
Approved Program Rates	*The rate per EI service unit approved by the Center for Health Information and Analysis (CHIA). The rates are certified by the Commonwealth and filed with the Secretary of the Commonwealth to govern payment for services as stated under 114.3 CMR 49.00.*
Billable Staff Member	*An individual in an Early Intervention program who possesses the required credentials and is certified by DPH as an Early Intervention Specialist to render billable Early Intervention services.*
Business Associate	*A person or entity who on behalf of a covered entity performs a service (i.e.) claims processing, data analysis, billing, benefit management, etc.*
Budget Fiscal Year	*The period in which a fiscal years budget can be expended.*
Certified Early Intervention Program	*A program under contract with DPH deemed in compliance with the EI Operational Standards set forth by the Massachusetts Department of Public Health.*
Centers for Medicare and Medicaid	*The federal agency that oversees the state administration of Medicaid.*
Claim Adjustment Reason Codes	*A national administrative code set that identifies the reason for differences between the original charge and payment.*
Claim and Line Status	*Claim: one or more records that share the same program code, client ID, record number, and service date. A claim has the potential of containing multiple records or transactions.* *Line status: based on the error codes resulting from either passing or failing DPH business rules, the line status can entail one of the following: ACCEPT (passed all business rules), SUSPEND, PENDED, WPEND, DENIED or REJECT.* *Claim status: summary of all line statuses within a claim. If all the records within a claim have an ACCEPT line status, the claim status will also read ACCEPT. If one or more of the records within a claim*

	have a PENDED or WPEND line status, the claim status for all claim records will read as PENDED or WPEND. Thus one line status that reads PENDED or WPEND will cause the claims status for all records of that claim to be pended. This is the same for claims with a SUSPEND or DENIED status. *Claim records with a REJECT line status are not associated with other records; they are removed from all ACCEPT, PENDED, WPEND, SUSPEND and DENIED records.*
Client	*Recipient of service(s) provided by an Early Intervention program and include a child, his or her parent(s) and/or siblings.*
CMS	*Centers for Medicare and Medicaid within the US Department of Health and Human Services*
Code Set	*Under HIPAA any codes used to encode data elements.*
Coinsurance	*A form of cost sharing that requires the member to pay a stated percentage of expenses after the deductible amount.*
Community Site	*Any location where all young children are welcome and typically spend time, and where services are provided in natural environments, as defined in federal law and regulation in which children without disabilities participate. This may include, but is not limited to, childcare settings, playgrounds, libraries, and community centers.*
Coordination of Benefits	*Submission of a denied claim to another payer. The submission includes supporting documentation from the denying insurer (also a request for other insurance information).*
Co-Payment	*A form of cost sharing that requires a member to pay a fixed amount when a service is received.*
Corrected Claims	*Original claims denied due to attribute corrections (i.e. incorrect member, incorrect ID number, incorrect date of service, missing procedure code/diagnosis/location, modifier, etc.).*
Co-Treatment	*A co-treatment service or visit involves two or more EI Specialists, the enrolled child, the enrolled child's parent, or both. Reimbursement for one co-treatment is allowed per month for an enrolled child. Co-treatment visits are usually for the purpose of consultation and coordination regarding treatment planning and approaches to treatment. They are billed on the basis of working hours with a maximum reimbursement of two hours per professional discipline or EI Specialist. Reimbursement for a co-treatment is limited to four working hours per session.*
Covered Entity	*A health care provider who transmits any health information electronically in a transaction covered by privacy rules.*

CPT	*A medical code set used for professional transactions.*
Daily Log	*Early Intervention Specialists should maintain a daily log of all client services. This daily log is essentially an attendance record and should relate to the documentation in the individual client record. The daily log indicates the name of the child/family receiving the service, the date of service, the type of service, the signature of the EI Specialist who provided it and the number of units of service provided. The daily log should be maintained at the program site and be readily available for routine monitoring. While providers do not need to submit a copy of the daily log to DPH, it provides service delivery and claim documentation for the billing and reporting of claims.*
Deductible	*A fixed dollar amount during a benefit period that a member pays before the insurer starts to make payments for covered services.*
Denial of a Claim	*Denial by an insurer to pay for services rendered.*
Determination of Eligibility	*Eligibility for Early Intervention is determined by an eligibility evaluation performed by a multidisciplinary team exercising sound clinical opinion, and using a developmental evaluation instrument approved by the Department of Public Health. Eligibility is determined only by certified Early Intervention programs.*
Duplicate Claim	*A service rejected due to duplicating with another service having the same service date and professional discipline for the same client.*
Early Intervention (EI) Program	*A program that has been certified by DPH as showing evidence of having met the EI Operational Standards of the Department of Public Health and that provides services such as therapeutic, educational, developmental and social services for children and their families. Services are provided to children who are between the ages of birth and three (3) years and who are deemed eligible due to established medical, developmental or environmental factors and conditions.*
Early Intervention Specialist	*An individual with professional credentials and certified as an Early Intervention Specialist by the Department of Public Health. This certification may be provisional, provisional with advanced standing, or full certification. EI Specialists are the only staff who may bill either third parties or DPH for services.*
Early Periodic Screening, Diagnosis and Treatment	*Medicaid benefits designed to promote early diagnosis and treatment of health needs.*
EIIS Client Registration Database	*The EIIS client registration database supports the collection and management of data on the infants and toddlers in each EI program. Information collected includes socio-demographics, functional status, medical diagnosis, eligibility criteria, and discharge status.*

Electronic Fund Transfer (EFT)	*It represents how a business can receive direct deposits for payments from the Commonwealth.*
Electronic Transactions	*HIPAA electronic transactions are predefined and include specific code and information. If an agency or EI program transmits claims electronically to insurers it must be done in the prescribed HIPAA format and codes. The following provides the most common HIPAA transactions to be used by EI programs for information inquiries and claim submission.* ***270: Health Care Eligibility & Benefit Inquiry transaction*** *An electronic transaction initiated by an EI program to an insurer for the purpose of acquiring information on a client such as insurance eligibility.* ***271: Health Care Eligibility & Benefit Response transaction*** *An electronic transaction from an insurer to an EI program in response to an X12 270 providing information on the client.* ***276: Health Care Claims Status Inquiry transaction*** *An electronic transaction initiated by an EI program to an insurer for the purpose of inquiring about the status of a claim.* ***277: Health Care Claim Status Response transaction*** *An electronic transaction from an insurer to an EI program in response to an X12 276.* ***835: Health Care Claim Payment & Remittance Advice transaction*** *Remittance response from an insurer to an EI program* ***837: Health Care Claim or Encounter transaction*** *Claim submission from an EI program to an insurer.* ***997: Functional Acknowledgement*** *A confirmation of an electronic HIPAA submission.*
Employee Retirement Income Security Act (ERISA)	*Broad reaching federal laws that establish the rights of participants regarding health insurance.*
Encumbrance	*A budget document that commits authorized funds for a specific purpose.*
Environmental Risk	*The presence of four or more environmental factors that have been deemed to pose a serious threat to a child's development including, but not restricted to, limited maternal and family care, inadequate health care, poor nutrition, limited opportunities for expression of adaptive behaviors and lack of physical and social stimulation.*
Established Risk	*The presence of a developmental delay or deviation of unknown etiology or the likelihood of a developmental delay or deviation due to a diagnosed medical disorder of known etiology.*

Exclusive Provider Organization (EPO)	*A more restrictive PPO under which members must use providers from the specific network.*
Expenditure	*Expenditure is an outlay of cash for a specific purpose.*
Filing Limits	*A first time claims submission denied for untimely filing.* • *Initial Filing Limit Days- the number of days elapsed between the date of service (and EOB date) if another insurer is involved) and the receipt by a plan.* • *Request for additional information- a first time claim submission that is denied for additional information i.e. unlisted procedure code, documentation not supporting code.*
First Dollar Mandate	*A Massachusetts legislative mandate that prohibits fully insured health plans from charging for a co-payment, coinsurance or deductible for EI services rendered by an EI provider.*
Fiscal Year	*A fiscal year is a period of 12 consecutive months used as an accounting period for revenue and expense reporting. The fiscal year for the state of Massachusetts starts July 1st and ends June 30th of the following year.*
Flexible Spending Account (FSA) Arrangements	*Accounts administered by employers that provide a way for employees to set aside pretax dollars to pay for a share to premiums or medical expenses not covered by the plan.*
Fully Insured Plan	*A plan where the employer contracts with another organization to assume responsibility for those enrolled to administer claims and administrative costs. Employers purchase health insurance coverage for their employees and the insurer assumes the financial risk. Insured plans in Massachusetts are subject to state law and are overseen in Massachusetts by the Division of Insurance.*
Full-Time Equivalent (FTE)	*The ratio of total paid hours (for a defined period of time) divided by the total number of working hours for that period.*
General Laws	*General Laws are statutes promulgated by the Legislature and published as the Massachusetts General Laws.*
HCPCs	*A medical code set that identifies health care procedures for claims submission purposes. CPTs Level I contains numeric codes maintained by the AMA. HCPCs Level II contain alpha numeric codes used to identify services not included in CPT code set. Level III contain alpha numeric codes assigned by Medicaid state agencies to identify services not defined in Level I or II. (Typically called local codes)*
Health and Human Services (HHS)	*The federal government department that has overall responsibility for implementing HIPAA.*
Health Insurance Portability and Accountability Act of	*Health Insurance Portability and Accountability Act of 1996 mandates the use of standards for the electronic exchange of health care data; specifies what medical and administrative code sets to be*

1996 (HIPAA)	*used within those standards; requires the use of national identification systems for health care patients, providers, payers (or plans), and employers; and specifies the types of measures required to protect the security and privacy of personally identifiable health care information.*
Health Level 7 (HL7)	*HIPAA standards for the exchange of information.*
Health Maintenance Organization (HMO)	*A health care system that assumes the financial risk associated with providing comprehensive care in a specific geographic area.*
Health Reimbursement Arrangement (HRA)	*Employer funded accounts used to pay certain out-of-pocket expenses.*
Health Savings Account (HSA)	*An employee owed account (as defined by the IRS) used to pay out-of-pocket expense. Typically members must be enrolled in a high-deductible plan.*
House 1	*The Governor's operating budget recommendations for the next fiscal year.*
ICD Code	*International Classification of Diseases*
Implementation Guide	*A document explaining the proper use of a standard for a specific purpose.*
Individual Client Records	*Each service delivered to a child, and/or family member must be documented in the individual client record. These records must meet documentation requirements outlined in the EI Operational Standards and are necessary to support units billed to DPH. Individual client records must be available to DPH staff for routine monitoring.*
Individualized Family Service Plan (IFSP)	*An Individualized Family Service Plan is a working document produced collaboratively by program staff and family members that contains the agreed upon Early Intervention services for an eligible child and family. It is written in accordance with federal regulations and the EI Operational Standards.*
Insurance Benefit Coverage	*Insurance coverage is based upon the insurer's definition of medical necessity and the benefits offered by the plan. MassHealth has accepted DPH's definition that if a child is deemed to be clinically eligible, they are eligible for coverage.*
Invoice	*An invoice is a summation of DPH claims from the Service Delivery Report (SDR) file. Fiscal year invoice reports are generated on the EI website for each uploaded SDR file.*
Legislative Branch	*The Massachusetts Legislature is a two house body consisting of 40 Senators and 160 Representatives.*
Line Amount	*In MMARS, the line amount is the dollar amount paid to a vendor for each individual accounting line on a payment document.*

Mandated Benefits	*Services that fully funded plans are required by the state to offer as benefits to their members. Specific benefits vary by state. Self-insured plans are exempt.*
Medicaid	*A public insurance program for low income individuals that is administered jointly by federal and state governments. It is overseen by the federal government but administered by the individual states.*
Medical Necessity	*A service that is appropriate for the treatment of a specific individual. Definitions and guidelines vary by health plan.*
Medical Savings Account (MSA)	*Savings accounts designed to cover out-of-pocket expenses. Employers and individuals are allowed to contribute to a savings account on pretax dollars. Typically MSAs are combined with a high deductible plan.*
MMARS or New MMARS	*Massachusetts Management, Accounting and Reporting System is the centralized, financial database system that supports the financial functions performed by the Commonwealth of Massachusetts.*
National Provider Identifiers (NPI)	*Are unique 10 digit National Provider Identifiers*
Network	*A group of providers who contract with a managed care organization to provide services.*
Object Codes	*A code that indicates the specific type of goods or services for which the Commonwealth funds are expected.*
Office of the Comptroller	*The Office of the Comptroller manages the proper accounting revenues and expenditures in the state accounting system (MMARS)*
Payment Voucher	*A payment voucher (PV) is a document that generates a summary and total of payable services received, authorizes the disbursement of funds, and references the appropriate encumbrance against which a payment will be charged.*
Payment Voucher (PV) Reference Number	*A PV reference number is an ID that identifies claim records approved for payment. It consists of 11 characters composed of a three-character provider-specific code, the date the payment voucher was generated (YYMMDD), and a two-character fiscal year budget account reference. It is included on each approved claim record on the remittance file with the summation of these records included on the PV document.* *The PV reference number is different from the PV number found on the MassFinance website. The MassFinance PV number is assigned by the state comptroller's office and references a check issued to a provider. When these two numbers are, in fact, the same, the provider is able to identify claim records to a check.*

Provider	*A provider, also known as the vendor, is an approved organization with which the state conducts business. A provider or vendor may manage many Early Intervention programs as well as other contracts with DPH.*
Point of Service Plan (POS)	*Open Ended – Is an HMO/PPO hybrid. POS plans resemble HMOs for in network services.*
Preferred Provider Organization (PPO)	*An indemnity plan where coverage is provided to participants through a network of selected health care providers.*
Provider	*A provider, also known as the vendor, is an approved organization with which the state conducts business. A provider or vendor may manage many Early Intervention programs as well as other contracts with DPH.*
Provider Taxonomy Codes	*An administrative code set for identifying the provider type and area of specialization.*
Recipient Eligibility Verification System (EVS and WEB EVS)	*The EVS system is a method to verify MassHealth client eligibility information and to obtain authorizations. WEB EVS is the internet version of this application.*
Regional EI Specialists	*Regional EI specialists are members of the DPH Early Intervention personnel who work out of the DPH regional offices throughout the state. Their primary responsibilities include (1) providing technical assistance to EI programs within a designated region and (2) monitoring the programs for compliance with the EI Operational Standards and with the federal regulations under Part C of the Individuals with Disabilities Education Act (IDEA).*
Request for Reimbursement Waiver	*An Early Intervention program may seek a request for reimbursement by submitting a written request to the appropriate personnel at DPH for services which exceed the guidelines specified within the EI Operational Standards. The Massachusetts Department of Public Health retains the authority to allow or deny the request.*
Retained Revenue	*This type of revenue is classified as funds available for expenditure for the purpose of specific activities.*
Scheduled Payment Date	*Scheduled payment date is the date that the Commonwealths' accounting system (MMARS) used to generate a check or EFT.*
Self-Insured Plans	*A plan offered by employers who directly assume the major cost of health insurance for their employees. Some self-insured employers contract with insurance carriers for claims processing and administrative services. Employers may offer both self-insured and fully insured plans to their employees.* *In self-insured plans (also called self-funded plans), instead of purchasing health insurance coverage employers pay for their*

	health care costs directly usually using a health insurer to administer benefits, enrollment and billing. Large companies frequently self insure for a variety of reasons. Self-insured plans are not subject to state law but are overseen at the federal level. Federal laws exempt self-insured plans from state mandates.
Service Contract (SC)	*A service contract is the MMARS transaction that encumbers funds to cover planned spending throughout a specified fiscal year. Service contracts for EI programs are both provider specific and 'open order' contracts.*
Service Delivery Report (SDR)	*The Service Delivery Report (SDR) is an automated data file of a program's service delivery records submitted to DPH. The SDR provides DPH with information about patterns of service delivery and payment sources for all third party payers in the state. The SDR is submitted to DPH and used to create a payment voucher. Once DPH creates the payment voucher, the SDR serves as the support documentation for the payment voucher.*
SERVICES: Assessment	*Assessment consists of those on-going procedures used by appropriately qualified personnel throughout the period of a child's eligibility for services to identify (1) the child's unique strengths and needs and the services appropriate to meet those needs; and (2) the resources, priorities and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of their child. Assessment may occur as part of an eligibility evaluation. Assessment hours are limited to ten hours per year based on the child's anniversary date.* ***Assessment Anniversary Date:*** *Assessment hours are renewed one year from the date of the first billed assessment service. This assessment anniversary date stays the same for the child until he/she reaches the age of three. This holds true for children who leave EI services and return at a later time. The exception to this is for children who leave EI and return at a time beyond the anniversary date. In this case the assessment anniversary date is reassigned according to when assessment services begin again.*
SERVICES: Center Individual Visit	*A center individual visit is a face-to-face meeting at the Early Intervention program's site or an approved satellite site with the enrolled child, the enrolled child's parent, or both, and an Early Intervention Specialist for the purpose of furthering the enrolled child's developmental progress. It is provided for a scheduled period of time ranging from 15 minutes to two hours although some payers may restrict the number of center individual visits they will pay per day. Center individual services may be provided in conjunction with child group services if this arrangement is clearly*

	specified on the child's IFSP. The combination of time for the center individual and group service must not exceed the scheduled duration of the group.
SERVICES: CHA (Comprehensive Health Assessment) for EIPP-Referred Children	*A CHA service is provided to EI children who have been referred from an EIPP program and occur at specified times during the child's first year of life.*
SERVICES: Community Child Group	*Child Focused Group. A face-to-face meeting at a community-based site of a group of enrolled children (2 or more), facilitated or co-facilitated by at least one certified Early Intervention Specialist (as defined in these standards) for the purpose of furthering the enrolled child's developmental progress. A community child group is a face-to-face meeting of 2 or more children at a community site, as defined in 114.3 CMR 49.02, facilitated or co-facilitated by certified EI staff members and designed to further the child's developmental progress and which must include both children enrolled in EI and children not enrolled in EI. Child groups are provided for a scheduled period of time ranging from 1 to 2 ½ hours per group, not to exceed 2 ½ hours per week for an individual child. Additionally, child groups do not meet more than two times weekly.* *For children receiving center individual services in conjunction with a child group service, the total billing time may not exceed the scheduled duration of the child group.*
SERVICES: Co-Treatment	*A co-treatment service or visit involves two or more EI Specialists, the enrolled child, the enrolled child's parent, or both. Reimbursement for one co-treatment is allowed per month for an enrolled child. Co-treatment visits are usually for the purpose of consultation and coordination regarding treatment planning and approaches to treatment. They are billed on the basis of working hours with a maximum reimbursement of two hours per EI Specialist. Reimbursement for a co-treatment is limited to four working hours per session.*
SERVICES: EI-Only Child Group	*A developmental group of two or more children where the only participants are children and families enrolled in EI. When a child participates in an EI-Only Child Group, the child's IFSP must include appropriate clinical justification as to why outcomes cannot be achieved in a natural setting, as well as a plan to move toward group services in a community setting. The justification and the plan need to be reviewed a minimum of every six months through the IFSP process. The Child Group should be specified on the IFSP as "EI-Only Child Group."* *An EI only child group is a face-to-face meeting of 2 or more children enrolled in Early Intervention, facilitated or co-facilitated*

	by certified EI staff and designed to further the child's developmental progress. All children in the group must be currently enrolled in Early Intervention. Child groups are provided for a scheduled period of time ranging from 1 to 2 ½ hours per group, not to exceed 2 ½ hours per week for an individual child. Additionally, child groups do not meet more than two times weekly. *For children receiving center individual services in conjunction with a child group service, the total billing time may not exceed the scheduled duration of the child group.*
SERVICES: (Eligibility) Evaluation	*A face-to-face meeting with the child and the parent(s) for the purpose of determining a child's initial or continuing eligibility for Early Intervention services. An evaluation is conducted by a multidisciplinary team certified as EI Specialist by DPH utilizing a DPH-approved developmental inventory tool and informed clinical opinion. Evaluation hours are billed at the assessment rate. Reimbursement is limited to 10 hours of assessment per year based on the child's anniversary date.*
SERVICES: Home Visit	*A face-to-face meeting at the enrolled child's home or a setting outside of the EI (lead) site with the enrolled child, the enrolled child's parent, or both, and an Early Intervention Specialist for the purpose of furthering the child's developmental progress. Reimbursement for a home visit is not to exceed two hours per visit. Although there is no DPH restriction on the number of home visits per day, some payers may restrict the number of visits they will pay per day.*
SERVICES: Parent Group	*A face-to-face meeting of a group of enrolled children's parents with an Early Intervention Specialist for the purpose of support and guidance. A Parent-Focused Group(s) is provided for a regularly scheduled period of time. If more than one parent of a child attends a group, the reimbursement for one of the parents (or both if no other insurance coverage) may be from the Department of Public Health. Time-limited (one or more sessions), topic-specific parent educational groups may be provided as Parent-Focused Groups. These sessions are based on a specific curriculum and have an evaluation component, kept on file at the program.* *A group for other members of the enrolled child's family, including siblings, may be offered for not more than twelve sessions in a twelve-month period. These sessions will be based on a specific curriculum that addresses the impact of the developmental needs of the enrolled child on family members.* *A parent group is a regularly scheduled face-to-face meeting of a group of enrolled children's parents lead by an EI Specialist which meets for a designated period of time for the purpose of support and guidance concerning the developmental issues of their child. A parent group can meet once a week for up to 1 ½ hours per week.*

	This timeframe has multiple children enrolled, each parent may attend the group and be billed under separate client IDs). Parent education and sibling groups are also types of parent-focused groups.
State Finance Law	*Includes statutes, regulations, rules and policies for receiving and expending commonwealth fund and reporting these revenues and expenditures.*
Supplemental Claims	*For Early Intervention services, supplemental claims are those claims submitted to DPH after the close of the state fiscal year (i.e.; August 31). Early Intervention programs have until March 10th of the following year to research and submit claims for services.*
Support Documentation	*EI providers must be able to document due diligence in their attempts to resolve non-covered claims before submitting them to DPH. Examples of support documentation justifying DPH payment of claims to be included with the Explanation of Benefits (EOB), Explanation of Payments (EOP) or Statement of Accounts for corresponding dates of service include: MassHealth EVS(Eligibility Verification System) printout, insurer eligibility print outs, correspondence from insurers, verbal confirmation from an insurer with a corresponding trace/tracking/verification number, employer non-covered account or group number , electronic non-covered reports from insurers, appeals, etc. Support documentation must justify why claims have been submitted to DPH and specify efforts to address all avenues of reimbursement with other payers prior to submitting the claims to DPH. Support documentation showing that third party billing rules have been followed must also be made available to DPH for review upon request.*
TVP Website	*The EI Transaction Validation Program (TVP) website is available to EI programs to be used to upload Service Delivery Report files. The website summarizes all appropriate claims to DPH and generates an invoice as well as unit, charge, and validation reports.*
Unit of Service	*A service unit is the basis on which a service is reported and reimbursed. A DPH unit of service is one hour of service provided to an enrolled child and/or family member. A MassHealth unit of service is 15 minutes of service provided to an enrolled child, i.e. one DPH unit = 4 MassHealth units.* *In the case of Home Visit, Center Individual Visit, Child Group, Community Child Group, EI-Only Child Group, and/or Parent Group, one unit is a one hour service provided to an enrolled child. In the case of an assessment, one unit is one hour of service provided by one professional EI staff member.* *Providers may bill units to DPH in fifteen-minute segments within the billing restrictions for each service. Providers may only bill for full fifteen-minute segments; thus a twenty-minute intervention*

	would be billed as a 0.25 unit.
Vendor	*A vendor, often referred to as a provider, is an approved organization with which the state conducts business. A vendor may manage many Early Intervention programs as well as other contracts with DPH. A specific provider code, based upon a FEIN number, is assigned for each vendor.*
Vendor Code	*A vendor code is the unique identifier used by MMARS to process payments for a vendor. This code is a 13-digit number, with the first 9 specifying the organization's FEIN number, and the next 3 defining an address for check distribution.*
Vendor Invoice Number	*A vendor invoice number is a system generated ten-digit number assigned by vendor to an invoice document. This field is 30 characters long and is also known as the payment reference number.*
Working Hour	*A work hour is defined as one hour worked on a home visit, center-based individual visit or assessment by one Early Intervention Specialist. For example, if three professionals work together for one hour to complete the assessment, the assessment is three working hours.*

Appendix 1

Early Intervention
Service Delivery Reporting (SDR)
File Transmission Specifications

Fiscal Years 2016 & 2017

Early Intervention Service Delivery Reporting (SDR)
File Transmission Specifications
Fiscal Years 2016 & 2017

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EARLY INTERVENTION SERVICE DELIVERY REPORT
FISCAL YEAR 2016 & 2017
Data Field Definitions & Requirements

GENERAL INFORMATION

Reportable Services
Service Delivery files (SDR) transmitted to DPH via the EI TVP web site include the following:

- Services billed to and paid by MassHealth or a commercial insurer
- Services directly billed to DPH
- Transfer charges billed to DPH due to a denied by MassHealth or a commercial insurer
- Credits or corrections *(reverse out of charges or services)*
- Services should NOT be bundled, regardless of how they were submitted to another payer.

Services Not Reportable to DPH

- Partial transfers to secondary payers *(e.g., BC/BS denies partial charges due to a deductible. The charge is transferred to MassHealth and they deny the charge due to ineligibility. The partial charge is then transferred to DPH. The SDR files are unable to report the partial transfer between BC/BS and MassHealth. The SDR would report the BC/BS charge as the initial SDR record and then report the partial charge to DPH.)*

Deadlines

- Monthly SDR files must be submitted by the 10th of each month. If the 10th falls on a weekend or holiday then the deadline is extended through the first business day following the weekend or holiday.
- Service and payer transfer records can be reported to DPH through March of the following year following the fiscal year closing. Credits to DPH can be submitted through July of the same year.
- Support documentation must be submitted to the EI Fiscal Manager by May of the following year following the fiscal year closing.

File Specification Updates

- There may be updates required on the SDR file specifications from time to time.
- Prior to any updates DPH will contact each practice management or billing system developer to ensure that the updates can be handled and implemented in a timely manner.
- DPH may need to require one or more test files from providers prior to final implementation of any significant change to the file specifications.

Other Updates

- There are updates required from time to time based on state requirements or need. Some of the updates may include the following:
    - Rate changes
    - New services
    - New service modifiers
- Although this does not affect the file specification requirements it does affect the content of the record and ability of the file to be validated through the DPH EI TVP website.
- DPH will contact each practice management or billing system developer to ensure that an update can be handled and implemented in a timely manner.

DATA FIELDS

PMLINEID: Practice Management Line ID

Definition:
A unique number for each record reported to DPH which is generated by a provider's practice management or billing system that does the following:

- Uniquely identifies each record within a given fiscal year
- **Provides a sequencing of activity for services with transfer records**
- The PMLINEID can be used by a provider to link DPH remittance information *(PV number, reason pended or denied)* to a specific activity within their billing system.

Requirements:

- Dbase data type: Character, Length: 8
- Text File: Columns 1 to 8
- Required for all records
- Must be all numbers (alpha characters are not allowed)
- Must indicate the sequencing of payer activity

RECORDNO: Record Number

Definition: A unique number for each service reported to DPH which is generated by a provider's billing system. A record number is unique per client for the duration of their stay in Early Intervention.

Requirements:

- Dbase data type: Character; Length: 7
- Text File: Columns 9 to 15
- Required for all records
- Must be all numbers (alpha characters are not allowed)
- Must be the same on all record types *(data field name: SDFORM)*

SDFORM: Record Type

Definition:

Record type being reported

Values:

ORIGINAL/INITIAL Record Types:

B = record with a service date (SDRDATE) same as the reporting month (REPMONTH)

C = record with a service date (SDRDATE) previous to the reporting month (REPMONTH)

TRANSFER Record Types:

D = unit transfers

E = partial payment transfers

Requirements:

- Dbase data type:: Character, Length: 1
- Text File: Column 16
- Required for all records
- A service MUST have one, and only one, original/initial record *(Note: A service cannot have both a "B" and "C" record)*.
- All services, regardless of payer are sent once on SDFORM B or SDFORM C. No service should be sent on SDFORM B AND SDFORM C even in future reporting months; Otherwise they will get rejected as a duplicate service.
- Unit transfer record (SDFORM = D):
  - Most unit transfers consist of two records:
    - denial of all hours and charges by one payer
    - payment request of all hours and charges by another payer
  - All third party denials, whether a service ultimately gets billed to DPH or not, must be included as a unit transfer on the SDR file. For example, if a program bills MassHealth after being denied payment by BC/BS, report both the BC/BS and MassHealth denials.
  - If the provider needs to reverse out the service for any reason then one unit adjustment credit (negative hours & charge) is submitted to DPH. The service is then ignored at DPH.
- Partial payment transfer record (SDFORM = E):
  - Oftentimes a third party will pay for some but not all of the charges for a service. Partial payments charged to DPH due to this type of denial is submitted as a partial pay transfer record.
  - IMPORTANT: Partial charges to secondary payers are NOT reported to DPH. The partial payment transfer record is ONLY for partial DPH charges. This is the only transaction type or activity that is not reportable to DPH. For example, if a child has a MassHealth secondary insurer the denied partial charge from the primary insurer to MassHealth is not reported to DPH.
  - If the provider needs to reverse out the partial charge for any reason then one partial pay credit (having a negative PARTDPH) is submitted to DPH.
- Unit and partial pay transfer records cannot be transmitted until the original/initial record has been transmitted either previously or within the same reporting month's SDR file.

REPMONTH: Month of Report

Definition:

The calendar month that corresponds to the DPH payment voucher reporting period.

- Provider payment vouchers/invoices are processed monthly and correspond to the 12 monthly calendar reporting periods for a given fiscal year identified on the SDR file.

Requirements:

- Dbase data type: Character, Length: 2
- Text File: Columns 17 to 18
- Required for all records

REPYEAR: Year of Report

Definition:

The calendar year that corresponds to the DPH payment voucher reporting period.

- Provider payment vouchers/invoices are processed monthly and correspond to the 12 monthly calendar reporting periods for a given fiscal year identified on the SDR file.

Requirements:

- Dbase data type: Character, Length: 4
- Text File: Columns 19 to 22
- Required for all records

SDRDATE: Date Service was Provided

Definition:

The date the service occurred.

Requirements:

- Dbase data type: Date, Length: 8
- Text File: Month: Columns 23 to 24
  Day: Columns 25 to 26
  Year: Columns: 27 to 30
- Required for all records

PRGCODE: Program Code

Definition:

The program code is a DPH assigned two-character field that identifies the program that rendered the service and submitted the SDR file.

Values:

See Program Code sheet.

Requirements:

- Dbase data type: Character, Length: 2
- Text File: Columns 31 to 32
- Required for all records

CLIENT: DPH Client ID

Definition:

The DPH client ID is a seven-character data field assigned to the child and must match the first seven-characters of the Client ID in the EIIS Client system:

- First two characters are the program code
- Last five characters uniquely identify a child within a program *(usually assigned by EIIS)*.

Secondary Services:

- If a child is enrolled in another EI program *(primary EI program)* and receives services from this EI program then those services are considered secondary services. The child does not get entered into EIIS at the secondary EI program.
- All services provided for this child from the secondary program are reported to DPH using the primary EI program's client ID. Therefore, the first two characters of the client ID will refer to the primary EI program.
- All secondary services must include a Request for Reimbursement authorization number (data field name: WAIVERNO) which is an approval from DPH for the child for secondary services.

Requirements:

- Dbase data type: Character, Length: 7
- Text File: Columns 33 to 39
- Required for all records
- First two characters are always the same as the Program Code *(data field name: PRGCODE)* with one exception *(see Secondary Services above).*

REFERRAL: Referral Number

Definition:

The referral number indicates whether this is a first time or subsequent referral of a child to a specific EI program. This number is automatically assigned when the EIIS *Add a Client* screen is completed and is referenced on all EIIS client forms. It is the eighth character of the DPH ID number in the EIIS client system.

Requirements:

- Dbase data type: Character, Length: 1
- Text File: Column 40
- Required for all records
- The DPH Client ID and Referral numbers must correspond to the same Client ID and Referral numbers for this child registered in the EIIS Client system.
- If the child has had multiple referrals to the EI program then the referral number in the SDR file must match to the appropriate referral number in the EIIS system. In other words, services under the SDR referral number must occur within the appropriate enrollment timeframe when matched to the referral number entered into the EIIS system.

MEDNUM

This data field is no longer used by DPH.

Requirements:

- Dbase data type: Character, Length: 10
- Text File: Columns 41 to 50
- *Default: NULL*

HOURS: Number of Hours Service was Provided

Definition:

Number of hours of service

Requirements:

- Dbase data type: Number, Length: 6
- Text File: Columns 51 to 56
- Format +/- 99.99
- Default: 0.00
- Must be greater than 00.00 for all original/initial records (SDFORM = B or C)
- Must be less than or greater than 00.00 for all unit transfer records (SDFORM = D)
- Must be 00.00 for all partial pay transfer records (SDFORM = E)
- Services may only be billed for full fifteen-minute segments; thus a twenty-minute session would be billed as 0.25 hours.

PROFDISC: Professional Discipline

Definition:

The professional discipline providing the service.

Values:

AA = Developmental specialist *(as stated under (a), (b) or (c) of Section V, Service Providers and Roles, of the MA EI Operational Standards)*
AS = Autism specialty provider *(SSP employees)*
BB = Developmental specialist *(as stated under (d) of Section V, Service Providers and Roles, of the MA EI Operational Standards)*
CS = Counselor/Psychologist
MH = Mental Health Specialist *(EIPP services of P, R or V ONLY)*
NS = Nurse
OA = Occupational Therapy Assistant
OT = Occupations therapist
PA = Physical Therapy Assistant
PT = Physical therapist
SA = Speech Language Pathology Assistant
SP = Speech/language therapist
SS = Specialty Provider *(EI program employees)*
SW = Social worker

Requirements:

- Dbase data type: Character, Length: 2
- Text File: Columns 57 to 58
- Required for all records

COTRTMT: Co-Treatment Session

Definition:
Identification flag to identify a co-treatment session
Values:

- 1 (Yes)
- 0 (No)

Requirements:

- Dbase data type: Character, Length: 1
- Text File: Column 59
- Required for all records when service *(data field name: SERVICE)* is a home visit or center-individual service.
- All other SERVICEs to be *NULL* or 0 (No) for COTRTMT

TPPELIG: Insurer Addendum Information for the Primary Insurer

Definition: Additional information about the primary insurer *(data field: PRIMARY)*
Values:

1 = MA Fully insured
2 = MA Self-insured/ASO
3 = Federal *(this code takes precedence over a code of "2")*
4 = HSA (Health Savings Account)/HRA/FSA (Flexible Spending Account)
5 = Union/Local/Trade Association plan *(this code takes precedence over a code of "2")*
6 = Group Insurance Commission (GIC)
7 = Out-of-state *(includes out-of-state self-insured)*
9 = Unknown

Requirements:

- Dbase data type: Character, Length: 1
- Text File: Column 60
- Only to be used when the primary insurer *(data field name: PRIMARY)* is a commercial insurer
- The “5” *(Union/Local/Trade)* value cannot be used when the insurer is Champus.
- The “6” *(GIC)* value can only be used when the primary insurer is one of the following:

  20 Harvard Pilgrim Health Care *(HPHC)*
  21 Tufts Associated Health Plan *(TAHP)*
  22 Fallon Community Health Plan *(FCHP)*
  24 Neighborhood Health Plan *(NHP)*
  27 Health New England
  66 Unicare
  70 United Behavioral Health *(UBH)*

- Default: *NULL*
- A *NULL* value is required when the primary insurer *(data field: PRIMARY)* is MassHealth or the child is uninsured.

TPPAUTH: Insurer Addendum Information for the Third Party Payer

Definition: Additional information about the third party payer *(data field: TPPCODE)*

Values:

1 = MA Fully insured
2 = MA Self-insured/ASO
3 = Federal *(this code takes precedence over a code of "2")*
4 = HSA (Health Savings Account)/HRA/FSA (Flexible Spending Account)
5 = Union/Local/Trade Association plan *(this code takes precedence over a code of "2")*
6 = Group Insurance Commission (GIC)
7 = Out-of-state *(includes out-of-state self-insured)*
9 = Unknown

Requirements:

- Dbase data type: Character, Length: 1
- Text File: Column 61
- Used for when commercial insurers are the payer *(data field name: TPPCODE)*
- The “5” (Union/Local/Trade) value cannot be used when the insurer is Champus.
- The “6” (GIC) value can only be used when the primary insurer is one of the following:

  20 Harvard Pilgrim Health Care *(HPHC)*
  21 Tufts Associated Health Plan *(TAHP)*
  22 Fallon Community Health Plan *(FCHP)*
  24 Neighborhood Health Plan *(NHP)*
  27 Health New England
  66 Unicare
  70 United Behavioral Health *(UBH)*

- A *NULL* value is required when the third party payer *(data field: TPPCODE)* is MassHealth or the child is uninsured.

SERVICE: Service type

Definition:

A specific session provided to one client on a specified day by one clinician.

Values:

A = Home visit
B = Center-based individual
D = Parent group
E = Comprehensive Health Assessment (CHA)
G = Initial assessment: all assessment/evaluation activities completed up to the Initial IFSP signature date are defined as an initial assessment. If a child has been re-referred or transferred from another EI program and the eligibility timeframe has expired *(the child is <u>not</u> under an active IFSP)* then the assessment/evaluation is considered an initial assessment.
H = Ongoing assessment: all assessment/evaluation activities for children with active IFSP's are defined as an ongoing assessment. If a child has been re-referred or transferred from another EI program and the eligibility timeframe has not expired than any assessment/evaluation activities are considered ongoing assessment.
I = Initial EI service
J = Autism specialty Intake service *(discontinued 10/1/2016)*
K = Autism specialty direct treatment service with supervision *(discontinued for DPH as of 7/1/2016; discontinued for all other payers as of 10/1/2016)*
M = Child group: Community
N = Child group: EI-only
S = Autism specialty service *(submission of all autism services under this code for DPH as of 7/1/2016 and all other payers by 10/1/2016)*
P = EIPP home visit
V = EIPP Initial Home visit

Requirements:

- Dbase data type: Character, Length: 1
- Text File: Column 62
- Required for all records
- Must correspond to the DMACODE, DENNUM and WAIVER codes:

SERVICE	DMACODE (CPT code)	DENNUM (Service Modifier)	WAIVER (Service Setting)
A	H2015	1,2 or 3	H01 or H02
B	T1015	1 or 2	V01, V02 or V03
D	T1027		P01
E	T1023		S01 or S02
G	T1024		S01 or S02
H	T1024		S01 or S02
I	H2015	1	H01 or H02
J	H2019		K01, K02 or K03
K	H2031		K01, K02 or K03
K	H2012		K01, K02 or K03
K	H2019		K01, K02 or K03
M	96153	2	C02
N	96153	1	C01
S	H0031		K01, K02 or K03
S	H0032		K01, K02 or K03
S	H2012		K01, K02 or K03
S	H2019		K01, K02 or K03
P	H2015		H01 or H02
R	H2015		H01 or H02
V	H2015		H01 or H02

PAYMENT: Payment Source

Definition:

EI payer source.

Values:

D = DPH
M = MassHealth *(non-MCO)*
X = MassHealth MCO *(Managed Health Plan for MassHealth eligible children)*
H = HMO
I = Commercial insurer

Requirements:

- Dbase data type: Character, Length: 1
- Text File: Column 63
- Required for all original/initial and unit adjustment records *(SDFORM = B, C or D)*
- Must correspond to the TPPCODE code *(see Third Party Payer & Primary Insurer code sheet)*

DMACODE: CMS or CPT Procedure Code

Definition:

CPT procedure codes for EI services:

Values:

96153 =Child group – EI only *(must use DENNUM = 1)*
96153 =Child group – Community *(must include DENNUM = 2)*
H2015 =EI Intake, regular home visit, home visit assessment or IFSP home visit *(including EIPP services of P and V)*
T1015 =Center-based individual visit
T1027 =Parent-focused group session
T1023 =Comprehensive Health Assessment *(CHA)*
T1024 =Assessment

CPT procedure codes for EI autism services:

Values:

Effective for DPH through 2/29/2016 (other payers, except BC/BS, may use this code through 9/30/2016) Note: DPH does not require the reporting of the "SE" modifier.

H2019-SE =Autism specialty services *(services J, K and S)*

Effective for DPH as of 3/1/2016 (other payers may not begin the use of these codes until 10/1/2016) Note: DPH does not require the reporting of the "UE" modifier.

H0031-UE = ASSESSMENT: Assessment and case planning for home services by a licensed professional[1] *(includes preparation of assessment report).*
H0032-UE = SUPERVISION: Supervision[2] for home services by a licensed professional.
H2012-UE = DIRECT TREATMENT/PARENT TRAINING BY A LICENSED PROFESSIONAL: Direct instruction or parent training[3] for home services by a licensed professional[1].
H2019-UE = DIRECT TREATMENT BY A PARAPROFESSIONAL: Direct instruction by a paraprofessional working under the supervision of a licensed professional.

Definitions and Information

- [1]Licensed professional: a BCBA or supervisor needs to have a license to be able to bill at the higher rate.
- [2]Supervision: clinical supervision that provides face-to-face instruction during a client session for the purpose of enhancing and supporting best clinical skills that will lead to improved outcomes.
- [3]Parent training: instructions to the parent or caregiver on follow-through activities, strategies, and/or techniques to be provided to the child at home.

Requirements:
- Dbase data type: Character, Length: 5
- Text File: Columns 64 to 68
- Required for all records
- The CPT code for a partial payment record should include the DPH CPT code for that service.

PRIMARY: Child's Primary Insurer

Definition:
The primary insurer for the child. If the child is uninsured, the primary insurer is DPH.
Values:
See Insurer code sheet.
Requirements:
- Dbase data type: Character, Length: 2
- Text File: Columns 69 to 70
- Required for all records
- If the child is insured and the service is a charge to DPH, the primary insurer field must include the code for the primary insurer; it should not be the DPH code of 00.
- If there is only one insurer (no 2ndary insurer) and the service is being billed to a third party, then the primary insurer (data field: PRIMARY) and insurer addendum (TPPELIG) code will always be the same as the TPPCODE (billed to) and payer addendum (TPPAUTH) code.
- Unlike TPPCODE there is no data field associated with PRIMARY to include a text field when the primary insurer is "Other". The PRIMARY8 used to be used for this but has now taken on another definition.

PRIMARY8: Child's Primary Insurer Member ID

Definition:
The child's member ID under their primary insurer. For MassHealth children this would be the child's RID number.
Requirements:
- Dbase data type: Character, Length: 20
- Text File: Columns 71 to 90
- Must be completed for all children whose primary insurer is MassHealth or a commercial insurer.
- If the child receives MassHealth as a secondary insurer then use the primary insurer member ID.
- Use a *NULL* value if the child is uninsured

TPPCODE: Third Party Payer Code

Definition:
The payer of the service.
Values:

- See Insurer code sheet.

Requirements:

- Dbase data type: Character, Length: 2
- Text File: Columns 91 to 92
- Required for all records
- If the service is being billed to DPH this data field should be coded 00 EXCEPT for partial pay records (SDFORM = E). The TPPCODE on all E records should reflect the insurer (exception: when using an E record to submit a credit to DPH then a code of 00 is allowed).
- TPPCODE must correspond to the PAYMENT code *(see Insurer code sheet)*
- If there is only one insurer *(no 2ndary insurer)* and the service is being billed to a third party, then the TPPCODE and payer addendum *(TPPAUTH)* code will always be the same as the PRIMARY (primary insurer) and insurer addendum *(TPPELIG)* code.

TPPCODE8: Third Party Payer is Other

Definition:
If the insurer code is designated as "Other" the name of the organization or program must be provided in this data field.
Requirements:

- Dbase data type: Character, Length: 20
- Text File: Columns 93 to 112
- Default: *NULL*
- Must be completed when TPPCODE = 88
- Must not include the name of an insurer listed on the Insurer code sheet.

REASON: Reason for Payment Request being Submitted to DPH

Definition:
The reason the payment request is being submitted to DPH.
Values:

- See Reason Code sheet.

Requirements:

- Dbase data type: Character, Length: 3
- Text File: Columns 113 to 115
- To be used for all records when DPH is the payer *(SDFORM = B, C or D and PAYMENT = D or SDFORM = E)*
- When DPH is not the payer for a unit transfer record then the reason code:
    - May be the same as the DPH reason code
    - May be *NULL*
    - May have a value of 00
- If an 835 HIPAA remittance generated by the insurer is received then use the HIPAA adjustment reason code as the DPH reason code. If there are multiple adjustment reason codes then select the one that is most appropriate for DPH payment.
- A non-HIPAA adjustment reason code received from an insurer is to be converted to the most appropriate DPH Adjustment Reason code.

- If no appropriate adjustment reason code exists *(according to the DPH Reason Code sheet)*, submit the record to DPH using a reason code of D99 *(Note: This will cause the record to pend. Support documentation should be sent to the EI fiscal manager for these services once pended).*

WAIVER: Service setting

Definition:
The setting where the service is provided.
Values:

S01 = Assessment provided at a non-community setting
S02 = Assessment provided at the home or a community setting
H01 = Home visit provided at the child's home *(including EIPP services of P and V)*
H02 = Home visit provided outside of the child's home (relative's home, babysitter, day care, playground, etc.)*(including EIPP services of P and V)*
K01 = Autism specialty service provided in the child's home
K02 = Autism specialty service provided in a natural setting outside the child's home
K03 = Autism specialty service provided in a non-community setting
V01 = Center-individual visit provided as part of a segregated child group service
V02 = Center-individual visit provided as part of a community-based child group
V03 = Center-individual visit, no child group service participation
C01 = Segregated child group service
C02 = Community-based child group service
P01 = Parent group service

Requirements:

- Dbase data type: Character, Length: 3
- Text File: Columns 116 to 118
- Required for all records
- Must correspond to the SERVICE, DMACODE and DENNUM codes *(see SERVICE)*

WAIVERNO: Request for Reimbursement/Authorization Number

Definition:
A unique number given to an EI program by DPH staff that identifies a request for reimbursement for a service.
Requirements:

- Dbase data type: Character, Length: 7
- Text File: Columns 119 to 125
- Default: *NULL*
- Must be included on the original/initial record regardless of payer if a request for reimbursement is in effect for that service.
- EI Autism Specialty services are not eligible for these types of requests from DPH.
- Do not on any services other than the approved service
- DO NOT include dashes

CHARGE: Charge to Payer Source

Definition: The charge for the service based on the service rate.

Requirements:

- Dbase data type: Number, Length: 8
- Text File: Columns 126 to 133
- Format: +/- 9999.99
- Default: 0.00
- Must be greater than 0000.00 for all original/initial records (SDFORM = B or C)
- Must be less than or greater than 0000.00 for all unit transfer records (SDFORM = D)
- Must be 0000.00 for all partial pay transfer records (SDFORM = E)
- The charge must reflect the unit rate in effect at the time the service was delivered.
- The following provides unit rate information:

	Effective to 2/29/2016		Effective 3/1/2016	
EI Service Type	**DPH Unit** *(1 Hour)*	**.25 Unit** *(1/4 Hour)*	**DPH Unit** *(1 Hour)*	**.25 Unit** *(1/4 Hour)*
EI Intake	$81.80	$20.45	$89.40	$22.35
Assessment	$109.72	$27.43	$119.92	$29.98
Home visit	$81.80	$20.45	$89.40	$22.35
Center-Based Individual	$68.60	$17.15	$74.96	$18.74
Child Group: EI Only	$23.88	$5.97	$26.12	$6.53
Child Group: Community	$31.40	$7.85	$34.32	$8.58
Parent-focused Group	$30.68	$7.67	$33.52	$8.38
CHA	$95.60	$23.90	$104.48	$26.12
EIPP Initial Home visit	$173.98	$43.50	$173.98	$43.50
EIPP Home visit	$86.99	$21.75	$86.99	$21.75
CHA	$95.60	$23.90	$104.48	$26.12

	Effective to 2/29/2016		Effective 3/1/2016	
EI Autism Service Type	**DPH Unit** *(1 Hour)*	**.25 Unit** *(1/4 Hour)*	**DPH Unit** *(1 Hour)*	**.25 Unit** *(1/4 Hour)*
Autism Intake *(eff to 9/30/16)*	$61.52	$15.38	$61.52	$15.38
Autism Dir Trtmt	$61.52	$15.38	*NA*	*NA*
Autism Dir Trtmt Sup	$61.52	$15.38	*NA*	*NA*
Autism assessment			$109.53	$27.38
Supervision			$109.53	$27.38
Parent training			$109.53	*NA*
Dir trtmt by a paraprofessional			$57.96	$14.49

	Effective 11/1/2007	
EIPP Service Type	**DPH Unit** *(1 Hour)*	**.25 Unit** *(1/4 Hour)*
EIPP Initial Home visit	$173.98	$43.50
EIPP Home visit	$86.99	$21.75

- Autism specialty service rate may vary when a commercial insurer is paying the service.

DENNUM: Service Modifier

Definition: Service modifier to be used for:

- EI child group service for the purpose of distinguishing one child group type from the other
- Identifying a home visit or center individual service as an IFSP or Assessment meeting
- Identify a BC/BS autism re-assessment when billing BC/BS under their 0359T-52 CPT code.

Values:

Child Group service:

1 = Service modifier for EI-only child group

2 = Service modifier for Community child group

Home visit service:

3 = Assessment meeting

BC/BS autism re-assessment using the 0359T-52 CPT code

5 = Service modifier for BC/BS when reporting to DPH a BC/BS re-assessment that uses the 039T-52 CPT code

Requirements:

- Dbase data type: Character, Length: 1
- Text File: Column 134
- Default: *NULL*
- Child group service is required to have a service modifier
- IFSP home visit is required to have a service modifier
- Assessment home visit is required to have a service modifier
- Must correspond to the SERVICE, DMACODE and WAIVER *(service setting)* codes. See Services.

INSAMT: Autism Specialty Provider Code

Definition:

Specialty Provider for autism services

Values:

102 = Beacon Services
103 = Building Blocks (NE Arc)Beacon Services
105 = Children Making Strides
106 = HMEA
107 = LEAP
101 = May Center
109 = New England Center for Children
112 = Pediatric Development Center
110 = REACH (ServiceNet)
201 = Amego
202 = Applied Behavioral language Services
203 = Behavioral Concepts
205 = Make a Difference in Children
206 = RCS Behavioral & Educational Consulting
207 = Reach Educational Services
208 = Spectrum Autism Treatment

Requirements:

- Dbase data type: Number, Length: 8
- Text File: Columns 135 to 142
- Default: 0.00
- All autism services must have an SSP code
- All non-autism services must have 0000.00

PARTINS: Not Applicable

This data field is no longer used by DPH.

Requirements:

- Dbase data type: Number, Length: 8
- Text File: Columns 143 to 150
- Format: +/- 9999.99
- Default: 0.00

PARTDPH: Cost Adjustment DPH Amount

Definition:

The partial pay charge to DPH when a third party payer denies part of the charges.

Requirements:

- Dbase data type: Number, Length: 8
- Text File: Columns 151 to 158
- Format: +/- 9999.99
- Default: 0.00
- Must be 0.00 for all original/initial and unit transfer records (SDFORM = B, C or D)
- Must be less than or greater than 0.00 for all partial pay transfer records (SDFORM = E)

SETTING: MassHealth Secondary Insurer

Definition:

the secondary insurer for a commercial insurer when the secondary insurer is MassHealth or MassHealth MCO.

Values:

47 = MassHealth: Basic
38 = MassHealth: Children's Medical Security Plan (CMSP)
51 = MassHealth: CommCare
43 = MassHealth: CommonHealth
50 = MassHealth: Essential
44 = MassHealth: Family Assist
48 = MassHealth: HSN (Health Safety Net)
49 = MassHealth: HSN – Partial
2 = MassHealth: Standard
35 = MassHealth MCO: BMC Healthnet Plan (Boston Medical Center)
6 = MassHealth MCO: Fallon
67 = MassHealth MCO: Health New England
8 = MassHealth MCO: Neighborhood Health
34 = MassHealth MCO: Network Health

Requirements:

- Dbase data type: Character, Length: 4
- Text File: Columns 159 to 162
- Default: *NULL*
- Do NOT populate wen the secondary insurer is a commercial insurer.

EARLY INTERVENTION SERVICE DELIVERY REPORT
FISCAL YEAR 2016 & 2017
File Transmission Specification

Data Field Name	Data Type	Length	SDFORM	Decimal: dBase Files Only	Columns: Text Files Only
PMLINEID	Char	8	B,C,D,E	-	1 – 8
RECORDNO	Char	7	B,C,D,E	-	9 –15
SDFORM	Char	1	B,C,D,E	-	16
REPMONTH	Char	2	B,C,D,E	-	17-18
REPYEAR	Char	4	B,C,D,E	-	19-22
SDRMONTH	Char	2	B,C,D,E	NA	23-24
SDRDAY	Char	2	B,C,D,E	NA	25-26
SDRYEAR	Char	4	B,C,D,E	NA	27-30
SDRDATE	Date	8	B,C,D,E	-	NA
PRGCODE	Char	2	B,C,D,E	-	31-32
CLIENT	Char	7	B,C,D,E	-	33-39
REFERRAL	Char	1	B,C,D,E	-	40
MEDNUM	Char	10		-	41-50
HOURS	Num	6	B,C,D	2	51-56
PROFDISC	Char	2	B,C,D	-	57-58
COTRTMT	Char	1	B,C	-	59
TPPELIG	Char	1	B,C,D,E	-	60
TPPAUTH	Char	1	B,C,D,E	-	61
SERVICE	Char	1	B,C,D,E	-	62
PAYMENT	Char	1	B,C,D	-	63
DMACODE	Char	5	B,C,D,E	-	64-68
PRIMARY	Char	2	B,C,D,E	-	69-70
PRIMARY8	Char	20	B,C,D,E		71-90
TPPCODE	Char	2	B,C,D,E	-	91-92
TPPCODE8	Char	20	B,C,D,E	-	93-112
REASON	Char	3	B,C,D,E	-	113-115
WAIVER	Char	3	B,C,D,E	-	116-118
WAIVERNO	Char	7	B,C,D,E	-	119-125
CHARGE	Num	8	B,C,D	2	126-133
DENNUM	Char	1	B,C,D,E	-	134
INSAMT	Num	8	B,C,D,E		135-142
PARTINS	Num	8		2	143-150
PARTDPH	Num	8	E	2	151-158
SETTING	Char	4	B,C,D,E	-	159-162

*Text Files Only: A Carriage Return and Line Feed character **MUST** be included at the end of each record.*

EARLY INTERVENTION SERVICE DELIVERY REPORT
FISCAL YEAR 2016 & 2017
EI Program Codes

Code	EI Program name
20	Aspire EI Prg
3	BAMSI Early Intervention Prg
2	Bay Cove EI Prg
67	Boston Children's Hospital EI Prg
6	Cape Cod & Islands Early Childhood Interv Prg
40	Center for Human Development EI Prg
50	Child Guidance Center EI Prg
79	Criterion – Boston EI Prg
73	Criterion – Heritage EI Prg
57	Criterion – Medford EI Prg
22	Criterion – Middlesex EI Prg
95	Criterion – Riverway EI Prg
48	Criterion – Stoneham EI Prg
25	Criterion – Valley EI Prg
43	Criterion – Wachusett EI Prg
89	Criterion – Worcester EI Prg
41	Dimock EI Prg
92	Eliot EI Prg/Cambridge-Somerville
39	Eliot EI Prg/Malden
33	Enable Inc. EI Prg
16	Harbor Area EI Prg
23	Kennedy Donovan Center EI Prg/Attleboro
26	Kennedy Donovan Center EI Prg/New Bedford
24	Kennedy Donovan Center EI Prg/Plymouth
35	Kennedy Donovan Center EI Prg/South Central
18	Lipton EI Prg
64	May Center for EI
8	Minute Man Arc for Human Services, Inc.
5	Northeast Arc-Cape Ann EI Prg
47	Northeast Arc-North Shore EI Prg
86	Northern Berkshire EI Prg
31	Pediatric Development Center
91	Pediatric Development Center/South Berkshire
13	People Inc. EI Prg
58	Pernet Family Service EI Prg
15	Professional Center for Child Development
54	Project BEAM EI Prg
32	REACH EI Prg
85	Riverside EI Prg/Cambridge-Somerville
75	South Bay EI Prg - Fall River
93	South Bay EI Prg - Framingham
94	South Bay EI Prg - Lawrence
76	South Bay EI Prg - Lowell
88	South Bay EI Prg - Worcester
37	Step 1 EI Prg
38	Taunton Area EI Prg
14	The Arc of the South Shore EI Program
56	The Schwartz Center
1	Thom Anne Sullivan Center
44	Thom Boston Metro EI Prg
82	Thom Charles River EI Prg
27	Thom Marlborough EI Prg
83	Thom Mystic Valley EI Prg
84	Thom Neponset Valley EI Prg
17	Thom Pentucket Area EI Prg
49	Thom Springfield Infant Toddler Services
21	Thom Westfield Infant Toddler Services
87	Thom Worcester EI Prg

EARLY INTERVENTION SERVICE DELIVERY REPORT
FISCAL YEAR 2016 & 2017
Insurer Codes
(Data Field Name: TPPCODE)
(Data Field Name: PRIMARY)

Code	Description	Corresponds to Payment Code
0	DPH *(Used under PRIMARY if child is uninsured; Used under TPPCODE if DPH is payer)*	D
38	MassHealth: Children's Medical Security Plan	M
43	MassHealth: CommonHealth	M
44	MassHealth: Family Assist	M
48	MassHealth: HSN *(Health Safety Net)*	M
49	MassHealth: HSN-Partial	M
2	MassHealth: Standard	M
35	MassHealth MCO: BMC HealthNet Plan *(Boston Medical Center)*	X
6	MassHealth MCO: Fallon	X
67	MassHealth MCO: Health New England	X
8	MassHealth MCO: Neighborhood Health	X
34	MassHealth MCO: Tufts Public	X
28	Aetna/US Health Care	I
60	Blue Cross/Blue Shield National Account/Blue Card	I
36	Blue Cross/Blue Shield	I
68	Celticare Health Plan	I
40	Champus/TriCARE	I
25	CIGNA	I
61	Connecticare	I
22	Fallon Community Health Plan *(FCHP)*	I
62	First Network/Coventry	I
18	GIC plan *(state) (All)*	I
41	Great West Health	I
42	Guardian Insurance	I
20	Harvard Pilgrim Health Care *(HPHC)*	I
27	Health New England	I
63	Health Plans, Inc.	I
64	Mega Health/Mid West	I
24	Neighborhood Health Plan *(NHP)*	I
65	Oxford	I
21	Tufts Associated Health Plan *(TAHP)*	I
66	Unicare	I
70	United Behavioral Health (UBH)/Optum [1]	I
71	Beacon Health Strategies (BHS) [1]	I
26	United Health Care	I
88	Other commercial insurer *(complete TPPCODE8 with insurer name)*	I

*DPH pays all services

[1] The UBH & BHS codes of 70 and 71 are used only for the third party payer (data field: TPPCODE) for autism services. The insurance addendum code should be the same as the primary insurer's addendum code.

Early Intervention Service Delivery Reports
Fiscal Year 2016 & 2017
DPH Reason Codes

(Data Field name: REASON)

The DPH adjustment reason code used on the SDR file must be based on the adjustment reason code received on the remittance from the insurer.
BLUE = Reason codes to be used for autism services only

The following codes can be used for BOTH original and unit and cost adjustment/transfer claim records:

Code	Description	Notes
1	Deductible Amount	
2	Coinsurance amount	
3	Co-payment amount	
50	Deemed not medically necessary by payer	
52	The rendering provider is not eligible to perform the service billed	*Use for MassHealth eligible children when directly billing DPH for professional discipine of Speech Language Pathology Assistant (SA).*
96	Non-covered benefit or charge	*DPH payment is made automatically when (1) the insurer is Champus, Children's Medical Security or federal, (2) client is matched to DPH's Insurer file, or (3) client is matched to DPH's override history file.*
109	Claim is not covered by this payer	
119	Benefit maximum has been reached	*Use 119 if self-insured and charge to DPH is due to benefit maximum reached.*
141	Claim adjustment because claim spans eligible & ineligible periods of coverage	
D01	Prior authorization for reimbursement *(e.g., excessive hours)*	
D02	Services received at a secondary EI program	
D05	Uninsured	
D06	Family refused access to insurance	
D07	Authorization is in progress-autism service	*To be used for commercially insured children where the Autism Specialty Service was provided prior to the clinical approval consent, including children who have MassHealth as a 2ndary insurer. This reason code is not allowed for the following insurers: Aetna, Cigna and Neighborhood Health Plan (not MassHealth MCO: NHP).*
D08	Authorization was denied-autism service	

Early Intervention Service Delivery Reports
Fiscal Year 2016 & 2017
DPH Reason Codes

(Data Field name: REASON)

The DPH adjustment reason code used on the SDR file must be based on the adjustment reason code received on the remittance from the insurer.
BLUE = Reason codes to be used for autism services only

The following codes can be used for BOTH original and unit and cost adjustment/transfer claim records:

Code	Description	Notes
D09	Autism service does not meet insurer requirements/No PA initiated	*To be used for MassHealth children who do not meet the MassHealth requirements for ABA services. Also to be used for commercially insured children for (1) intake services (through 9/30/2016), (2) services provided by a non-ABA specialty provider, and (3) primary insurer is TriCARE or insurer is federal.*
D11	Autism contract has not yet been established	*To be used for commercially insured children where the contract for autism services has not been established with the insurer. This reason code is not allowed for the following insurers: Aetna, BC/BS of MA, BMC (not MassHealth MCO: BMC), Cigna, Fallon Community Health Plan, Harvard Pilgrim, Health New England, Neighborhood Health Plan (not MassHealth MCO: NHP), Network Health (not MassHealth MCO: NWH), Tufts Health Plan or United Behavioral Health/Optum*
D22	Non-BCBA clinician provided an autism service where insurer requires BCBA for service	
D24	BC/BS child is provided an autism service in a child care setting	
D25	Autism service is not a covered benefit	*To be used for commercially-insured children only where an autism benefit is not covered (do not use D09 or 096).*
D99	Other (will pend at DPH to be reviewed by DPH staff)	
P10	EIPP Home and Initial Home visit	

Early Intervention Service Delivery Reports
Fiscal Year 2016 & 2017
DPH Reason Codes

(Data Field name: REASON)

The DPH adjustment reason code used on the SDR file must be based on the adjustment reason code received on the remittance from the insurer.

BLUE = Reason codes to be used for autism services only

The following codes can ONLY be submitted on Unit & Cost Adjustment claim records:

Code	Description	Notes
26	Expenses incurred prior to coverage	
27	Expenses incurred after coverage terminated	
28	Coverage not in effect at the time the service was provided	
32	Our records indicate dependent is not an eligible dependent as defined	
33	Claim denied. Insured has no dependent coverage	
39	Services denied at the time authorization/ pre-certification was requested	
45	Charges exceed contracted fee arrangement	
62	Payment denied for absence of pre-certification/authorization	
63	Correction to a prior claim	*DPH negative charge only*
123	Payer refund due to over payment	*DPH negative charge only*
125	Payment adjustment due to submission/billing error	*DPH negative charge only*
177	Recipient is ineligible on this date of service	
B14	Payment denied due to insurer maximum has been exceeded	*To be used for (1) Home visit services for a MassHealth child where MassHealth does not pay for more than one 4 visits per day, (2) CHA Assessment service for EIPP-referred child where MassHealth only pays for 1.0 hour (bill DPH for the extra 1/2-hour under this reason code) or (3) Autism services for a MassHealth child where services exceed 6 hours per day.*

Early Intervention Service Delivery Reports
Fiscal Year 2016 & 2017
DPH Reason Codes

(Data Field name: REASON)

The DPH adjustment reason code used on the SDR file must be based on the adjustment reason code received on the remittance from the insurer.

BLUE = Reason codes to be used for autism services only

The following codes can ONLY be submitted on Partial Pay Adjustment claim records:

Code	Description	Notes
D10	Contractual adjustment-autism services	*To be used for Autism Specialty Services when the insurer is BC/BS and pays at the lower rate of $48.52. The contractual adjustment amount should be the difference between the insurer rate of $48.52 and the DPH rate of $61.52. Note: to be discontinued for services rendered on or after 10/1/2016.*
D20	Rate charge difference between old and new EI services rate	*To be used for EI services when the insurer denies the difference between the old and new rate for EI (not EI autism) services rendered on or after 3/1/2016. DPH created transactions in August 2016 with a D20 reason code that provided a 3.45% rate increase for autism services rendered on or after 3/1/2016 that were paid or pended under the old rate.*

Appendix II

Early Intervention
TVP Website Instructions

MA DEPARTMENT OF PUBLIC HEALTH
EARLY INTERVENTION INFORMATION SYSTEM
TRANSACTION VALIDATION INVOICE PROCESSING (TVP)
WEBSITE INSTRUCTIONS

SUMMARY: The EI Transaction Validation Invoice Processing (TVP) website accepts automated service delivery (SDR) data files that report an EI program's services and subsequent service activity for a given calendar month. The SDR file is extracted from an EI provider's practice management or billing system conforming to DPH's service delivery transmission specifications (see *Appendix I, "EI Service Delivery Data Transmission Specifications"*). Both dBase and text files from EI vendors are allowed to be uploaded to this website.

The TVP website provides summary and validation reports to allow the vendor to pre-check service delivery data before transmittal to DPH. The system encrypts all data for privacy during upload and transmission to the Department.

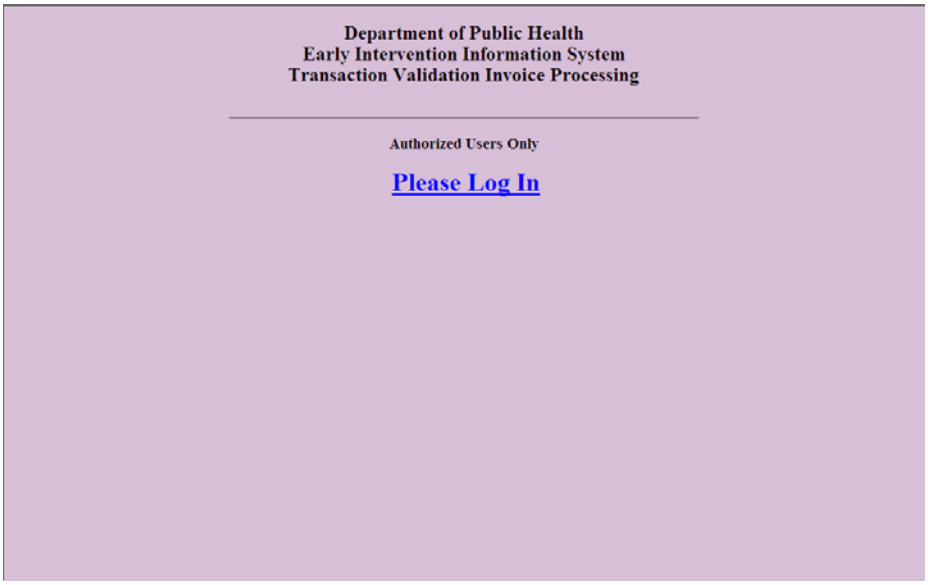
VENDOR REQUIREMENTS: All providers need Internet Service Providers (ISPs) and a browser (i.e., Internet Explorer) in order to access the EI TVP website. SDR files that comply with DPH specifications are the only acceptable data that can be uploaded and transmitted.

The vendor should know their **Username** and **Password** before entry into the TVP website. Contact Jean Shimer at DPH at (617) 624-5526 if you have forgotten your username and/or password.

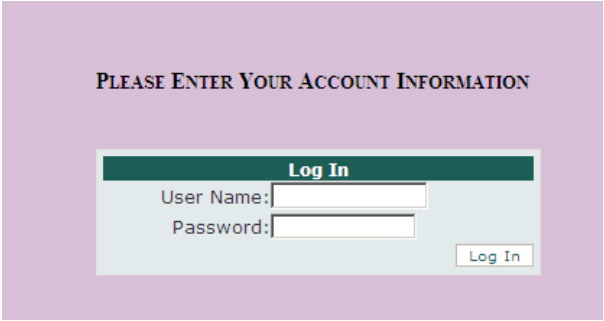
TVP WEBSITE INSTRUCTIONS:

1. Go to the ://tvp.dph.state.ma.us/tvp/ website.

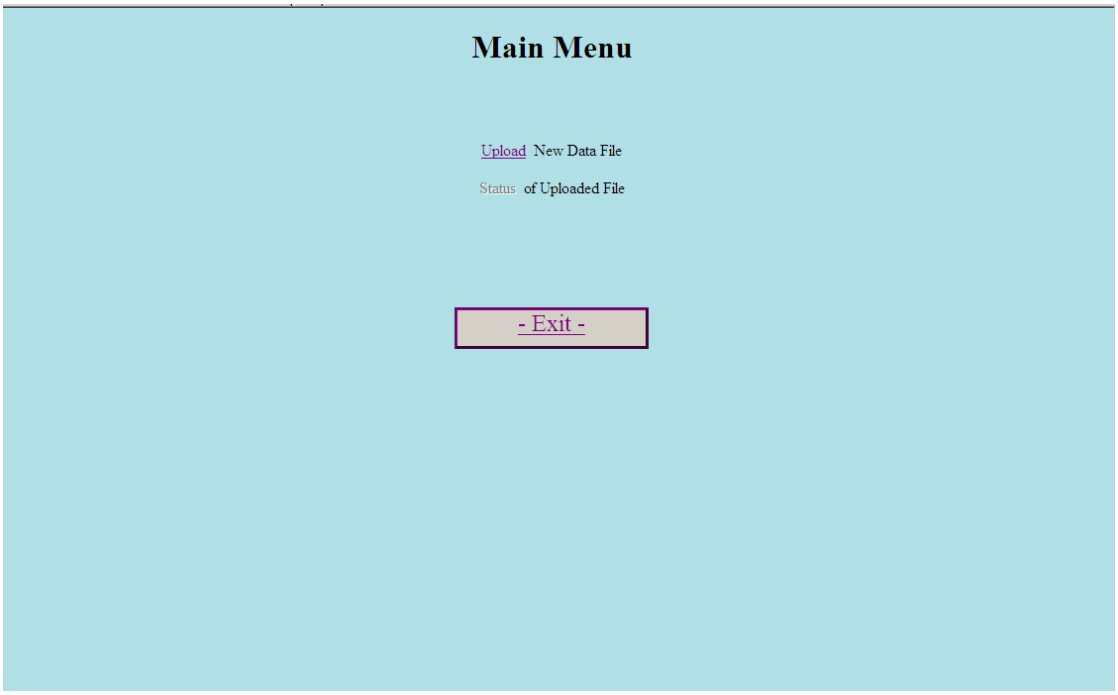
   Click **Please Log In**



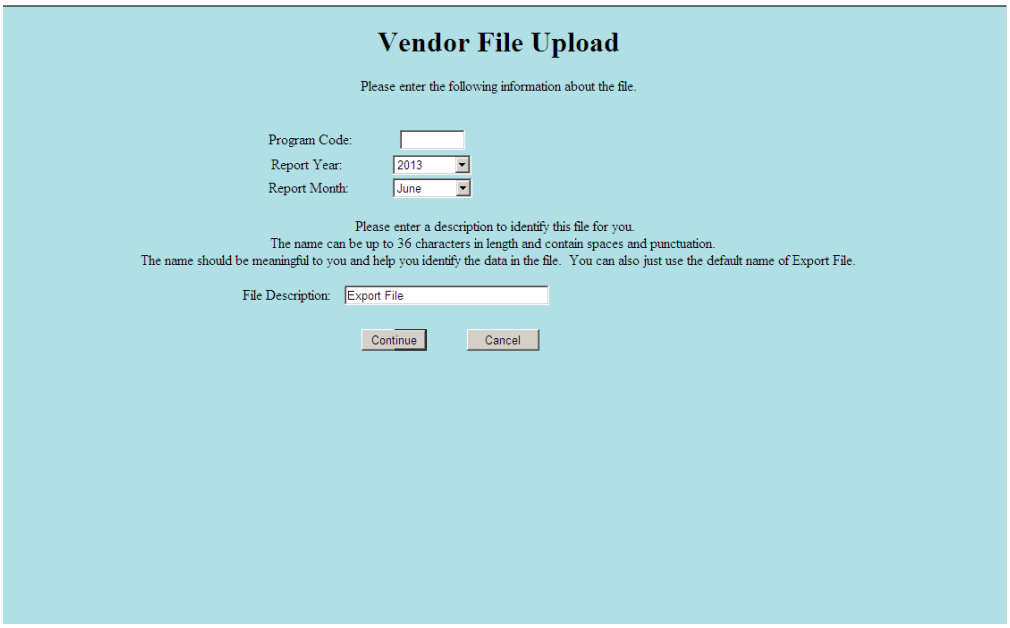
1. Type in your username and password, then click on the ***Log In*** button.



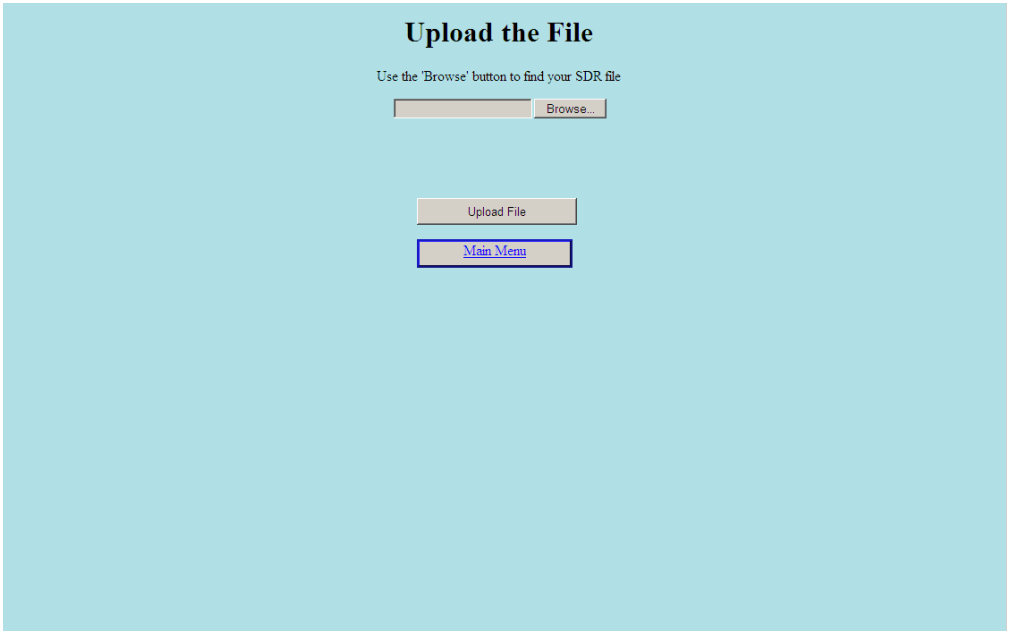
2. Click Upload New Data File.



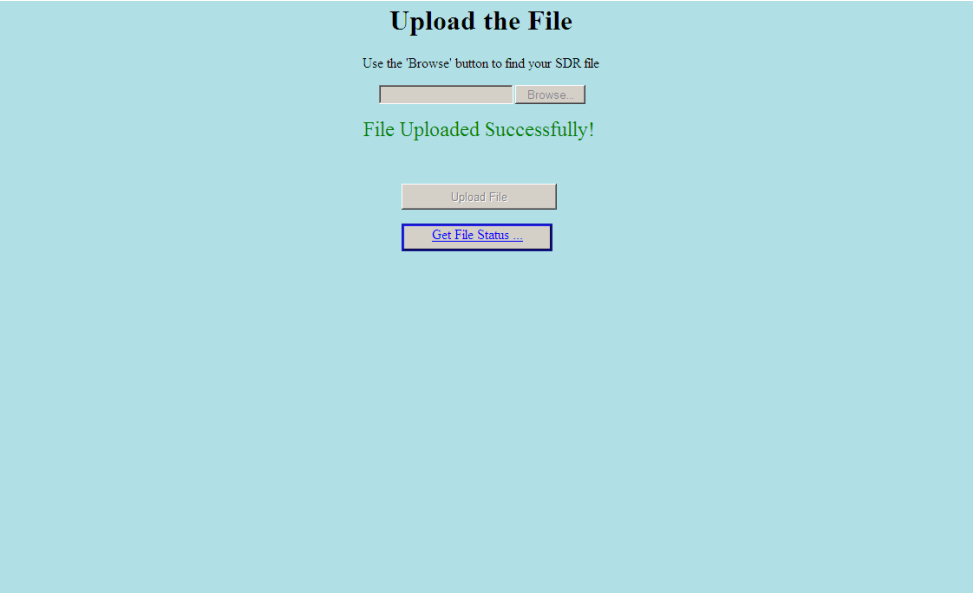
3. Enter your Program Code, the Report Year and Report Month. You can keep the file name of *Export File* or enter a file name under *File Description* such as *PRG99JUN*. This is an arbitrary label for this file during your session on the website. Click the **Continue** button.



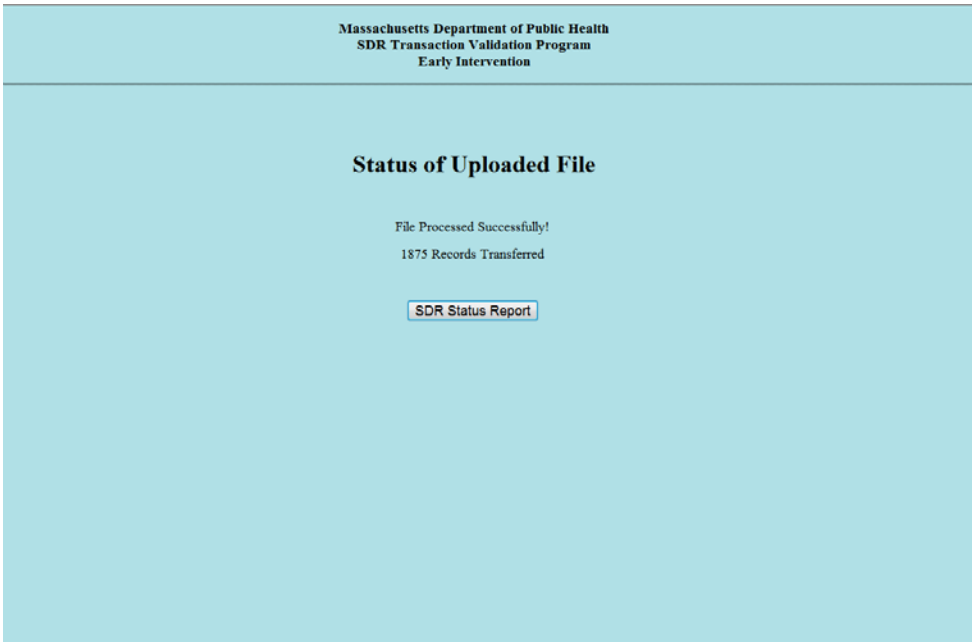
4. You will now upload your SDR file from your computer or network up to the website. This is the file you have exported from your practice management software or billing system Click the **Browse** button, locate your file and then double click the file. Click the **Upload File** button. Uploading may take a little while, depending on the file size and activity on the Internet.



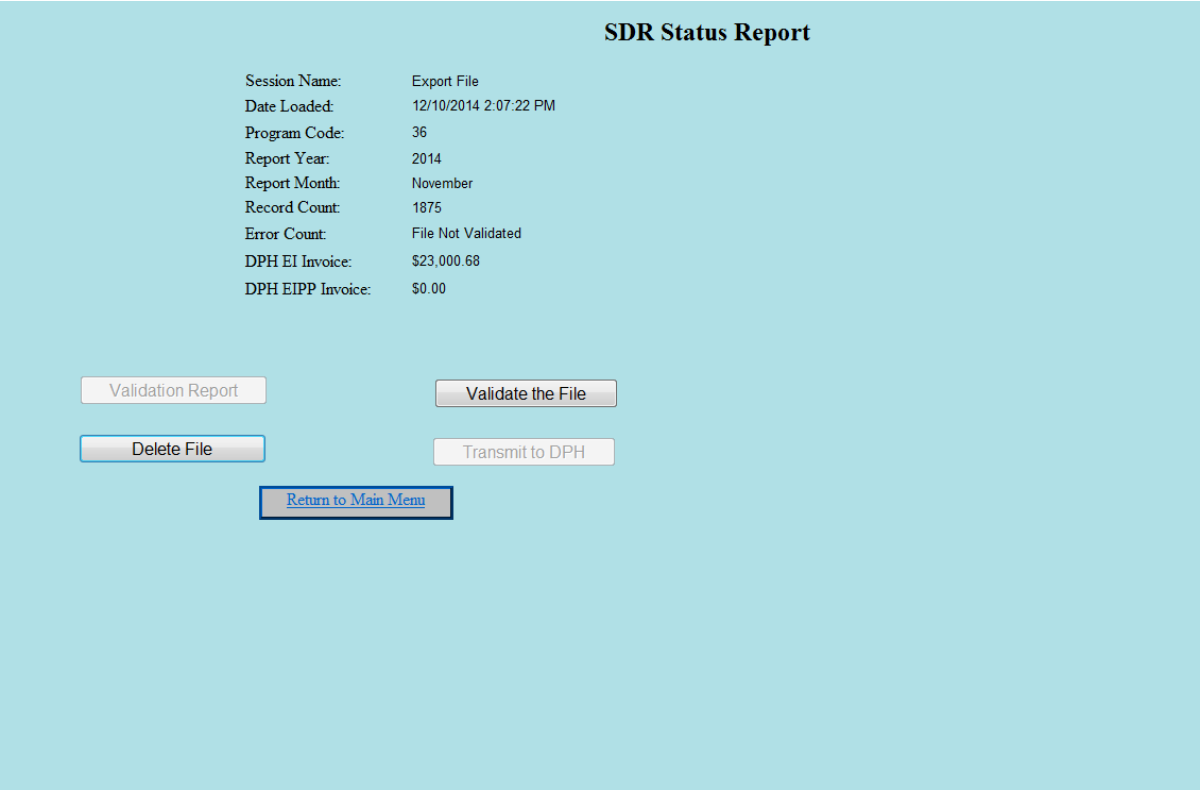
7. You will receive a message that your file has been uploaded successfully. Click the Get File Status button. PLEASE be patient. This may take a few seconds to complete.



8. The File Status page provides you with the number of records that are in your file. Click the **SDR Status Report** button to go to the *SDR Status Report* page.



9. The SDR Status Report provides you with information about your file. Click the **Validate File** button.



The SDR Status Report provides a summation of the records uploaded to the TVP website, including a DPH Invoice total (total amount charged to DPH). The electronic service delivery file or report is, in essence, the bill to DPH of services delivered and reported for a given reporting month for an EI program. Compare the DPH EI Invoice and DPH EIPP Invoice totals on the SDR Status Report with the total amount being billed to DPH based on reports from your practice management or billing system. Both the DPH Invoice amounts and your system total amount should be the same. If there is a discrepancy, you will need to identify the reason for this.

The SDR Status Report can be printed and used for documentation purposes.

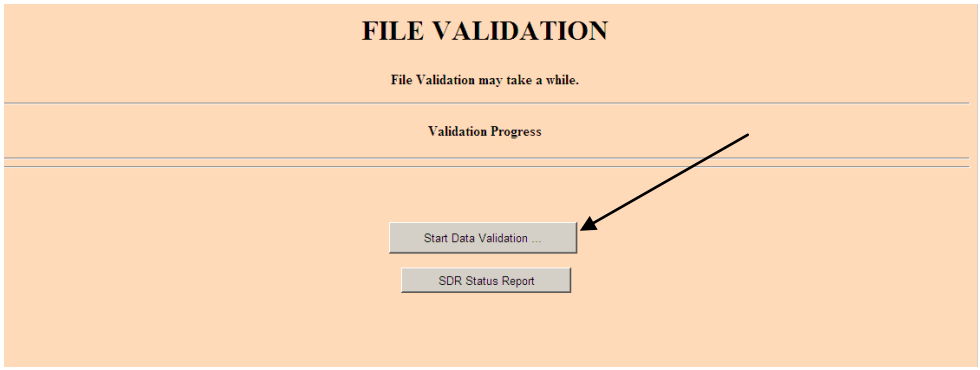
Definitions of Fields on the SDR Status Report

- *Session Name: The arbitrary name you assigned to this session*
- *Date Loaded:* the date that the file was uploaded to the website.
- *Program Code:* the DPH designated EI program code of the file uploaded.
- *Report Year:* the calendar year that you are reporting to DPH for services delivered. This information is based on what you entered on the previous screen under the reporting year question.
- *Report Month:* the calendar month that you are reporting to DPH for services delivered. This information is based on what you entered on the previous screen under the reporting month questions.
- *Record Count:* The total number of records uploaded.
- *Error Count:* The number of errors after validating your file. If the file has not been validated then this will be stated.
- *DPH EI Invoice:* Total EI (including autism) charges to DPH charge.
- *DPH EIPP Invoice:* Total EIPP (including autism) charges to DPH charge.

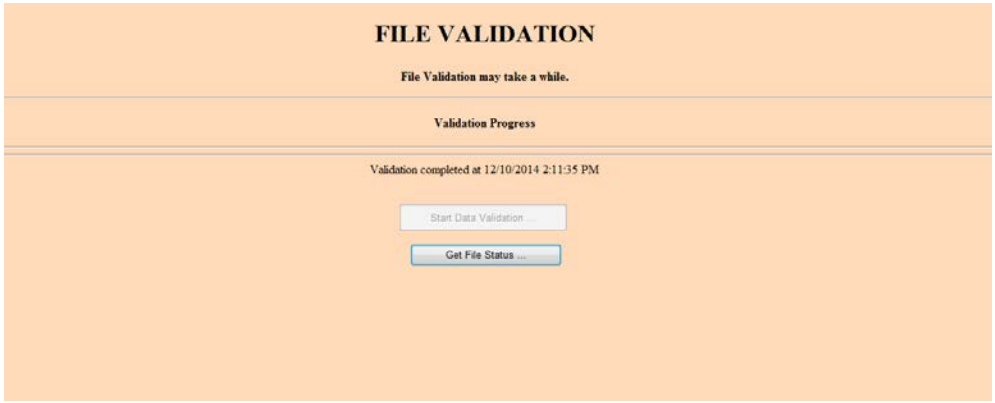
10. Click the *Start Data Validation* button. The validation of records is a two-phase process:

    Error Identification: The first process identifies errors on your data file (records with illogical or missing data). This process will search for errors and provide a counter showing how many records have been processed. If there are no errors this process will search for warnings and potential problems on non-DPH insurer records
    Recording Results: This process takes a little while to record any errors or warnings for the validation report.

    Make sure you click the *Start Data Validation* button.



    Once completed the *Validation completed* message should appear. Click the **Get File Status** button.



11. This will bring you back to an updated SDR Status Report which provides you with a validation message.

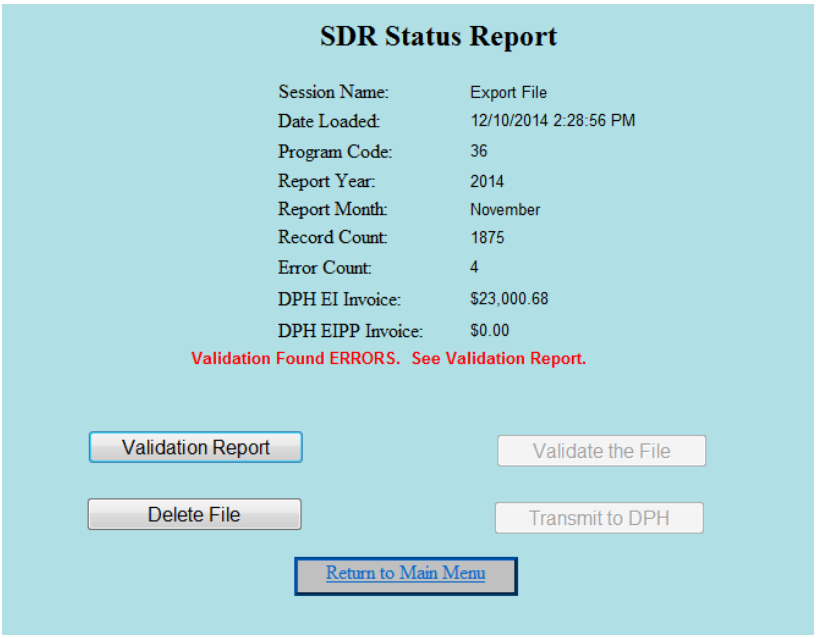
    Validation Report
    The validation report is an "exception report" that identifies problem claim records such as incomplete data or inconsistent information within a claim record. One or more service records identified on this report as having an error prevents EI providers from transmitting the entire SDR file of records to DPH. *Appendix III, "EIIS Website Validation Identification Instructions"*, provides a list of all EI TVP website errors along with suggestions for resolution of claim records with these errors.

    The validation report may also identify claim records having warnings. Warnings do not block submission of files, but they are noted on the website's Validation Report so that the provider can review and/or correct them. DPH warns EI providers of these records because they may lead to other billing issues. For example, some warn of errors that may lead DPH or third party payers to reject claims.

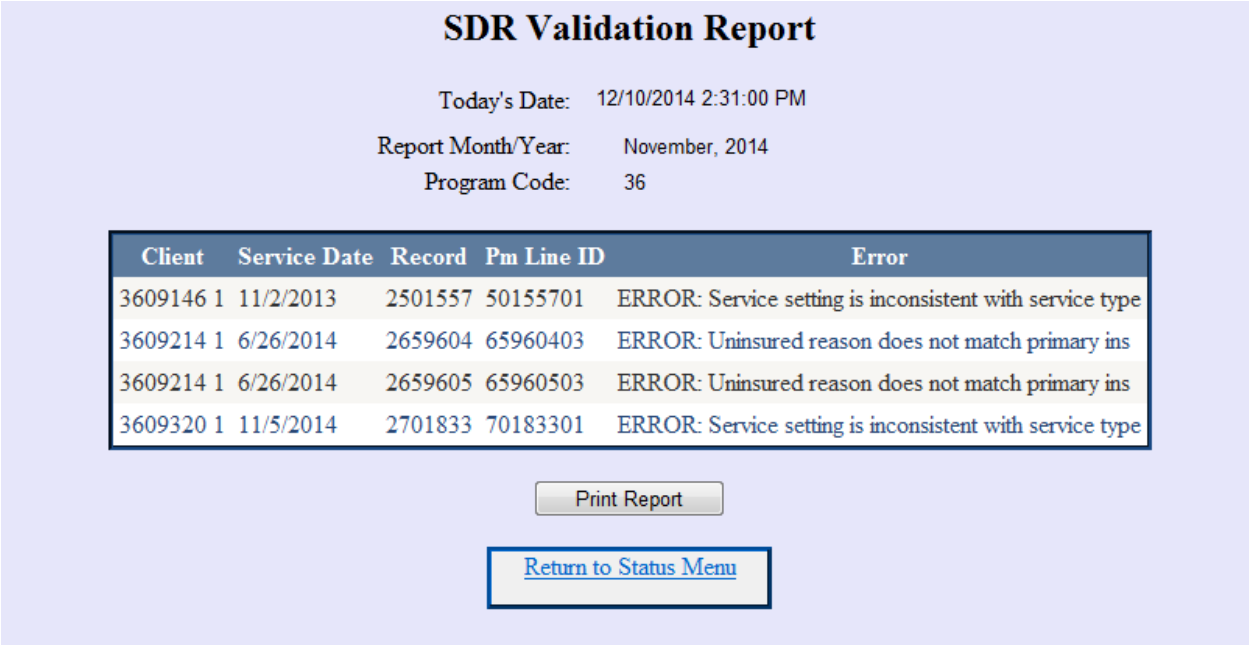
    The Validation Report cannot identify all errors that may cause DPH to reject claims. For example, the report cannot check whether the same claim is a duplicate of one submitted at an earlier date. DPH checks for duplicate and other problematic claims after the file is transmitted.

    After running the validation report the EI provider must make corrections of problem claim records on their practice management or billing systems and re-upload the corrected file to the EI TVP website. The validation report must be generated again to verify that no fatal errors exist.

    A. File Has Errors:
    - If the validation found errors then click the **Validation Report** button.



- The *Validation Report* can be printed out. If the report has multiple pages then you will need to select each page and click the *Print Report* button. Each error is recorded separately. Therefore, if the same record has three errors then each error is recorded in this report on a separate line.



SDR Validation Report

Today's Date: 12/10/2014 2:31:00 PM
Report Month/Year: November, 2014
Program Code: 36

Client	Service Date	Record	Pm Line ID	Error
3609146 1	11/2/2013	2501557	50155701	ERROR: Service setting is inconsistent with service type
3609214 1	6/26/2014	2659604	65960403	ERROR: Uninsured reason does not match primary ins
3609214 1	6/26/2014	2659605	65960503	ERROR: Uninsured reason does not match primary ins
3609320 1	11/5/2014	2701833	70183301	ERROR: Service setting is inconsistent with service type

Print Report

Return to Status Menu

- *The Pm Line ID*
  The PM Line ID is a service line identifier that your practice management or billing system generates that (a) uniquely identifies each service delivery record or line within a given fiscal year, and (b) provides a sequencing of service activity for services with multiple transactions or records (the greater the Pm Line ID the more recent the activity).

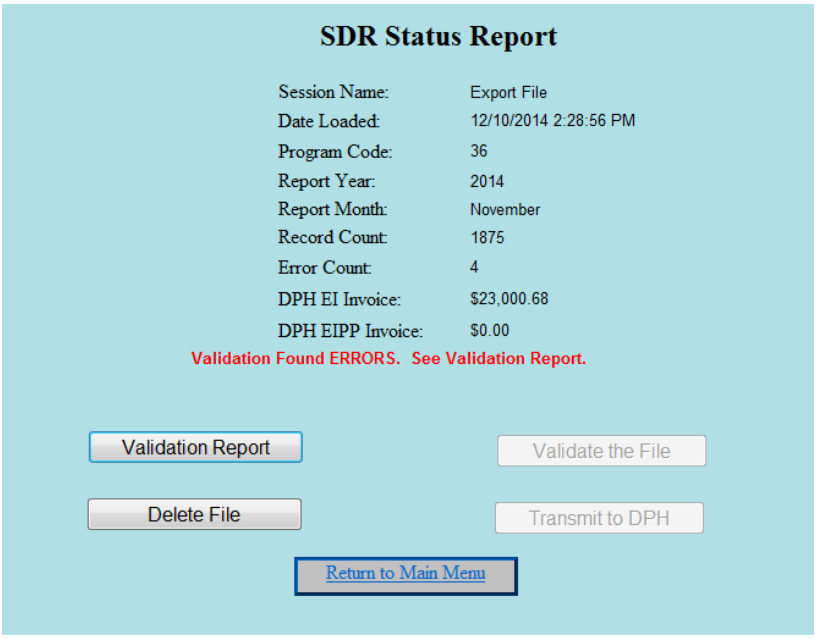
  The Pm Line ID differs between practice management systems. The ARPlus system generates the Pm Line ID by using the last 6 characters of the record # plus a counter (01, 02, 03, etc.). The counter provides a sequencing of the payer events that occurred for a service (see example above). However, the Pm Line ID is not unique per record and the counter number (01, 02, 03, etc.), may be repeated as additional activity occurs.

  The Thom and other practice management systems use a counter to identify each unique record. The Thom Pm Line ID is unique per record activity and uses the Pm Line ID during the upload process of the DPH remittance file to connect to the correct service and activity in the Thom billing system.

- Click the Return to Status Menu button after you have finished printing out all necessary pages.

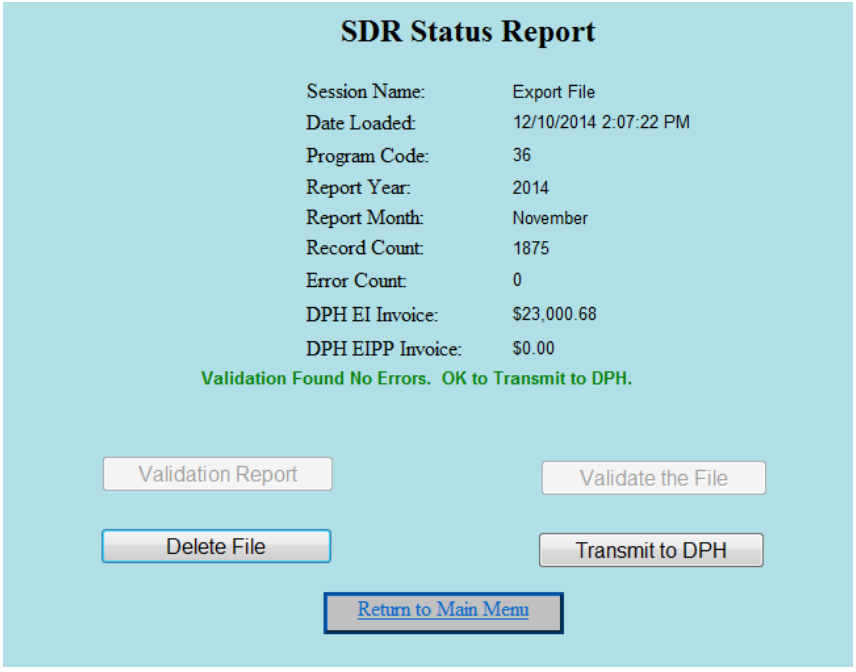
  No further processing of this file on the website will be allowed until these claims have been corrected. Use the Validation Instruction Sheet *(see Appendix III of the EI Service Delivery Reporting Requirements and Reimbursement for Services manual)* to provide guidance in identifying the reason for the error. Corrections should be made to your billing or practice management system.

- You will not be able to transmit your data file until you run the *Validation Report* and the *Transmit to DPH* option is highlighted. Click the **Delete File** button if your file had problems. Once the errors have been corrected in your billing or practice management system you can upload another file.

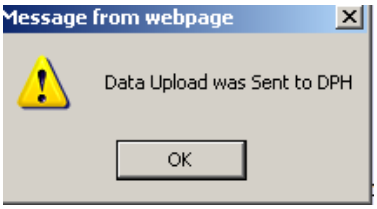


B. File Has No Errors - Transmitting the SDR File and Confirming the DPH Receipt

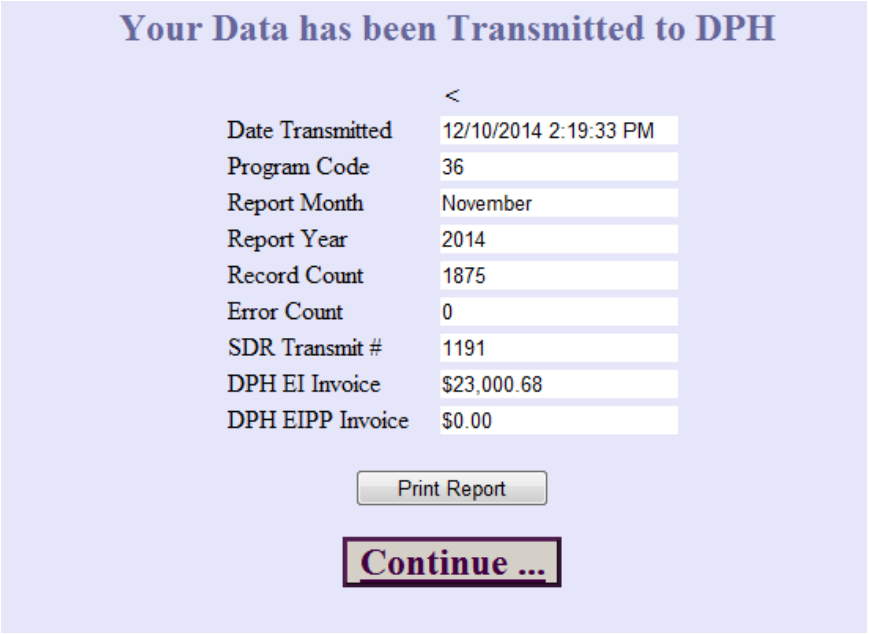
- If the validation did not find errors then click the *Transmit to DPH* button.



- A small screen will appear notifying you that the submission has been completed.
- Click **OK**.



- The following screen will appear

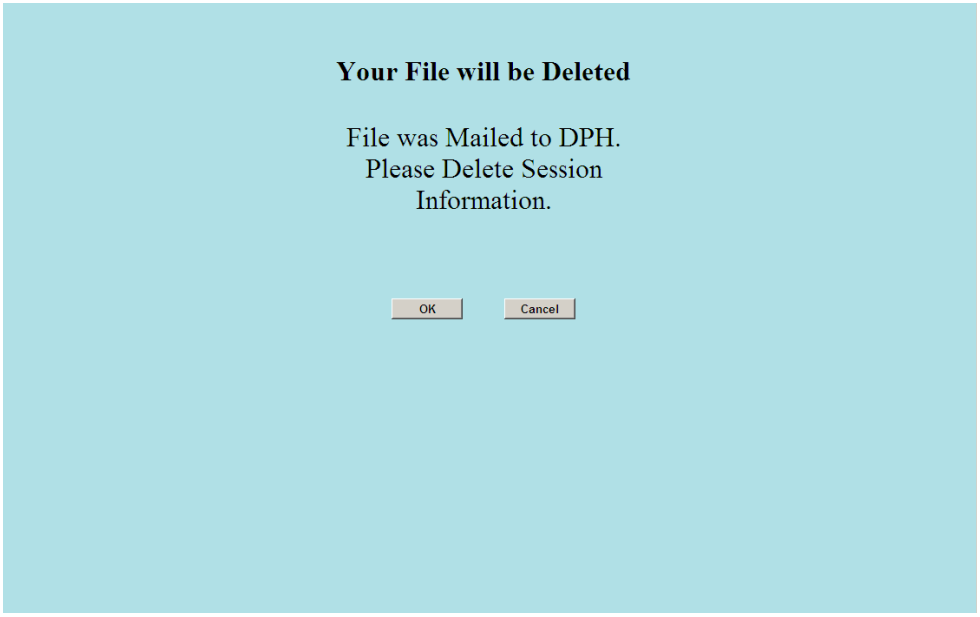


- Click **Print Report** so that you have documentation of the file that you have transmitted. This print-out provides a record of the program code, report month, report year, number of records in the file, the date of transmission and the SDR Confirmation # information for this file. The SDR Confirmation # identifies a successful transmission of your uploaded SDR file to the web server. Keep this as a record of file transmission to DPH.

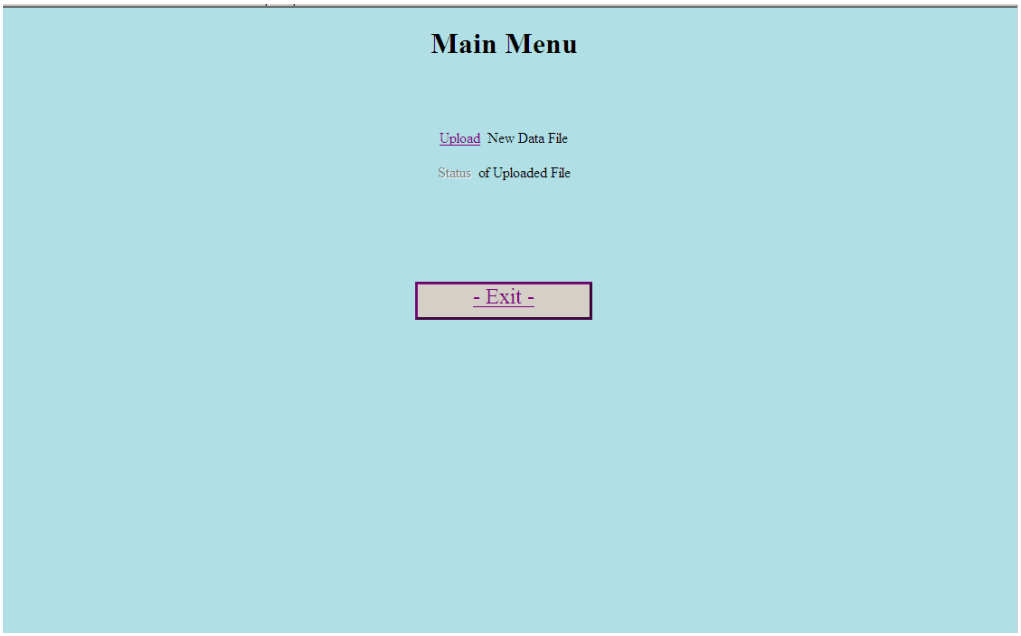
  This file is the *ONLY* invoice DPH will accept for payment. The provider submits this file under all the legal strictures that apply to paper invoices and payment vouchers. All files submitted shall be under the pains and penalties of perjury as true, correct and accurate as attested by the Executive Director or Chief Financial Officer of the Agency. Providers must ensure appropriate security of their own systems so that only authorized staff can submit the electronic invoices.

- Click **Continue** in order to delete the file for this session.

- Before deleting, you will be asked to confirm that this is what you wish to do. Click **OK**.



- This will bring you back to the Main Menu. You can now either upload another file or exit from the website.



12. Keeping a Backup File: The data file you uploaded to the website can be kept in a directory or folder on your computer as a backup record. If there are any problems with a transmission or any questions regarding the data content, you will have a backup data file for your use.

    If there are any problems with a file transmission or any questions from DPH regarding the data content, you will have a backup data file for your use. Failure to maintain a backup of each transmission to DPH may result in lost claims if anything were to happen to these data.

13. Other Information
    a. *Changing your password*. You are not able to change your password. If you forget your password or would like to change it then contact Jean Shimer at DPH at (617) 624-5526.
    c. *Getting help*. Contact Jean Shimer at DPH at (617) 624-5526 or .shimer@state.ma. if you have any questions or need help with this website.

Appendix III

Early Intervention
TVP Website
Validation Identification Instructions

EARLY INTERVENTION
TVP WEBSITE
VALIDATION IDENTIFICATION INSTRUCTION SHEET

Error and Warning Messages

The Validation Report on the EI TVP website will identify service records with the errors listed below. If one or more service records on your service delivery (SDR) file has one or more errors, the error will need to be corrected prior to transmitting the file to DPH. Warnings identify potential problems with the record but will allow the transmission of your SDR file to DPH. The following provides the list of all possible errors on the EI TVP website and provides additional information for how to correct them.

ERROR MESSAGE	POSSIBLE DATA FIELDS NEEDING CHANGE	DESCRIPTION OF PROBLEM
ERROR: Charge is not based on the unit rate	CHARGE SERVICE HOURS SDRDATE	Multiplying the HOURS by the charge rate (based on the service type and date of service) does not match the CHARGE. The system calculated charge must be within +/- 10¢ of the CHARGE amount.
ERROR: EIPP Initial HV charge is not based on the unit rate	SERVICE CHARGE	The SERVICE is an EIPP initial home visit (SERVICE is V) and the CHARGE does not match the unit rate.
ERROR: EIPP Ongoing HV charge is not based on the unit rate	SERVICE CHARGE	The SERVICE is an EIPP ongoing home visit (SERVICE is P or R) and the CHARGE does not match the unit rate.
ERROR: EIPP service date problem (prior to or after current FY)	SERVICE SDRDATE	The service date (SDRDATE) for an EIPP service type (SERVICE is P, V or R) is missing or is prior to or after the current fiscal year.
ERROR: Excessive hours to DPH/no waiver	SERVICE HOURS WAIVERNO	1) The HOURS for a home visit (SERVICE is A), Center-individual (SERVICE is B) or Intake (SERVICE is E) exceeds 2 hours. 2) The HOURS for a child group (SERVICE is N or M) exceeds 2.5 hours. 3) The HOURS for a parent group (SERVICE is D) exceeds 1.5 hours. 4) The HOURS for an assessment exceeds 10 hours. 5) A record with excessive HOURS is okay if there is a waiver authorization number (WAIVERNO).
ERROR: Hours & charge inconsistency	HOURS CHARGE	1) HOURS is negative but CHARGE is positive. 2) HOURS is positive but CHARGE is negative.
ERROR: Incorrect 2ndary insurer code	PRIMARY SETTING	1) If the PRIMARY insurer is a commercial insurer then the 2ndary insurer (SETTING) must be blank or a MassHealth plan. 2) If the PRIMARY insurer is a MassHealth plan then the 2ndary insurer (SETTING) must be blank.

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ERROR MESSAGE	POSSIBLE DATA FIELDS NEEDING CHANGE	DESCRIPTION OF PROBLEM
ERROR: Incorrect autism professional discipline	SERVICE PROFDISC	If the service type is an autism specialty service then the PROFESSIONAL DISCIPLINE must be an autism specialty provider (PROFDISC = AS).
ERROR: Incorrect Autism Rate for BCBS	SERVICE PAYMENT TPPCODE HOURS x CHARGE	The HOURS x CHARGE for an autism service for a BC/BS client must match to $61.52, $48.52 or $97.00.
ERROR: Incorrect Autism Rate for non-BCBS	SERVICE PAYMENT TPPCODE HOURS x CHARGE	The HOURS x CHARGE for an autism service for a non-BC/BS client must match to $61.52.
ERROR: Incorrect autism reason	REASON DMACODE SDRDATE	A reason code of D07, D08, D09, D10, D11, D22, D23, D24 and D25 can only be used for an autism service.
ERROR: Incorrect Autism Reason Code for Primary Insurer	REASON DMACODE PRIMARY SDRDATE	1) Reason code D23 must have Tufts as the primary insurer 2) Reason code D24 must have BC/BS as the primary insurer 3) Reason code D07 or D08 cannot have NHP, CIGNA or Aetna/US Health Care as the primary insurer or United Behavioral Health/Optum as the payer
ERROR: Incorrect client ID	CLIENT	The CLIENT ID is blank, incomplete or contains symbols.
ERROR: Incorrect client referral number	REFERRAL	The REFERRAL number is not a number.
ERROR: Incorrect CMS/CPT code for D20 reason code	REASON DMACODE SDRDATE	The D20 reason code must have a service date on or after 1/1/2014 and must occur for EI services only (should not be used for autism services)

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ERROR MESSAGE	POSSIBLE DATA FIELDS NEEDING CHANGE	DESCRIPTION OF PROBLEM
ERROR: Incorrect CMS/CPT service code	SERVICE DMACODE	The CMS/CPT service code (DMACODE) must be 96153, H2012, H2015, H2019, H0031, T1015, T1023, T1024 orT1027.
ERROR: Incorrect co-treatment code	COTRTMT SERVICE	The COTRTMT must be "No" (COTRTMT is 0) or "Yes" (COTRTMT is 1) when SERVICE is a home visit (SERVICE is A) or center-individual (SERVICE is B)
ERROR: Incorrect EIP, reason code	REASON	The REASON must be P10 for an EIPP SERVICE (SERVICE is P, V or R).
ERROR: Incorrect Ins Addendum (TPPAUTH) for UBH/BHS Payer	TPPCODE TPPAUTH TPPELIG	The insurance addendum code when United Behavioral Health (UBH) or Beacon Health Strategies (BHS) is the payer must be the same as the insurance addendum code of the primary insurer.
ERROR: Incorrect Ins Addendum code (TPPAUTH)	TPPCODE TPPAUTH	The payer (TPPCODE) is a commercial insurer and the insurance addendum code (TPPAUTH) is blank. Appropriate codes are: 1 (fully insured), 2 (self-insured/ASO), 3 (federal), 4 (HAS/HRA/FSA), 5(Union/Local/Trade Association), 6 (GIC) or 9 (unknown).
ERROR: Incorrect Ins Addendum code (TPPELIG)	PRIMARY TPPELIG	The PRIMARY insurer is a commercial insurer and the insurance addendum code (data field: TPPELIG) is blank. Appropriate codes are: 1 (fully insured), 2 (self-insured/ASO), 3 (federal), 4 (HAS/HRA/FSA), 5(Union/Local/Trade Association), 6 (GIC) or 9 (unknown).
ERROR: Incorrect Ins addendum for reason 119	REASON TPPELIG	The REASON code of 119 (Benefit maximum has been reached) can only be used for fully insured (TPPELIG = 1) insurer plans.
ERROR: Incorrect insurer for D10 reason	REASON PRIMARY TPPCODE	The REASON code of D10 (contractual adjustment-autism service) can only be used when BC/BS is the primary insurer or Beacon Health Strategies is the payer.

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ERROR MESSAGE	POSSIBLE DATA FIELDS NEEDING CHANGE	DESCRIPTION OF PROBLEM
ERROR: Incorrect insurer for D20 reason code	REASON SDRDATE PRIMARY SETTING (2ndary insurer)	The reason code of D20 for autism services on or after 7/1/2014 can only be used when the primary or secondary insurer is MassHealth MCO: Neighborhood Health or Other.
ERROR: Incorrect insurer payer code (tppcode)	TPPCODE	The payer code (TPPCODE) is not correct. Appropriate codes are: blank, 0, 2, 6, 8, 18, 20, 21, 22, 24, 25, 26, 27, 28, 34, 35, 36, 38, 40, 41, 42, 43, 44, 47, 48, 49, 50, 51, 60, 61, 62, 63, 64, 65, 66 and 88 (see the *Code Sheet for Insurers - Appendix I* of the EI billing manual for the payer code descriptions).
ERROR: Incorrect payment code	PAYMENT	The payer type (PAYMENT) is not D, M, X, H or I.
ERROR: Incorrect PM Line ID	PMLINEID	One or more of the 8 characters of the program line ID (PMLINEID) is blank or is not numeric.
ERROR: Incorrect primary insurer code	PRIMARY	The PRIMARY insurer is not correct. Appropriate codes are: blank, 0, 2, 6, 8, 18, 20, 21, 22, 24, 25, 26, 27, 28, 34, 35, 36, 38, 40, 41, 42, 43, 44, 47, 48, 49, 50, 51, 60, 61, 62, 63, 64, 65, 66, 67 and 88 (see the *Code Sheet for Insurers - Appendix I* of the EI billing manual for the payer code descriptions).
ERROR: Incorrect professional discipline	PROFDISC	1) The professional discipline (PROFDISC) is not DS, AA, BB, SS, NS, OT, PT, SP, CS or SW for an EI service (SERVICE is A, B, D, E, G, H, M or N). 2) The professional discipline (PROFDISC) is not NS, SW, MH for an EIPP service (SERVICE is P, V or R). 3)
ERROR: Incorrect program code	PRGCODE CLIENT (1st two chars)	The program code (PRGCODE) is blank, not a number or does not match the two characters of the CLIENT ID.
ERROR: Incorrect reason (P10) for an EI child	REASON CLIENT	Reason code of P10 is allowed for EIPP clients only.

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ERROR MESSAGE	POSSIBLE DATA FIELDS NEEDING CHANGE	DESCRIPTION OF PROBLEM
ERROR: Incorrect reason code	REASON SDFORM	1) The following reason codes can be used on both initial and transfer records (SDFORM B, C, D or E): 001, 002, 003, 050, 052, 096, 109, 141, 149, D01, D02, D05, D06, D07, D08, D09, D11, D22, D23, D24, D25, D99 and P10 2) The following reason codes can be used on transfer records only (SDFORM=D or E): 026, 027, 028, 032, 033, 039, 045, 062, 063, 123, 125,177 and B14 3) The following reason codes can be used on partial payment transfer records only (SDFORM=E): D10 and D20 See the *Code Sheet for Adjustment Reason - Appendix I* of the EI billing manual for reason code descriptions.
ERROR: Incorrect reason for autism intake	REASON SERVICE	The only acceptable REASON codes for an autism intake service are D)% (uninsured child) or D09 (autism service does not meet insurer requirements)
ERROR: Incorrect reason for commercially insured	REASON PRIMARY TPPCODE	1) Reason codes D07, D08, D11, D22, D23, D24 and D25 allowed when the primary insurer is a commercial insurer. 2) Reason code D10 allowed when BC/BS is the primary insurer or Beacon health Strategies (BHS) is the payer
ERROR: Incorrect reason for DPH charge for non-ABA SSP	INSAMT (SSP code) REASON	Reason codes D09 is the only reason code to be used for autism services for PDC and REACH specialty providers when billing DPH directly.
ERROR: Incorrect autism reason for non-commercially insured	INSAMT (SSP code) REASON	Reason codes D07, D08, D10, D11, D2, D23, D24 and D25 cannot be used autism services for PDC and REACH specialty providers.
ERROR: Incorrect reason for uninsured child	REASON PRIMARYINS	The only acceptable REASON codes for an uninsured child are D05 (uninsured child), D06 (family refused access to insurance) and P10 (EIPP service)

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ERROR MESSAGE	POSSIBLE DATA FIELDS NEEDING CHANGE	DESCRIPTION OF PROBLEM
ERROR: Incorrect report month/report year	REPMONTH REPYEAR	1) The reporting month (REPMONTH) is not correct (must be 01 to 12). 2) The reporting year (REPYEAR) is not correct.
ERROR: Incorrect sdform	SDFORM	The service delivery form type (SDFORM) is not: B (service date occurs during this reporting year/month) C (service date occurs prior to this reporting year/month) D (unit rate payer adjustment/transfer) or E (partial payment adjustment/transfer)
ERROR: Incorrect service date for ABA reason code	SDRDATE REASON	1) The service date for reason code D23 must occur between 7/1/2014 and 11/30/2014.
ERROR: Incorrect service for EIPP Mom	CLIENT SERVICE	An EIPP client is allowed services V (EIPP initial home visit), P (EIPP home visit) and R (MBD consultation).
ERROR: Incorrect service modifier	SERVICE DENNUM	1) The SERVICE type is a community child group (SERVICE is M) and the service modifier (DENNUM) is blank or not "2". 2) The SERVICE type is an EI-only child group (SERVICE is N) and the service modifier (DENNUM) is blank or not "1". 3) The SERVICE type is a Home visit (SERVICE is A) and the service modifier (DENNUM) is not “1”, “2” or “3”.
ERROR: Incorrect service setting code	WAIVER	The service setting code (WAIVER) is not H01, H02, V01, V02, V03, C01, C02, P01, S01 or S02.
ERROR: Incorrect service type code	SERVICE DMACODE	1) The SERVICE type is not A, B, D, E, G, H, M, N, P, V or R. 2) The SERVICE type is E, P, V or R for a non-EIPP program.

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ERROR MESSAGE	POSSIBLE DATA FIELDS NEEDING CHANGE	DESCRIPTION OF PROBLEM
ERROR: Incorrect SSP code	DMACODE INSAMT (SSP code)	Autism service must have an SSP code of 101, 102, 103, 105, 106, 107, 109, 110, 112, 888 or on or after 7/1/12014 a code of 201, 202, 203, 204, 205, 206, 207, 208 or 888.
ERROR: Incorrect SV/PAYMENT code for UBH/BHS Payer	TPPCODE PAYMENT SERVICE	United Behavioral Health (UBH) and Beacon Health Strategies should have a PAYMENT code of I (commercial insurer) for autism services only.
ERROR: Incorrect text for "Other" payer	TPPCODE TPPCODE8	The payer (TPPCODE) is "Other" (TPPCODE is 88) and the “Other” text field (TPPCODE8) is should be re-coded (e.g., TPPCODE is 88 and TPPCODE8 is “HCHC” should be re-coded to TPPCODE is 20) (see the *Code Sheet for Insurers - Appendix I* of the EI billing manual for the payer code descriptions).
ERROR: Incorrect use of D09 autism reason code	REASON SDRDATE PRIMARY SERVICE TPPELIG (ins addendum) INSAMT (SSP code)	A reason code of D09 for autism services on or after 7/1/2014 are allowed for the following: 1) SSP is PDC or REACH 2) MassHealth is primary or 2ndary insuer 3) Commercial insurer: intake service, Champus/TriCARE or federal
ERROR: Ins Addendum (TPPAUTH) does not match TPPcode	TPPAUTH TPPCODE	1) The insurance addendum code is "Union/Local/Trade Association plan" (TPPAUTH is 5) and the payer code (TPPCODE) is "Champus/TriCARE" (TPPCODE is 40). 2) The insurance addendum code is "Group Insurance Commission (GIC)" (TPPAUTH is 6) and the payer code (TPPCODE) is not 20, 21, 22, 24, 27 or 66.
ERROR: Ins Addendum (TPPELIG) does not match Primary ins	TPPELIG PRIMARY	1) The primary insurer addendum code is "Union/Local/Trade Association plan" (TPPELIG is 5) and the PRIMARY insurer code is "Champus/TriCARE" (code of 40). 2) The primary insurer addendum code is "Group Insurance Commission (GIC)" (TPPELIG is 6) and the PRIMARY insurer code is not 20, 21, 22, 24, 27 or 66.

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ERROR MESSAGE	POSSIBLE DATA FIELDS NEEDING CHANGE	DESCRIPTION OF PROBLEM
ERROR: Ins member ID problem (primary8)	PRIMARY8 PRIMARY	The child's primary insurer member ID is either missing or does not contain one or more numbers (exception is for Aetna clients). If the child is uninsured (primary insurer is DPH) then there should be no member ID.
ERROR: Insurer in TPPCODE8 should not be '88'	TPPCODE TPPCODEOTHERNAME	If the TPPCODE (payer) is 88 (Other) then the text (TPPCODEOTHERNAME) cannot be an insurer that is on the DPH insurance list.
ERROR: Last character of client ID is not numeric	CLIENT	The last character of the client ID is not numeric.
ERROR: Missing charge	PAYMENT CHARGE	The service delivery form type (SDFORM) is B, C or D and the payer type is DPH (PAYMENT is D) and the CHARGE is $0.00.
ERROR: Missing PARTDPH charge	SDFORM PARTDPH	The service delivery form type (SDFORM) is a partial payment adjustment/transfer (SDFORM is E) and the DPH cost adjustment amount (PARTDPH) is $0.00.
ERROR: Missing record number	RECORDNO	The record/transaction number is missing.
ERROR: Missing service date	SDRDATE	The service date is missing.
ERROR: Missing text for "Other" payer	TPPCODE TPPCODE8	The payer (TPPCODE) is "Other" (TPPCODE is 88) and the "Other" text field (TPPCODE8) is blank (see the *Code Sheet for Insurers - Appendix I* of the EI billing manual for the payer code descriptions).
ERROR: Negative charge on Initial service record	SDFORM CHARGE	The charge on an initial/original record (SDFORM is B or C) is a negative charge.
ERROR: Prg code does not match to File Prg code	PRGCODE PRGCODEFILE (code user entered in TVP)	The program code in the file does not match to the program code entered on the TVP website by the user.

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ERROR MESSAGE	POSSIBLE DATA FIELDS NEEDING CHANGE	DESCRIPTION OF PROBLEM
ERROR: Primary insurer is inconsistent w/autism CMS/CPT code	DMACODE (CMS code) PRIMARY TPPCODE (payer code)	A CMS/CPT code (DMACODE) of H2012 or H0031 is allowed when the primary insurer is BC/BS or the payer is Beacon Health Strategies (BHS).
ERROR: Reason code 052 but not Assistant prof disc	PROFDISC PRIMARY REASON SDFORM	If the professional discipline is a speech therapist (PROFDISC must be SA) where the PRIMARY insurer is MassHealth (PRIMARY is 2, 6, 8, 34, 35, 38, 43, 44, 47, 48, 49, 50, 51 or 67) then the REASON code on an initial/original record (SDFORM is B or C) billed to DPH must be 52 (rendering provider is not eligible to perform the service) (REASON is 52).
ERROR: Reason code 63,123,125 w/DPH positive charge amount	REASON CHARGE	If the REASON code on a record billed to DPH is 63, 123 or 125 (payment refund/adjustment/correction) then the CHARGE must be negative.
ERROR: Reason code not allowed for autism sv (use D25)	SERVICE REASON	The REASON code of D25 must be used for autism services when “Benefit or claim is not covered”.
ERROR: Reason code P10 but not EIPP client	REASON CLIENT	The REASON code on a record is P10 (EIPP service) but the CLIENT is not an EIPP mom.
ERROR: Reason code P10 but not EIPP (P,V,R) service	REASON SERVICE	The REASON code on a record billed to DPH is P10 (EIPP service) but the SERVICE is not an EIPP service (SERVICE is P, V or R).
ERROR: Reason D01 or D02/No waiver#	REASON PRGCODE WAIVERNO	Reason code D01 and D02 are allowed if there is a waiver authorization number.
ERROR: Secondary service/No waiver#	PRGCODE CLIENT WAIVERNO	The first two characters of the CLIENT ID must match to the program code unless there is a waiver authorization number.

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ERROR MESSAGE	POSSIBLE DATA FIELDS NEEDING CHANGE	DESCRIPTION OF PROBLEM
ERROR: Service code is inconsistent w CMS/CPT service code	DMACODE SERVICE	The CMS/CPT service code (DMACODE) is not consistent with the SERVICE type: 1) If the SERVICE type is a home visit (SERVICE is A, P, V or R) then the CMS/CPT service code (DMACODE) must be H2015. 2) If the SERVICE type is a center- individual (SERVICE is B) then the CMS/CPT service code (DMACODE) must be T1015. 3) If the SERVICE type is an EI-only child group (SERVICE is N) then the CMS/CPT service code (DMACODE) must be 96153. 4) If the SERVICE type is a community child group (SERVICE is M) then the CMS/CPT service code (DMACODE) must be 96153. 5) If the SERVICE type is a parent group (SERVICE is D) then the CMS/CPT service code (DMACODE) must be T1027. 6) If the SERVICE type is an intake (SERVICE is E) then the CMS/CPT service code (DMACODE) must be T1023. 7) If the SERVICE type is an assessment (SERVICE is G or H) then the CMS/CPT service code (DMACODE) must be T1024.
ERROR: Service date problem (prior to previous FY or after current FY)	SDRDATE	The service date (SDRDATE) is missing or is prior to the previous fiscal year or is after the current fiscal year.
ERROR: Service Setting is inconsistent with service type	SERVICE (service type) WAIVER (service setting)	The service setting (WAIVER) does not match SERVICE: 1) If the SERVICE type is a Home Visit or an EIPP Home Visit (SERVICE is A, P, V or R) then the service setting must be H01 or H02 (WAIVER is H01 or H02). 2) If the SERVICE type is Center-Individual (SERVICE is B) then the service setting must be V01, V02 or V03 (WAIVER is V01, V02 or V03). 3) If the SERVICE type is Child Group (SERVICE is M or N) then the service setting must be C01 or C02 (WAIVER is C01 or C02). 4) If the SERVICE type is Parent group (SERVICE is D) then the service setting must be P01 (WAIVER is P01). 5) If the SERVICE type is Assessment (SERVICE is G or H) then the service setting must be S01 or S02 (WAIVER is S01 or S02).

EARLY INTERVENTION
TVP WEBSITE
VALIDATION IDENTIFICATION INSTRUCTION SHEET

Error and Warning Messages

The Validation Report on the EI TVP website will identify service records with the errors listed below. If one or more service records on your service delivery (SDR) file has one or more errors, the error will need to be corrected prior to transmitting the file to DPH. Warnings identify potential problems with the record but will allow the transmission of your SDR file to DPH. The following provides the list of all possible errors on the EI TVP website and provides additional information for how to correct them.

ERROR MESSAGE	POSSIBLE DATA FIELDS NEEDING CHANGE	DESCRIPTION OF PROBLEM
ERROR: TPP/payer (tppcode) does not match payment	TPPCODE PAYMENT	The payer code and payment code do not match (see the *Code Sheet for Insurers - Appendix I* of the EI billing manual for the payer code descriptions): 1) If the child is uninsured then the payer code (TPPCODE) must be 00. 2) If the payer code (TPPCODE) is 2, 38, 43, 44, 47, 48, 49, 50 or 51 then the PAYMENT must be MassHealth (PAYMENT is M). 3) If the payer code (TPPCODE) is 6, 8, 34, 35 or 67 then the PAYMENT must be MassHealth MCO (PAYMENT is X). 4) If the payer code (TPPCODE) is 18, 20, 21, 22, 24, 25, 26, 27, 28, 36, 40, 41, 42, 60, 61, 62, 63, 64, 65, 66 or 88 then the PAYMENT must be commercial insurer (PAYMENT is I).
ERROR: Uninsured child but payer is an insurer	PRIMARY TPPCODE	If the PRIMARY code on a record is 00 (child is uninsured) then the TPPCODE insurer must be 00 (child is uninsured.
ERROR: Uninsured reason does not match primary ins	REASON PRIMARY	If the REASON code on a record billed to DPH is D05 (uninsured) then the PRIMARY insurer must denote that this child is uninsured (PRIMARY is 00).
WARNING: Excessive EIPP charges to TPP	SERVICE CHARGE	The CHARGE amount for an EIPP service (SERVICE is P, V or R) must be in accordance to the current standard rate.
WARNING: Excessive hrs to TPP/no waiver auth #	SERVICE HOURS WAIVERNO	The HOURS on a third party record for each service type (SERVICE is A, B, D, E, G or H) exceeds the standard. Review the record to make sure HOURS is correct.

Appendix IV

Business Rule
Error Code Descriptions

Fiscal Year 2016 & 2017

EARLY INTERVENTION INFORMATION SYSTEM
Business Rule Error Code Descriptions
FISCAL YEARS 2016 & 2017

ERROR CODE	BUSINESS RULES	LINE STATUS
NO ERROR	**Acceptable service record** All business rules passed for this record.	ACCEPT
20	**Problem record: Duplicate PMLINEID** The PMLINEID data field for this record already exists on a record previously submitted to DPH and so the record is considered to be a duplicate. No two records can have the same PMLINEID within the same fiscal year. What you should do: The generation of the PMLINEID and problems with this data field are specific to the billing system you are using. You may need to contact your technical support consultant for your billing system to resolve ongoing problems. Otherwise, do the following: 1. If it is a duplicate record to another record that has been accepted by DPH, do nothing. 2. If it is not a duplicate record, resubmit the record, ensuring unique PMLINEID.	Rejected as Not Processed
60	**Problem record: Program request to reject this record** Your program has requested that this record be rejected. What you should do: There is nothing to do with these records. See the O_STATUS data field on the remit file for this record for an explanation of the problem.	REJECT
61	**Problem record: Missing or incorrect data** One or more data fields on this record have data that is either missing or incorrect. What you should do: See the O_STATUS data field on the remit file for this record for an explanation of the problem.	REJECT
63	**Late submission** EI Services: NO ERROR, No payment due to receipt of record after the DPH fiscal year supplemental deadline (March 10th of each year). EIPP Services: No payment due to receipt of record past the state's accounts payable deadline (July 10th of each year). What you should do: Do nothing. DPH will not pay for services submitted past the deadline.	DENIAL
64	**Charges for this fiscal year exceed DPH budgeted amount** Budget amounts are used for EIPP services. What you should do: Do nothing. DPH will not pay for services past the amount budgeted for the program.	DENIAL

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ERROR CODE	BUSINESS RULES	LINE STATUS
2M	**Over or Underpayment: Incorrect charge** The charge on the adjustment record is (1) either greater or less than the charge on the original/initial service record, or (2) not equal to the difference between the old and new rate. What you should do: Review all transactions submitted for the service. These records cause either excessive hours or charges (or negative hours/charges) to either a third party or DPH. 1. If the problem continues notify Jean Shimer at (617) 624-5526 of any considerations regarding the service that would affect appropriate DPH payment.	REJECT
2N	**Excessive Contractual Obligation Amount** The contractual obligation charge for an autism specialty service is greater than the autism rate of $61.52 (based on the third party charge on the original service record). What you should do: Review service for appropriate correction.	REJECT
3A	**Duplicate original/initial service record** 2 or more DPH original/initial services with the same program code, client ID and referral #, service date, service type, service setting & professional discipline. No waiver authorization # on service record. What you should do: 1. If it is a duplicate record to another record that has been accepted by DPH, do nothing. 2. If the record was the same service provided by a professional of the same discipline as another service processed for this child, resubmit the record with the appropriate waiver authorization number.	REJECT
3B	**Duplicate original/initial service record** 2 or more original/initial services with the same program code, client ID and referral #, service date and record number. What you should do: If the service record is not a duplicate, resubmit the service record using another record number. Include waiver authorization # if needed.	REJECT
3C	**Duplicate cost adjustment service record** 2 or more cost adjustment service records with the same client ID and referral #, service date, third party payer code and amount billed to DPH. What you should do: If these are legitimate records that have been rejected (this may happen when a service has a lot of activity associated with it) then contact Jean Shimer at DPH at (617) 624-5526.	REJECT
3E	**Duplicate original/initial service record** The same as 3A except there is a waiver authorization # on both records (Exception: does not reject assessments). What you should do: Do nothing. DPH will review waiver for acceptability and will re-remit after approval/denial. An approved service record will have a PV reference number; a denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file for this record.	wPEND

EARLY INTERVENTION INFORMATION SYSTEM
Business Rule Error Code Descriptions
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ERROR CODE	BUSINESS RULES	LINE STATUS
3F	**Duplicate original/initial service record** The same as 3A except there is a waiver authorization # on only one record. (Note: does not reject assessments) (Explanation: This will allow rejected duplicate services to be resubmitted and paid if a waiver authorization is present only on this second resubmission.) What you should do: Do nothing. DPH will review waiver for acceptability and will re-remit after approval/denial. An approved service record will have a PV reference number; a denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file for this record.	wPEND
3T	**Duplicate non-DPH original/initial service record** The same as 3A above except for non-DPH service records. What you should do: 1. If it is a duplicate record to another record that has been accepted by DPH, do nothing. 2. If the record was the same service provided by a professional of the same discipline as another service for this child, resubmit the record with the appropriate waiver authorization #.	REJECT

4C	**Reason code for DPH payment is unacceptable**
	The reason code on a DPH service record is one of the following:
	
	`1 (Deductible amount)`
	`2 (Coinsurance amount)`
	`3 (Co-payment amount)`
	`45 (Charges exceed contracted fee arrangement)`
	`50 (Deemed not medically necessary by payer)`
	`119 (Benefit maximum for this time period has been reached)`
	`D05 (Uninsured)`
	
	AND the third party payer code or secondary insurer code on the original/initial service record is one of the following:
	
	MassHealth: CommonHealth
	MassHealth: Essential
	MassHealth: Family Assist
	MassHealth: HSN
	MassHealth: HSN-Partial
	MassHealth: Standard
	MassHealth: MCO: Fallon
	MassHealth: MCO: Health NE
	MassHealth: MCO: Neighborhood Health
	MassHealth: MCO: Network Health
	MassHealth: MCO: BMC Healthnet Plan (Boston Medical Center)
	
	What you should do:
	Submit support documentation and forward all questions to:
	
	Steve McCourt
	MDPH, 250 Washington Street, 5th floor
	Boston, MA 02108
	
	Phone: (617) 624-5954
		PENDED

EARLY INTERVENTION INFORMATION SYSTEM
Business Rule Error Code Descriptions
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ERROR CODE	BUSINESS RULES	LINE STATUS
	Support Documentation DPH providers must follow-up with insurers to make sure that the service record was not incorrectly denied and should verify the insurer benefit status. Support documentation includes the following: ▪ An EOB plus any of the following support documentation: o Corresponding eligibility verification to include coverage status, coverage dates, EI benefit status, dates of service o Employer group non-covered number o Non-covered reports from insurer o MassHealth EVS (Eligibility Verification System) print out o Insurer-specific eligibility information o HIPAA Verification 270/271 o Insurer-specific website information confirming that EI is not a covered benefit o Verbal confirmation with trace/tracking number o Correspondence with insurer Note Services with these reason codes are NOT matched to other services that were approved with support documentation. Approval/Denial DPH re-remits all pended services unless payment has been approved. An approved service record will have a PV reference number. If approval has been denied then the denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file. *Note: MassHealth: Essential, MassHealth: HSN, MassHealth: HSN-Partial service records to DPH should include an adjustment reason code of 96.*	

5B	**Reason is Co-payment. Coinsurance, Deductible**
	The reason code on a DPH service record is one of the following:
	`1 (Deductible amount)`
	`2 (Coinsurance amount)`
	`3 (Co-payment amount)`
	AND the primary insurer addendum information states one of the following:
	`1 (Fully insured)`
	`9 (Unknown)`
	
	What you should do:
	Submit support documentation and forward all questions to:
	
	Steve McCourt
	MDPH, 250 Washington Street, 5th floor
	Boston, MA 02108
	
	Phone: (617) 624-5954
	
	Support Documentation
	DPH providers must follow-up with insurers to make sure that the service record was not incorrectly denied and should verify the insurer benefit status. Support documentation includes the following:
	▪ An EOB plus any of the following support documentation:
	o Corresponding eligibility verification to include coverage status, coverage dates, EI benefit status, dates of service
	o Employer group non-covered number
	o Non-covered reports from insurer
	o MassHealth EVS (Eligibility Verification System) print out
	o Insurer-specific eligibility information
		PENDED

EARLY INTERVENTION INFORMATION SYSTEM
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ERROR CODE	BUSINESS RULES	LINE STATUS
	o HIPAA Verification 270/271 o Insurer-specific website information confirming that EI is not a covered benefit o Verbal confirmation with trace/tracking number o Correspondence with insurer Note Support documentation should be sent only once for services submitted for the same child having the same primary insurer & reason code. Approved overriding support documentation will automatically result in payment of all services. Approval/Denial DPH re-remits all pended services unless payment has been approved. An approved service record will have a PV reference number. If approval has been denied then the denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file.	
5J	**Incorrect use of Service Correction Reason Code** The charge to DPH is greater than $0.00 and the reason for DPH payment is one of the following: 63 (correction) 123 (payer refund) 125 (payment adjustment) What you should do: Re-submit the service record with the correct reason for DPH payment.	REJECT
5K	**Reason code and/or primary insurer in need of support documentation** Reason code on service record is one of the following: 28 (Coverage not in effect at time service provided) 50 (Deemed not medically necessary by payer) 52 (Rendering provider is not eligible to perform the service billed) 62 (Payment denied for absence of authorization) 96 (Non-covered charge) 109 (Claim is not covered by this payer) 119 (Benefit maximum has been reached) 177 (Recipient is ineligible on this date of service) B14 (Payment denied because only one visit per day is covered) D08 (Autism service – authorization was denied) D09 (Autism service does not meet insurer requirements/No PA initiated) D25 (Autism service is not a covered benefit) Exceptions DPH will pay services for the following clients: • Child is included on the DPH Insurance file (excludes autism services) • Child's primary insurance is federal • Child's primary insurance is one of the following: o Children's Medical Security Plan (CMSP) o Champus/Tricare o MassHealth: Basic o MassHealth: CarePlus o MassHealth: CommCare o MassHealth: Essential o MassHealth: HSN o MassHealth: HSN-Partial • MassHealth eligible clients with a reason code of 52 and a professional discipline of SA (Speech Language Pathology Assistant)	PENDED

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Business Rule Error Code Descriptions
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ERROR CODE	BUSINESS RULES	LINE STATUS
	• Autism service is provided by PDC or REACH (non-ABA services) • Autism intake service for commercially insured child What you should do: Submit support documentation and forward all questions to: Steve McCourt MDPH, 250 Washington Street, 5th floor Boston, MA 02108 Phone: (617) 624-5954 Support Documentation DPH providers must follow-up with insurers to make sure that the service record was not incorrectly denied and should verify the insurer benefit status. Support documentation includes the following: • An EOB plus any of the following support documentation: o Corresponding eligibility verification to include coverage status, coverage dates, EI benefit status, dates of service o Employer group non-covered number o Non-covered reports from insurer o MassHealth EVS (Eligibility Verification System) print out o Insurer-specific eligibility information o HIPAA Verification 270/271 o Insurer-specific website information confirming that EI is not a covered benefit o Verbal confirmation with trace/tracking number o Correspondence with insurer Note Support documentation should be sent only once for services submitted for the same child having the same primary insurer & reason code. Approved overriding support documentation will automatically result in payment of all services. Approval/Denial DPH re-remits all pended services unless payment has been approved. An approved service record will have a PV reference number. If approval has been denied then the denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file.	
5P	**Reason code and/or primary insurer in need of support documentation** Reason code on service record is one of the following: 26 (Expenses incurred prior to coverage) 27 (Expenses incurred after coverage terminated) 32 (Our records indicate dependant is not an eligible dependant) 33 (Insured has no dependent coverage) 39 (Services denied at time authorization was requested) 45 (Charges exceed contracted fee arrangement) 141 (Claim adjustment because claim spans eligible & ineligible periods of coverage) D07 Authorization in progress for autism service(service date is 3+months from initial autism service) D99 (Other) Exceptions Services are paid for clients on the DPH Insurance file or clients having Children's Medical Security Plan (CMSP), Champus/Tricare, a federal plan, MassHealth: Basic, MassHealth: Essential, MassHealth: HSN, MassHealth: HSN-Partial.	PENDED

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ERROR CODE	BUSINESS RULES	LINE STATUS
	What you should do: Submit overriding support documentation and forward all questions to: Steve McCourt MDPH, 250 Washington Street, 5th floor Boston, MA 02108 Phone: (617) 624-5954 Support Documentation DPH providers must follow-up with insurers to make sure that the service record was not incorrectly denied and should verify the insurer benefit status. Support documentation includes the following: ▪ An EOB plus any of the following support documentation: o Corresponding eligibility verification to include coverage status, coverage dates, EI benefit status, dates of service o Employer group non-covered number o Non-covered reports from insurer o MassHealth EVS (Eligibility Verification System) print out o Insurer-specific eligibility information o HIPAA Verification 270/271 o Insurer-specific website information confirming that EI is not a covered benefit o Verbal confirmation with trace/tracking number o Correspondence with insurer Note Services with these reason codes are NOT matched to other services that were approved with support documentation. Approval/Denial DPH re-remits all pended services unless payment has been approved. An approved service record will have a PV reference number. If approval has been denied then the denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file.	
5R	**Autism reason code of D10 or primary insurer in need of support documentation** Autism service: D10 reason code (contractual adjustment) is not appropriate for DPH charge: 1) Primary insurer is not Blue Cross/Blue Shield or payer is not Beacon Health Strategies 2) BCBS rate is $97.00 3) Charge to DPH is not the difference between the $48.52 and $61.62 rate What you should do: Review these services and make appropriate adjustments Approval/Denial DPH remits all pended services until payment has been approved. An approved service record will have a PV reference number; a denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file for this record.	REJECT
5T	**Authorization for Autism Service has been in Process for Over 3 Months** The D07 reason code should be used for commercially insured children, including children who have MassHealth as a secondary insurer, when autism services are provided before prior authorization or clinical approval is in place. Autism services having a date that is greater than 3 months after the initial autism service will pend if submitted using the D07 reason code.	PENDED

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ERROR CODE	BUSINESS RULES	LINE STATUS
	No DPH history of approvals will be created after a review of documentation. Therefore, every individual service after this 3 month grace period will need support documentation. What you should do: 1. If either the reason code or primary insurer is incorrect, reverse out the DPH charge and re-submit the record with the correct codes. 2. Submit support documentation and forward all questions to: Steve McCourt MDPH, 250 Washington Street, 5th floor Boston, MA 02108 Phone: (617) 624-5954 Approval/Denial DPH remits all pended services until payment has been approved. An approved service record will have a PV reference number; a denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file for this record.	
6A	**Client is not registered into EIIS** The client ID has not been entered into the EIIS database or the client ID in EIIS differs from the client ID in the billing system. What you should do: Identify the client in your billing system receiving these services. 1. If the DPH ID for this client in your billing system is okay contact the EIIS data manager. 2. If the client has not been entered into EIIS, the EIIS data manager must enter this client into the data system. b. If the client has been entered into the EIIS data system under a different client ID the data manager must contact Linda Mosesso at DPH at (617) 624-5521 in order to update the EIIS client ID. 3. If the client ID on an SDR file was incorrect, notify Jean Shimer at DPH at (617) 624-5526 with the correct ID so that all services previously reported to DPH can be updated.	SUSPEND
6B	**EI service: Date of service is prior to EIIS referral date or after EIIS Last Service Date** What you should do: 1. Verify that the date of service is correct. If it is correct contact the EIIS data manager. The data manager must correct the Date of Referral or Last Service Date in EIIS. 2. If the service delivery date is incorrect notify Jean Shimer at DPH at (617) 624-5526.	SUSPEND
6C	**Child's EIIS name, birth date and/ gender are missing** What you should do: Contact the EI program's EIIS Client system manager. The EIIS manager must make sure that all data is complete or correct on the EIIS Referral screen.	SUSPEND

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ERROR CODE	BUSINESS RULES	LINE STATUS
6E	**Child's third birth date, according to the EIIS date of birth, occurs prior to service date** (no waiver authorization #) What you should do: 1. Contact the EI program's EIIS Client system manager. The EIIS manager must verify that the birth date in the EIIS system is correct. If the birth date on the EIIS Referral screen is incorrect, the EIIS manager must make sure that this information is corrected in EIIS. 2. If the date of service is incorrect the EIIS manager or biller should contact Jean Shimer at (617) 624-5526 to update the service date.	SUSPEND
6F	**Child's third birth date, according to the EIIS date of birth, occurs prior to service date** (has a waiver authorization #) What you should do: Do nothing. DPH will review the waiver for acceptability and will re-remit after approval/denial. An approved service record will have a PV reference number; a denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file for this record.	wPEND
6H	**CHA Assessment Service (Service = E) for a non-EIPP Referral** What you should do: 1. If this child for this referral was referred by an EIPP program then do the following: a. Review the EIIS Referral screen to make sure that "Who suggested that this family contact this EI program" states "EI Partnerships (EIPP)". b. Contact the EIPP data manager to make sure that this child has been entered into the EIPP database. 2. If this child for this referral was not referred by an EIPP program then reverse out the claim and submit it again under the correct service type.	SUSPEND
6S	**Missing EIIS Autism Specialty Data** EIIS specialty data is missing or is incomplete. What you should do: Enter or complete the autism specialty data form and enter into EIIS Client system.	SUSPEND
7A	**Unit or cost adjustment service record received with no original/initial service record** What you should do: 1. If the original/initial service record was never sent to DPH, submit the original/initial service record and the adjustment records in your next transmittal. 2. If the original/initial service record was rejected as a 3T, resubmit the original/initial service record with the appropriate waiver authorization # along with the adjustment or transfer record.	REJECT
8A	**EIPP Service: EIPP Client is not registered** What you should do: Identify the client in your billing system receiving these services. 1. If the DPH ID for this client in your billing system is okay contact the EIPP data manager. a. If the client has not been entered into the EIPP database, the EIPP data manager must enter this client into the data system. b. If the client has been entered into the EIPP data system under an incorrect client ID the EIPP data manager must update the client ID to the correct one. 2. If the client ID on an SDR file was incorrect, notify Jean Shimer at DPH at (617) 624-5526.	SUSPEND

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ERROR CODE	BUSINESS RULES	LINE STATUS
8B	**EIPP Service: EIPP Date of service is prior to the Intake Date or after the Discharge Date** What you should do: Verify that the date of service is correct. 1. If it is correct, contact the EIPP data manager. The data manager must correct the Intake or Discharge date in the EIPP data system. 2. If the service delivery date is incorrect notify Jean Shimer at DPH at (617) 624-5526.	SUSPEND
8C	**EIPP Service: Original/initial EIPP service can only be billed once per client enrollment** What you should do: Review service for appropriate corrections. Re-submit as a regular home visit.	REJECT
8F	**EIPP Service: EIPP home visits are not allowed after child turns 4 months of age** *(effective for services on or after 1/6/14; prior to this 2 months of age)* What you should do: Review the child's EIIS birth date and service dates for appropriate corrections.	REJECT
8K	**EIPP Service: Service Delivery Date does not match to Home Visit Date** What you should do: Review the EIPP database to make sure that the home visit table includes this service record. If the record does not exist then enter this visit's data into the EIPP database. If the record does exist but the service date is incorrect in the EIPP database then update the EIPP home visit date. If the service date in your billing system is incorrect then (a) notify your biller to update the service with the correct service date AND (b) contact Jean Shimer to update the DPH database with the correct service date .	SUSPEND
8J	**EIPP Service: MBD Service occurs more than once per enrollment and/or child is not between the ages of 4 and 12 months** What you should do: Re-submit this service if it meets the billing requirements above.	REJECT
9A	**Excessive child group service hours, no waiver** Child group service hours for a client exceed 2-1/2 hours per week or two times per week. What you should do: If the service had a prior authorization from DPH then re-submit the adjustment or transfer records with the prior authorization/waiver number.	REJECT
9C	**Initial EI Visit exceeds 2 hours per child enrollment (service = I)** An initial EI visit cannot exceed 2 hours or 2 sessions per child enrollment and must occur prior to all other services. An initial EI visit can occur on multiple days if within 2 weeks of one another. What you should do: If appropriate, submit with the appropriate hours.	REJECT
9E	**Excessive parent group service hours, no waiver** Parent group service hours for a client exceed 1-1/2 hours per week or once per week. What you should do: If appropriate, re-submit with the appropriate hours	REJECT

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ERROR CODE	BUSINESS RULES	LINE STATUS
9N	**Excessive child group service hours, with waiver** Waived child group service exceeds 2-1/2 hours or occurs more than twice within a week What you should do: Do nothing. DPH DPH will review waiver for acceptability and will re-remit after approval/denial. An approved service record will have a PV reference number; a denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file for this record.	wPEND
9P	**Excessive parent group service hours, with waiver** Waived parent group service exceeds 1-1/2 hours or occurs more than once per week What you should do: Do nothing. DPH will review waiver for acceptability and will re-remit after approval/denial. An approved service record will have a PV reference number; a denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file for this record.	wPEND
9R	**Waived service** Reason code is D01 (clinical waiver) What you should do: Do nothing. DPH will review waiver for acceptability and will re-remit after approval/denial. An approved service record will have a PV reference number; a denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file for this record.	wPEND
9S	**Waived service** Reason code is D02 (services received at a secondary EI program) What you should do: Do nothing. DPH will review waiver for acceptability and will re-remit after approval/denial. An approved service record will have a PV reference number; a denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file for this record.	wPEND
9U	**Excessive center-based individual service hours, no waiver** Center-based individual service hours exceed 2 hours per session. What you should do: Review service for appropriate corrections.	REJECT
9V	**Excessive center-based individual service hours, with waiver** Waived center-based individual service hours exceed 2 hours per session. What you should do: Do nothing. Will review waiver for acceptability and will re-remit after approval/denial. An approved service record will have a PV reference number; a denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file for this record.	wPEND
9W	**CHA for child over 12 months or exceeds the maximum of 5 between birth and 12 months** CHA services exceed EIPP standard: maximum of 5 between birth and 12 months What you should do: Review service for appropriate corrections.	REJECT

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ERROR CODE	BUSINESS RULES	LINE STATUS
9X	**Excessive CHA service hours** CHA service exceeds EIPP standard: maximum of 1.5 hours per enrollment What you should do: Review services for duplication issue.	REJECT
9Y	**Excessive home visit hours, no waiver** Home visit hours exceed 2 hours per session What you should do: Review service for appropriate corrections.	REJECT
9Z	**Excessive home visit hours, with waiver** Waived home visit hours exceed 2 hours per session What you should do: Do nothing. DPH will review waiver for acceptability and will re-remit after approval/denial. DPH will review waiver for acceptability and will re-remit after approval/denial. An approved service record will have a PV reference number; a denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file for this record.	wPEND
S2	**Autism Specialty Intake can only be billed once per child enrollment per SSP** What you should do: Review service for appropriate corrections. Re-submit as a direct treatment service.	REJECT
S3	**Autism Specialty Intake service exceeds 2.0 hours** What you should do: Review service for appropriate corrections.	REJECT
S4	**Autism Specialty Direct Treatment service exceeds 3.0 hours** What you should do: Review service for appropriate corrections.	REJECT
S5	**Autism Specialty services exceed maximum of 30 hours per week** What you should do: Review service for appropriate corrections.	REJECT
S6	**Child meets MassHealth requirements for payment of Autism Specialty services** What you should do: Submit the charges to MassHealth and provide DPH with a credit.	DENIED

EARLY INTERVENTION INFORMATION SYSTEM

DESCRIPTION OF LINE & CLAIM STATUS

FISCAL YEARS 2016 & 2017

LINE & CLAIM STATUS: Each service record is assigned a line status based on the error codes for that line. A service will have one original/initial service record and then can have multiple adjustment or transfer records (unit or cost adjustment records). Therefore, a service with multiple service records could have multiple line statuses.

If a service record has an error code that results in the line having a *REJECT* status then the service record is ignored as a valid transaction. If a service record has a line status of ACCEPT but another transaction within the service has a line status of SUSPEND, PENDED or wvPEND the claim status for all the service lines within the service will state SUSPEND, PENDED or wvPEND.

The following are definitions for the DPH line and claim status:

- ACCEPT — The service line has passed all business rules.
  If the error code is 63 (receipt of service or charge occurs after EI or EIPP deadline) or 64 (exceeds EIPP budget cap amount) you do not need to do anything. DPH will not pay for services past the deadline or over the amount budgeted for the EIPP program.
- SUSPEND — The service will be on hold, waiting for corrections (EIIS client database may need to be updated or the client ID submitted on the SDR file may not be correct) by the EI program. When the next month's service delivery is processed, if the correction has been made the service status will change to "accept" and be processed for payment.
- PENDED — For error codes 4C, 5B, 5H, 5K or 5P you must submit appropriate overriding support documentation and forward all questions to Steve McCourt at (617) 624-5954 (MDPH, 250 Washington Street, 5th floor, Boston, MA 02108). DPH will re-remit after approval/denial. An approved service record will have a PV reference number; a denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file for this record.
- wvPEND — For error codes 3E, 3F, 6F, 9N, 9P, 9R, 9S, 9V or 9Z you do not need to do anything. DPH will review the waiver for acceptability and will re-remit after approval/denial. An approved service record will have a PV reference number; a denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file for this record.
- DENIED — DPH Payment is denied *(error code S6)*.
- DENIAL — Late DPH charge submission or Charges exceed DPH budgeted amount *(error codes 63 and 64)*
- *REJECT* — *No payment of the service will be made. Rejected services may be corrected by the EI program and resubmitted.*
- *NotProcessed* — *No payment of the service will be made. A service record was rejected prior to being processed through the DPH business rules. These service records will have an error code of 20.*

Appendix V

MassHealth & Third Party Insurance Guidance

Early Intervention

MassHealth & Third Party Insurance Guidance

A. Insurance Guidance

A summary listing of Early Intervention Insurance Contacts is periodically updated by DPH. These individuals have been identified by the insurers as a contact to assist EI providers if there are issues that cannot be resolved by standard procedures. Many of these contacts also participate with the Insurance Coordinators group and are very familiar with EI. For some insurers, (e.g. Cigna) the individual identified must also be contacted to verify the EI coverage status.

1. Aetna Health Care

Benefits Verification - Early Intervention providers should call 1- 800-624-7056 for HMO plans and 1-888-632-3862 for Traditional plans. Traditional plans start with the letter W and are followed by a series of numbers. The HMO plans can be identified by the member ID which is an alphanumeric combination. In verifying benefits ask the Customer Service Representative (CSR) whether the members plan is self insured or fully insured.
The mandate exempts self insured plans for payment under the insurance policy unless there are specific benefits outlined. Also, there is an internal processing guideline for all Aetna CSR's to reference. If there is an issue with understanding the Early Intervention program and Aetna's policy, reference the Early Intervention document which the CSR can find in e-policies, specifically Legislation/Massachusetts/Early Intervention.

The Early Intervention Guideline is an Aetna internal document that describes the handling of EI claims and the Massachusetts mandate. The Provider Service Center (PSC) will provide the reference /target number for any claims that are to be reconsidered.

Claims Submission - Questions regarding the status of claims should be directed to the PSC at 1 800- 624-0756 for HMO plans and 1 888-632-3862 for Traditional plans.

Claims Reconsideration < 10 Claims – Issues, concerns, questions regarding processed EI claims can be sent to the PSC at 1-800 -624-0756 for HMO plans and 1-888-632-3862 for Traditional plans within 180 calendar days of the initial claims decision. Reference the Early Intervention Guideline if there are issues with the PSC. The PSC will provide reference/target number for any claims sent for reconsideration. The 9 digit reference/target number should be referenced and included in any correspondence submitted to DPH.

Claims Reconsideration > 10 Claims- Issues regarding Early Intervention claims can be sent to the Provider Service Teams (PST) as a large project within 180 calendar days of an initial claim decision. The PSC will provide a reference/target number for any project sent

to be reconsidered. The 9 digit reference/target number should be referenced and included in any correspondence submitted to DPH.

The project can be submitted via a spreadsheet to PST at ALTPST@aetna.com. The spreadsheet must have the required fields as listed on the PST Spreadsheet Required Fields and be accompanied by the Aetna Claim Special Project Form. The project will be routed to a Market Aligned Project Lead (MAPL) who is responsible for completion of the project and reporting back to the provider. Be sure to include a valid e-mail address, so the PST can respond to you with the results.

Additional Appeal - An Early Intervention program may appeal any reconsideration within 60 calendar days. The appeal can be initiated by calling 1- 800-624-0756 for HMO plans or 1-888-632-3862 for Traditional plans or by writing to:

Aetna
Provider Resolution Team
PO Box 14020
Lexington, KY 40512
Fax – (859) 455 - 8650

Aetna- Early Intervention Program Clinical Policy Bulletin information can be referenced through:
://www.aetna.

Claim Inquiries
Providers should use @aetna. for claim inquiries.

Information valid as of 10/25/2014.

2. Blue Cross/ Blue Shield (BC/BS) of Massachusetts

Providers should use *Bluelinks for Providers* which is an online access to verify claims status, eligibility, and benefits. This website also provides information such as: FYI's, Provider Focus Newsletters, Medical Policies, and other information that will assist EI providers in doing business with BCBSMA. Updated Early Intervention claims submission information and reimbursement guidance can be obtained with registration on BlueLinks.

The website is ://www.bluecrossma. . If providers need assistance with this website they can contact the Provider Self Service Help Line at 1-800-771-4097. Appeals, denials, and partial payments should be handled by the Providers Service Department at 1- 800- 451-8124.

Quarterly, DPH receives files from BCBSMA of non-covered clients with BlueCard and National accounts. This information is uploaded directly to the DPH EIIS system. Providers can request from BC/BS to receive a copy of their program specific files. Elizabeth.pereira@bcbsma.com

3. BMC HealthNet Plan

Provider Web site- ://www.BMCHP. to access the BMC HealthNet Plan's Provider Manual. Information specific to EI is listed in the provider manual.

Provider Line: 800-900-1451

Option 1 Claim/Member Eligibility.
Behavioral Health Call Beacon if DOS is on or after 3/1/10 866-444-5155 or help with 24 hour assistance for BH questions

Option #2 Speak with a Representative regarding claims or Provider Enrollment status

Option #3 Medical Services and Authorizations, notifications other than Behavioral Health and Pharmacy

Option #4 Pharmacy, Authorizations and Eligibility other than Claim Status

Claims Address-
BMC HealthNet Plan PO Box 55282
Boston, Ma. 02205-5282

Member Eligibility Verification
- WebEVS (internet access): ://newmmis-portal.ehs.state.ma.us/EHSProviderPortal/appmanager/provider/ ; AVR (automated voice response): (800) 554-0042
- NEHENNET.org: (New England Health- care EDI Network) Eligibility, pcps, claims; or call (781) 290-1290
- BMCHP.org: must have login and pass-word; or call (800) 900-1451 (option #2 eligibility)

4. Cigna HealthCare/Great West Health Care

Cigna/Great West Health Care has a website where all information pertaining to EI can be found. The website is called: http://www.cignaforhcp.com. EI providers can verify eligibility and benefits and obtain access of key information.

To facilitate the handing and processing of Cigna/Great West Health Care members, EI providers should take the following steps. Call 1- 800- 88CIGNA for the child's eligibility. Press 2 for provider, then press 1 for medical, then press 2 for eligibility/benefits, and press 0 for a live representative.
Ask the representative whether the member is enrolled in a Fully - Insured or a Self - Funded plan.

If the member is enrolled in a Fully-Insured plan, then CIGNA/Great West Health Care is responsible for EI coverage as stated per the state mandate.

If the member is enrolled in a Self-Funded plan, then the next step is to ask the representative if there is a separate line item for Early Intervention in the members benefit package. If there is no specific benefit line called Early Intervention in the benefit package then the member doesn't have coverage for Early Intervention services.

If the member doesn't have Early Intervention coverage then submit the members name, ID, and date of birth, to Matthew Bancroft at Cigna/Great West Health Care, (_bancroft@cigna.) and request a denial letter that will be submitted to DPH. The letter should indicate if the plan is self funded and does not carry EI benefits.

5. Harvard Pilgrim Health Care (HPHC)

Key information for Early Intervention providers is available on line at .harvardpilgrim. . Click the Providers link on the left to access the Provider Manual for the most up to date information on Harvard Pilgrim products, programs, policies and procedures; including billing, reimbursement, appeals and payment policies.

You may call the Provider Call Center at 800-708-4414 to verify eligibility or obtain claim status or you may email them at _callcenter@hphc.

For ease, you may also verify information through *HPHConnect.* *HPHConnect* is Harvard Pilgrim's highly acclaimed Web-based transaction service. It provides health plan information for your Harvard Pilgrim patients, 24/7, it is HIPAA-compliant, and *it is free.*

With *HPHConnect* you can perform the following transactions online...

- Submit Claim Batch Files (HIPAA 837 Format)
- Verify Patient Eligibility
- Find the Status of a Claim
- Send/Receive Specialty Referrals
- Submit Notification/Receive Authorization
- View a Patient's Personal Health Record (PHR)

In addition, you get Harvard Pilgrim news, information and reports:

- Provider Manual, *Network Matters* and Provider Directory
- Drug Formulary
- Diagnosis, Procedure and Revenue Codes
- PCP Membership Reports
- Claims Reports

6. MassHealth – PCC Plan

MassHealth claims and billing guidance is on the MassHealth website Mass.Gov in the Early Intervention Manual and Companion Guides and includes MMIS instructions.

7. Neighborhood Health Plan (NHP)

NHP's Provider manual link includes references to many useful guides for EI providers on billing, appeals and referral authorizations.
://www.nhp.org/pages/providers_providermanual.

NHP's Administrative link to other secondary resources for EI Providers:
http://www.nhp.org/pages/providers_adminresources.

For questions concerning provider or member appeals, member benefits, and eligibility verification call the Customer Care Center at 800-462-5449.
The NHP Provider manual is your resource on how the Neighborhood Health Plan works and provides convenient web links to many other resources on the NHP website.

8. Network Health

Provider Relations 1 (888) 257-1985
Web site ://www.network-health.

Reference the "Doing Business with Us and Getting Paid" for information on member eligibility, claims, claims status, and EI Services Payment Policies.

9. Tufts Health Plan (THP)

The link to the Early Intervention Policy for Tufts HP is:
://www.tuftshealthplan.com/providers/pdf/payment_policies/early_inter.
There are additional links within the policy that can further assist providers as needed including: general benefit information, billing information, and reimbursement information.

The THP provider manual provides EI staff with the most up to date information on the structure, products polices, and procedures of the plan.

10. Fallon Community Health Plan

FCHP has a Provider Tools page on our website: ://www.fchp.org/providers/provider-tools. .
Contracted and non-contracted providers can verify member eligibility.

There is a section in our Provider Manual that has billing guidelines for EI claims:
://www.fchp.org/providers/provider-manual/~/media/Files/FCHP/Imported/Billing_procedures.pdf. .

Lastly, we have a medical policy for Early Intervention:
://www.fchp.org/providers/medical-management/~/media/Files/ProviderPDFs/MedicalPolicies/EarlyInterventionSvcs. .

11. UniCare State Indemnity Plan

The UniCare State Indemnity Plan covers medically necessary Early Intervention Services for children from birth until their third birthdays includes occupational therapy, physical therapy, speech therapy, nursing care, psychological counseling, and services provided by early intervention specialists or by licensed or certified health care providers working with an Early Intervention Services program approved by the Department of Public Health.

The UniCare State Indemnity Plan is a self funded plan. The benefit for Early Intervention Services for children is 80% up to a calendar year maximum benefit of $5,200 per child per calendar year, and a
lifetime maximum benefit of $15,600. The 20% coinsurance amount does not count toward the out-of-pocket maximum.

If there are any questions, please contact the Andover Service Center at **1-800-442-9300** from 7:30 a.m. to 6:00 p.m. Monday through Thursday, or from 7:30 a.m. to 5:00 p.m. on Friday.
You can also e-mail us from our web site at **.unicare-cip.com** by clicking on “Contact Us.”

12. UnitedHealth Care of New England

://www.UnitedHealthcareOnline.

1(800)-708-4414 - Claims submission, payments, billing for services appeals, etc. For EDI information call 1(800)842-1109. Providers should call the customer service number on the back of the member's ID card for assistance on benefit information.

United Healthcare periodically sends to DPH (for distribution to EI providers) a listing of employer group numbers of groups that do not have an Early Intervention benefit.

EARLY INTERVENTION
PAYER CONTACT INFORMATION
as of October 27, 2014

Doreen Dami	Aetna	(860) 613-2079	DamiD@Aetna.com
Nicole Tully	BC/BS MA	(617) 246 -9334	Nicole.Tully@BCBSMA.com
Lori Marshall	BMC HealthNet	(508) 990-2450	Lori.Marshall@BMCHP-wellsense.org
Matthew Bancroft	CIGNA/Great West	(888) 244- 6264 #1 #76461	Matthew.Bancroft@cigna.com
Janet Pasque	Connecticare	(860) 674-7025	jpasqua@connecticare.com
Stephen McCourt	DPH	(617) 624- 5954	steve.mccourt@state.ma.us
Tara Rivera	Fallon	(508) 368- 9084	tara.rivera@fchp.org
Courtnie Tower	HPHC	(603) 656-9529	Courtnie_Tower@harvardpilgrim.org
Barbara Barrows	MassHealth	(617) 222-7524	.Barrows@State.Ma.
Joann Gordon	Network Health	(781) 393- 3127	joann.gordon@network-health.org
Amanda Palmer	Tufts Health Plan	(617) 972- 9411 x 8739	amanda_palmer@tufts-health.com
Caroline LeBlanc	Unicare/GIC	(978) 474- 6814	caroline.leblanc@wellpoint.com

Appendix VI

Early Intervention
Autism Specialty Services
DPH Billing Requirements & Guidance

EARLY INTERVENTION AUTISM SPECIALTY SERVICES
DPH BILLING REQUIREMENTS & GUIDANCE

DEFINITIONS

EI Child Eligible for Autism Specialty Services: An IFSP child is eligible to receive autism specialty services if they have received a confirmed autism spectrum diagnosis from a physician or licensed psychologist.

Autism Specialty Service: The Intensive Service Model for children under age three who are enrolled in an EI program with an autism spectrum diagnosis and have high intensity service needs.

Staff qualifications: Services would be delivered by individuals meeting the credentialing requirements specified in the DPH Operational Standards and who have knowledge and expertise in treating infants and toddlers with autism spectrum disorder.

Specialty service types: Families can receive either a specialty intake service or direct treatment specialty service, which includes a supervision service. Families are allowed to receive an intake service (an initial face-to-face visit), from multiple specialty providers prior to choosing a provider for receipt of direct treatment services. One 2-hour intake service is allowed per family per specialty agency.

> *Autism Intake service:* The first face-to-face meeting between the family and an autism specialty provider for the purpose of information gathering. This service occurs for an IFSP child who is eligible for autism specialty services once a referral has been made to a specialty provider.
>
> - Families are allowed to visit multiple specialty providers prior to choosing a provider for receipt of services. Service Coordinators are required to inform families of all approved specialty providers in their area, share any written information that the SSPs have offered, and encourage parents to view the SSP websites to help narrow down their selection.
>
> *Note: This service differs from the EI Intake which is the first face-to-face pre-assessment planning visit with the family prior to the determination of EI eligibility.*

Specialty Service Referrals
The Department takes the position that it is best practice for EI Providers to inform families of all approved Specialty Service Providers operating within the EI Program's respective catchment area regardless of whether the EI Provider holds a subcontract with all Specialty Service Providers.

MASSACHUSETTS PAYERS

The following provides information about specialty service requirements for each of the Massachusetts payers. The rate, maximums and benefits covered for autism specialty services differs by health care provider. However, there are certain maximums that DPH, as the lead state agency, requires all provides to adhere to regardless of payer. These include the following:

- Autism Intake service:
  - 2 hours per specialty agency per referral
    - *MassHealth will pay for intake services.*
    - *Commercial insurers will not pay for intake services*
  - Two specialty providers are allowed to provide an Autism Intake service on the same day as long as the total hours for the service does not exceed 2 hours
  - An autism intake service must occur prior to direct treatment services
- Autism Direct Treatment Service:
  - Maximum length of service: 3 hours/session
  - Maximum hours per week: 30 hours
    - *The 30 hours is cumulative and includes supervision hours as well as direct service time.*
    - *IFSP entries should not exceed 30 hours per week in total for ASD intensive behavioral services (ABA, ESDM, Floortime)*

INSURER VERIFICATION

DPH expects that providers will continue to make all reasonable efforts to secure reimbursement for services from the appropriate insurer and follow established DPH billing rules and claim submission requirements. Providers must be able to fully justify the appropriateness of claims being submitted to DPH, document due diligence in their attempts to resolve non-covered claims prior to submission to DPH and continue to verify benefits and coverage for autism services. DPH expects providers to verify the insurance status for changes, minimally, on a quarterly basis.

MASSHEALTH

MassHealth, including all MassHealth MCO providers, pays for both intake and direct treatment specialty services. Do not submit claims to the MassHealth MCO; instead, submit these claims directly to MassHealth. Use the following *MassHealth Checklist* to determine if autism specialty services should be billed to MassHealth.

Checklist Items	**Response**	
Has one of the following MassHealth products: • MassHealth Standard • MassHealth CommonHealth • MassHealth Family Assist Premium • MassHealth MCO: BMC HealthNet Plan • MassHealth MCO: Fallon • MassHealth MCO: Health New England • MassHealth MCO: Neighborhood Health • MassHealth MCO: Network Health	YES	NO
Does not participate in the MassHealth DDS Waiver Program	YES	NO
Has a diagnosis of Autism Spectrum Disorder (ICD-9 299.0) conferred by a physician or licensed psychologist	YES	NO
Receiving specialty services from one of the following providers: • AMEGO • Applied Behavioral Lang Svs • Beacon ABA Services • Behavioral Concepts • Children Making Strides • Community Health Link • Futures Behavior Therapy Center • HMEA • Make a Difference in Children • May Institute • NE Arc/Building Blocks • New England Ctr for Children • RCS Behavioral & Educational Consulting • Reach Educational Services • Spectrum Autism Treatment	YES	NO

If **ALL** responses are **YES**, submit intensive autism specialty services to MassHealth.
If **ANY** response is **NO**, submit intensive autism specialty services to DPH.

Claims for any MassHealth child that do not match all of the above criteria should be sent directly to DPH. Providers should NOT submit a claim initially to MassHealth in order to get a denial prior to submitting to DPH; claims can be sent directly to DPH.

Other MassHealth Billing Requirements

- CMS Service Code: H2019
- Service modifier: SE
- Rate: $15.38 per 15 minutes or $61.52 per hour
- Maximum hours per day: 6 hours *(Note: cannot exceed a maximum of 3 hours per session)*
- A prior authorization is not needed unless the **maximum per day**, if scheduled as such on the child's IFSP, is to be exceeded. Maximum of 30 hours per day must be adhered to for MassHealth children as a DPH standard.
- MassHealth will pay for intake services
- Intake service: 2 hours per specialty agency per referral. Submit intake services to MassHealth using the CMS service code and modifier of H2019-SE. *Note: Families are allowed to visit multiple specialty providers prior to choosing a provider for receipt of services.*

MassHealth Members in MCOs

If a MassHealth member has coverage through a MassHealth MCO then autism specialty services, unlike traditional EI services, are **not** covered by the MCO and EI providers must submit claims directly to MassHealth.

MassHealth Members with Other Insurance

If the MassHealth member has private insurance, the EI provider must bill the member's primary insurer before submitting the autism specialty service claim to MassHealth as a secondary payer if the MassHealth product is MassHealth Standard, MassHealth CommonHealth or MassHealth Family Assist. If the MassHealth secondary is other than these then submit the charge to DPH.

COMMERCIAL INSURERS

Most commercial insurers will require a prior authorization before EI providers can bill for services. Once the prior authorization is in place and the commercial insurer denies charges for these services all denials should be submitted to DPH using an appropriate adjustment reason code (see *Code Sheet for Adjustment Reason* under Appendix I). The following insurers do NOT require a prior authorization for autism services:

- Aetna/US Health Care
- CIGNA
- Neighborhood Health Plan (NHP)

Commercial Insurer Billing Requirements

- If appropriate, prior authorization for autism services is required
- CMS Service Code: varies by insurer
  - All insurers with the exception of BC/BS and Beacon Health Strategies (BHS) will be using the CMS procedure code of H2019-SE code at a rate of $61.52 per hour.
  - BC/BS and Behavioral Health Strategies (BHS) have the following CMS procedure codes:
    - H2019
    - H2012
    - H0031

    Note for BC/BS Only: If a provider is not licensed and is not a BCBA, H2012 services are not reimbursable. For BCBAs that are not licensed, H2012 services are reimbursable. H2012 services provided by a paraprofessional should be billed to DPH as a H2019 service with a reason code of D22.
  - When billing an insurer the H2019 procedure code and the SE modifier is required to ensure that the service is processed as the Early Intervention autism specialty service
- Commercial insurers will not pay for intake services.
- Maximums: varies by insurer
- Several in-state and some out-of-state insurers provide behavioral and mental health services under a partnership with United Behavioral Health (UBH) or Beacon Health Strategies (BHS). Once a prior authorization for autism services has been approved by UBH or BHS an Early Intervention program will bill UBH or BHS for autism services for children covered under these insurers.
  - Third party payer (data field name: TPPCODE)
    70 (United Behavioral Health)
    71 (Beacon Health Strategies)
- Other requirements: varies by insurer
  - If a child has received an autism service by a non-BCBA for a service required by the insurer to be performed by a BCBA then providers bill the service directly to DPH using a reason code of D22 (non-BCBA clinician provided service where insurer requires BCBA for service)
    - BC/BS Only: If a provider is not licensed and is not a BCBA, H2012 services are not reimbursable. For BCBAs that are not licensed, H2012 services are reimbursable. H2012 services provided by a paraprofessional should be billed to DPH as a H2019 service with a reason code of D22.

- If a child has BC/BS and an autism service is provided in a child care setting then providers should bill the service directly to DPH with a reason code of D24 (BC/BS child is provided an autism service in a child care setting)

DEPARTMENT OF PUBLIC HEALTH

DPH REPORTING AND BILLING REQUIREMENTS FOR AUTISM SPECIALTY SERVICES

DPH Reporting and Billing Codes and Rates

- Specialty service types *(data field name: SERVICE)*:
  - J: autism specialty intake; initial face-to-face visit with the family for information sharing and gathering
  - K: autism direct treatment supervision service
  - S: autism direct treatment service
- CMS service code *(data field name: DMACODE)*
  - Uninsured children: H2019
  - TriCARE children: H2019
  - MassHealth children: H2019
  - Commercially insured children:
    - If billing DPH: H2019
    - If reporting a service after receipt of the prior authorization: report insurer procedure code

  Note: DPH does not require the reporting of the SE modifier for the H2019 procedure code.
- Service setting *(data field name: WAIVER)*:
  - K01 = specialty service provided in the child's home
  - K02 = specialty service provided in a natural setting outside the child's home *(e.g., child care center, playground, etc.)*
  - K03 = specialty service provided in a non-community setting *(e.g., EI site, specialty provider site)*
- Professional Discipline *(data field name: PROFDISC)*: AS *(autism specialty service provider). Note: the provisional certification form for these clinicians will always state SS.*
- Autism Specialty provider *(data field name: Insamt)*:

  - 201 Amego
  - 202 Applied Behavioral Language Services
  - 102 Beacon Services
  - 203 Behavioral Concepts
  - 103 Building Blocks-NE Arc
  - 105 Children Making Strides
  - 204 Futures Behavior Therapy Center
  - 106 HMEA
  - 107 LEAP
  - 205 Make a Difference in Children
  - 101 May Center
  - 109 New England Center for Children
  - 112 Pediatric Development Center
  - 206 RCS Behavioral & Educational Consulting
  - 110 REACH-ServiceNet
  - 207 Reach Educational Services
  - 208 Spectrum Autism Treatment

  Note: All transaction types (initial, transfer or partial payments)) should provide the SSP agency code for autism services.
- Rate:
  - Uninsured children: $15.38 per 15 minutes or $61.52 per hour
  - TriCARE children: $15.38 per 15 minutes or $61.52 per hour
  - MassHealth children: $15.38 per 15 minutes or $61.52 per hour
  - Commercially insured children:
    - Billing MassHealth, DPH and most commercial insurers: $15.38 per 15 minutes or $61.52 per hour
    - Report insurer rate for BC/BS and Beacon Health Strategies (BHS)

Other DPH Billing Requirements

- Autism Intake service:
  - 2 hours per specialty agency per referral *(Note: MassHealth will pay for intake services. Commercial insurers will not pay for intake services.)*
  - Two specialty providers are allowed to provide an Autism Intake service on the same day as long as the total hours for the service does not exceed 2 hours
  - An autism intake service must occur prior to direct treatment services
- Autism Direct Treatment Service:
  - Maximum length of service: 3 hours/session
  - Maximum hours per week: 30 hours
- Two or more specialty disciplines can provide an SSP service on the same day without the need for a waiver.
- Do NOT bundle services when reporting to DPH
- Commercially insured children:
  - Original transaction: Report all original autism services that were billed to an insurer using the insurer CMS code and rate.
  - Full denial transfer from insurer: Report all transfer transactions with insurer denial information using the insurer CMS code and rate.
  - Full transfer of charges to DPH: Report all transfer transactions having a DPH charge using the insurer CMS code at the DPH rate of $61.52.
  - Partial transfer to DPH: Report all contractual adjustments or partial denials to DPH.

DPH Reason Code Requirements

The following adjustment reason codes can be used for autism services billed directly to DPH as well as for denied charges from insurers:

D05 – Uninsured child
D07 – Authorization in process
D08 – Authorization denied
D09 – Autism service is not covered by insurer
D11 – Contract has not been established
D22 – Non-BCBA clinician provided service where insurer requires BCBA for service
D24 – BC/BS child is provided an autism service in a child care setting
D25 – Autism service is not a covered benefit
D99 – Other

The following provides information regarding when to use DPH reason codes for autism services:

- D05 *(uninsured)* should be used for children receiving specialty services who do not have insurance. Children with MassHealth who may not be eligible at the time of service are considered MassHealth recipients and should not be designated as uninsured.

- D11 *(autism contract has not yet been established)* is a reason code to be used for commercially insured children when the contract with the insurer for autism services has not been authorized or established. This reason code will not be allowed for the following insurers with whom providers should already have a contract in place:
    - Aetna
    - BC/BS of MA
    - BMC *(not MassHealth MCO: BMC)*
    - Cigna
    - Fallon Community Health Plan
    - Harvard Pilgrim
    - Health New England
    - Neighborhood Health Plan *(not MassHealth MCO: NHP)*
    - Network Health *(not MassHealth MCO: NWH)*
    - Tufts Health Plan
    - United Behavioral Health/Optum

  DPH will automatically pay for autism services using a reason code of D11 for all other insurers. Support documentation is not needed but should be available if requested.

- D07 *(authorization is in progress)* used for commercially insured children, including children who have MassHealth as a secondary insurer, when autism services are provided before a prior authorization or clinical approval is in place. Autism services having a date that is greater than 3 months after the initial autism face-to-face service date will pend if submitted using the D07 reason code. No DPH history of approvals will be created after a review of documentation. Therefore, every individual service after this 3 month grace period will need support documentation.

  The D07 reason code is not allowed for the following insurers due to the fact that autism services for children are handled as an extension of EI services and prior authorizations to these insurers is not required:
    - Aetna
    - Cigna
    - Neighborhood Health Plan *(not MassHealth MCO: NHP)*

  .
- D08 *(authorization was denied)* should be used for autism services for commercially insured children, including children who have MassHealth as a secondary insurer, when the prior authorization for services is denied by the insurer.

  The D08 reason code is not allowed for the following insurers due to the fact that autism services for children are handled as an extension of EI services and prior authorizations to these insurers is not required:
    - Aetna
    - Cigna
    - Neighborhood Health Plan *(not MassHealth MCO: NHP)*

  Autism services using the D08 reason code will pend at DPH. DPH history of approvals after a review of documentation will be created. Therefore, support documentation is needed only for one of the services having a D08 reason code *(all other D08 services will be approved based on this one approval).*

- D09 *(autism specialty service does not meet insurer requirements/No prior authorization initiated)* should be used for the following:
    - Specialty Service Provider is REACH or PDC
    - MassHealth children who do not meet the MassHealth requirements for specialty service billing, including children having MassHealth as a secondary insurer.
        - DPH will automatically pay when the primary insurer is one of the following MassHealth products:
            - MassHealth: Children's Medical Security Plan
            - MassHealth: Basic
            - MassHealth: HSN *(Health Safety Net)*
            - MassHealth: HSN-Partial
            - MassHealth: Essential
            - MassHealth: CommCare
            - MassHealth: CarePlus

          A D09 used for ABA services for a MassHealth child under any other MassHealth product will pend at DPH. DPH history of approvals after a review of documentation will be created. Therefore, support documentation is needed for only one of the services having a D09 reason code (all other D09 services for this child under MassHealth will be approved based on this one approval).

    - Commercially insured children for the following services:
        - Autism Intake services *(these services do not meet insurer requirements)*
        - Primary insurer is TriCARE
        - Insurer is federal

      Providers should not bill an insurer for the above services where the primary insurer is commercial. Instead, bill these autism services directly to DPH using a D09 reason code and DPH will automatically pay for these services.

- D10 *(contractual adjustment)*: Used when BC/BS or Beacon Health Strategies (BHS) pays in full at a rate that is lower than $61.52. The contractual adjustment amount should be the difference between the insurer rate of $48.52 and the DPH rate of $61.52.
  Note: if the child has MassHealth as a secondary insurer DO NOT sent the contractual adjustment amount to MassHealth. The contractual adjustment charge should only be sent to DPH.
    - Autism charges using the D10 reason code will be rejected if the primary insurer is not BC/BS or BHS or if the difference between the BC/BS rate of $48.52 and the DPH rate of $61.52 is not correct.
    - Contractual adjustments are partial payment charges to DPH and, therefore, the partial payment transaction type (DPH data field: Sdform=E) must be used.

- D22 *(non-BCBA clinician provided service where insurer requires BCBA)*: The D22 reason code should be used for a commercially insured child that has been provided an autism service by a clinician that is not a BCBA where the child's insurer specifically stated that a BCBA is required. Do not submit these charges to the insurer. Instead, submit these services directly to DPH. DPH will automatically pay for autism services using a reason code of D22. Support documentation is not needed but should be available if requested

- D24 *(BC/BS child is provided an autism service in a child care setting)*: The D24 reason code should be used for a child insured by BC/BS that has been provided an autism service in a child care setting. Do not submit these charges to the insurer. Instead, submit these services directly to DPH. DPH will automatically pay for autism services using a reason code of D24 if the primary insurer is BC/BS. Support documentation is not needed but should be available if requested.

- D25 *(autism service is not a covered benefit)*: The D25 reason code is allowed for commercially insured children only:
    - Bill DPH directly (do not submit charge to the insurer) for a child that has been provided an autism service where autism is not a covered benefit under the child's commercial insurer.
    - Autism services using the D25 reason code will pend at DPH. If a provider does not submit a claim to the insurer then support documentation should include communication with the insurer that confirms a non-covered status (e.g., trace tracking number for a phone call with dates and note regarding phone communication, appeal letter, verification letter). DPH history of approvals after a review of documentation will be created. Therefore, support documentation is needed only for one of the services having a D25 reason code *(all other D25 services for this child will be approved based on this one approval)*. Note: DPH expects providers to verify the insurance status for changes, minimally, on a quarterly basis.
    - The D25 reason code, not the 096 reason code, must be used for autism services.

- D99 *(Other)*: The D99 reason code should be used for a commercially insured child whose autism service does not meet an insurer's requirement. Autism services using the D99 reason code will pend at DPH. Support documentation is needed to approve payment but NO history is created. Therefore, each D99 service will require support documentation to be sent.

  Note: Currently DPH is not aware of any other insurer requirements other than what has been stated in this document.

DPH WEB SITE AND BUSINESS RULES/REMITTED ERROR CODES

TVP Web Site

The TVP web site ensures accuracy of specialty service data based on *DPH Billing Codes* and *Other DPH Billing Requirements/Information* found above. Some of the TVP web site business rules for autism include the following:

- ERROR: Incorrect autism professional discipline
- ERROR: Incorrect Autism Rate for BC/BS
- ERROR: Incorrect Autism Rate for non-BC/BS

- ERROR: Incorrect autism reason
- ERROR: Incorrect Autism Reason Code for Primary Insurer
- ERROR: Incorrect insurer addendum for UBH/BHS payer
- ERROR: Incorrect reason for autism intake
- ERROR: Incorrect reason for non-ABA SSP
- ERROR: Incorrect service/payment code for UBH/BHS payer
- ERROR: Incorrect use of D09 autism reason code
- ERROR: Incorrect SSP code
- ERROR: Primary insurer is inconsistent w/autism CMS/CPT code

DPH Business Rules/Error Codes

The following business rules are additional business rules applied only to autism specialty services as part of the Department's payment voucher processing:

Error Code	*Business Rule Description*	Status
2N	Autism service: Excessive contractual obligation amount (total exceeds $61.52)	Reject
5K	Reason code and/or primary insurer in need of support documentation	Pended
5R	Autism reason code or primary insurer in need of support documentation	Pended
5T	Authorization for Autism Service has been in Process for Over 3 Months	Pended
6S	Missing EIIS autism data	Suspend
S2	Autism intake can only be billed once per child enrollment per SSP	Reject
S3	Autism intake service exceeds 2.0 hours per session	Reject
S4	Autism service exceeds 3.0 hours per session	Reject
S5	Autism services exceed maximum of 30 hours per week	Reject
S6	Autism service: child meets MassHealth requirements for payment	Denied

DPH Claim Status Outcomes for Autism Specialty Services

DPH Suspend

Autism specialty services are matched to EIIS Client data. If the EIIS Autism form has not been entered into EIIS then all autism specialty services for the child will suspend. The EI program must enter this information into EIIS in order to receive payment. Additionally, if the autism specialty provider in EIIS does not match the specialty provider in the service delivery record or if the EIIS specialty provider Date of Referral comes after the service date the service will suspend until a correction is made.

DPH Pended

- Original transactions for MassHealth Family Assist autism specialty services will end up being pended by DPH. DPH expects the program to bill Family Assist and will only pay charges that are submitted as denials *(the exceptions to this are for LMHC diagnosed children and children in the DDS Waiver program).*
- DPH expects that all autism specialty services be paid by the insurer once the prior authorization has been approved. Any services submitted after this approval is in place will be pended awaiting further support documentation to justify DPH payment.

DPH Denied

- Charges billed to DPH for a MassHealth child who meets all MassHealth requirements will be denied by DPH. A denied claim will be remitted with a claim and line status of "Denied". Further documentation is NOT expected to be sent from the EI program. The service will not get paid and will have an error code of S6 *(child meets MassHealth requirements for payment of autism service).*

DPH Reject

- Excessive autism specialty service hours per session or week will get rejected.
- Excessive contractual obligation amounts, charge requests where the total payment from the commercial insurer added to the DPH contractual obligation requested amount exceeds $61.52, will get rejected with an error code of 2N *(Excessive contractual obligation amount).*

DPH PAYMENTS FOR AUTISM SPECIALTY SERVICES

The following are the autism specialty services that will be paid by DPH.

Uninsured and Commercially Insured Children
DPH will pay for all autism specialty services for uninsured *(children with MassHealth who may not be eligible at the time of service are considered MassHealth recipients and should not be designated as uninsured) (Reason code: D05)*

MassHealth Children – Autism Specialty Services to be sent to DPH
The following additional services for MassHealth children will be paid by DPH.

Checklist Requirements Not Met
DPH will pay for all specialty services for MassHealth children who do not meet the MassHealth criteria on its Checklist. EI programs should submit these services to DPH using a reason code of D09. The following children will not meet the requirements on the MassHealth checklist:

- Children receiving MassHealth benefits under one of the following MassHealth products:
  - MassHealth: CMSP
  - MassHealth: Basic
  - MassHealth: HSN
  - MassHealth: HSN-Partial
  - MassHealth: Essential
  - MassHealth: CommCare
- MassHealth children who participate in the MassHealth DDS Waiver Program

IMPORTANT: Do not submit an initial claim for specialty services to MassHealth in order to receive a denial prior to submission to DPH; instead submit the claim directly to DPH using a reason code of D09.

MassHealth as Secondary Insurer
If MassHealth is the secondary insurer then MassHealth will not pay for services without an appropriate denial from the primary insurer. Therefore, if an EI program is not billing the commercial insurer for certain services *(i.e., autism specialty intake)* then these services should be billed directly to DPH using a reason code of D09. The following services are not billable to the primary insurer and therefore not billable to MassHealth and should be billed to DPH for children having MassHealth as a secondary insurer:

- Intake service
- No Prior Authorization
- Prior Authorization is not approved
- Service does not meet primary insurer requirements.

MassHealth Family Assist Premium
Autism specialty services for MassHealth Family Assist Premium children are payable by MassHealth. However, an EI provider may not know if the Family Assist product is the Premium plan until after billing MassHealth. Therefore, it is expected that if a child is covered under Family Assist that the EI program bill MassHealth for autism specialty services. This should occur when Family Assist is the primary or secondary insurer. DPH

will pay autism specialty service charges for denials from Family Assist. When submitting a denial for these children you must use the appropriate adjustment reason codes (see *Code Sheet for Adjustment Reason* under Appendix I). However, DPH will pay autism specialty services when billed directly to DPH *(original charges)* for Family Assist clients when the client does not meet the MassHealth requirements *(use a reason code of D09)*.

MassHealth Denials or Transfers

- DPH will pay a charge from MassHealth Family Assistance if the charge is submitted to DPH as a denial or transfer. The EI program should use an appropriate denial code (see *Code Sheet for Adjustment Reason* under Appendix I).
- If a MassHealth child who meets all MH requirements receives more than 6 hours of autism specialty services on one day it is expected that all services be billed to MH. Denials for excessive services *(more than 6 hours)* from MH should then be billed to DPH using an appropriate denial code.

Commercially-Insured Children – Autism Specialty Services to be sent to DPH

The following additional autism specialty service transactions will be paid by DPH for children who have a commercial insurer.

Autism Intake service

Submit all autism intake services for children having a commercial insurance, including where MassHealth is the secondary insurer, directly to DPH using a reason code of D09.

Services provided by non-ABA providers:

MassHealth and commercial insurers will not pay for non-ABA services. Therefore, these services should be submitted directly to DPH using a reason code of D09. Currently the following two autism specialty providers are non-ABA providers:

- Pediatric Development Center (PDC)
- ServiceNet

Children insured by TriCARE *(Reason code: D09)*

A reason code of D09 should be used for children having TriCARE insurance.

Children insured by federal plans *(Reason code: D09)*

A reason code of D09 should be used for children having a federal plan.

Autism specialty services provided while prior authorization is in progress

Autism specialty services that occur prior to the receipt of the prior authorization and verification of autism as a covered service should be sent directly to DPH using a reason code of D07 *(authorization is in progress)*.

- DPH expects that all EI providers will make good faith efforts to work with insurers to get the prior authorization. Once the prior authorization is in place it is expected that providers will begin billing the insurer.
- EI programs should have a process in place to acquire the prior authorization. There should be collaboration between the EI program and specialty provider staff to ensure that a process has been clearly worked out for the writing, submission and communication of the prior authorization and resultant outcome. Since EI programs will be able to bill DPH before this approval is in place it is important that EI billing staff be informed of the approval outcome and re-direct all billing to the insurance company if approval has been received.

A Prior Authorization was not Approved by the Insurer
If the insurer denies a prior authorization then bill all autism specialty services to DPH using a reason code of D08 *(authorization was denied).*

Autism Specialty Service Does not Met Insurer Requirements
If for some reason the autism specialty service does not meet the insurer's requirements *(e.g., no allowable procedure code for the service due to specialty service provider)* then do not submit the service to the insurer. Instead, submit the service and charges to DPH as an original transaction with an appropriate reason code:

D22 – Non-BCBA clinician provided service where insurer requires BCBA for service
D24 – BC/BS child is provided an autism service in a child care setting
D25 – Autism service is not a covered benefit

Commercial Insurer Denials or Transfers
Once autism specialty services are billed to an insurer after a prior authorization has been given, any denials from the insurer should be submitted to DPH using an appropriate denial code (see *Code Sheet for Adjustment Reason* under Appendix I).

Contractual Obligation Amounts
The only third party insurers having a different autism rate than the $61.52 per hour are Blue Cross/Blue Shield and Beacon Health Strategies (BHS). If the rate for an autism specialty service is less than $61.52 then DPH will reimburse the EI program the difference between the insurer rate and the DPH rate. The CMS code and rate billed to BC/BS or BHS should be reported to DPH. If the CMS Code billed to BC/BS or BHS had a rate of $48.52 then the program should submit a partial charge adjustment transaction *(sdform data field code is "E")* to DPH for the amount of $13.00 per hour using a reason code of D10 *(contractual adjustment).*

Note: if the child has MassHealth as a secondary insurer DO NOT sent the contractual adjustment amount to MassHealth. The contractual adjustment charge should only be sent to DPH.

DPH Contact Information

If you have any questions or concerns regarding any of the information or guidance within this letter then please contact Jean Shimer at (617) 624-5526 or jean.shimer@state.ma.us. If you have any questions regarding insurance issues for autism specialty services please contact Steve McCourt (617) 624-5954.

Appendix VII

Autism Specialty Services
Autism Insurance Guidance for ABA Services

Fiscal Year 2014 & 2015

Early Intervention
Autism Insurance Guidance for ABA Services

General Process Guidelines

- When contacting insurers it is important to identify at the start that services being provided are ABA services for a child under three with an Autism diagnosis. This applies to eligibility and benefits verification, claims inquiries and prior authorization.

- To initiate the process check a member's benefits and eligibility to determine if the member has coverage for ABA based on an Autism diagnosis. Call numbers listed on the member's card or use other resources specifically identified by the insurer (i.e. insurer websites, portals, etc.). Autism eligibility and benefits verification should be handled separately from EI.

- Benefits differ depending upon the insurance plan and the employer group.
    - Some employer accounts do not offer ABA services as a covered benefit.
    - Another entity may administer behavioral health services which include ABA/Autism services *(this will be based on the employer's plan design as determined by the insurer).*

- Once verification of benefits is received providers should follow the authorization process designated for treatment.

- Guidance information has been provided by the major Massachusetts insurers. For insurers that do not have specific guidance for claims submission, clinical reporting requirements or the prior authorization process, contact the insurer's Provider Relations office.

- Most insurers recognize the use of CPT Code H2019 or H2019 with the SE modifier for all ABA/Autism Services. For children under three with an Autism diagnosis payment for ABA services is based upon a blended rate. BC/BS also allows for the use of H0031 (Assessment) and H2012 (Care Coordination*). Refer to 6/12 BC/BS FYI*

- Insurers using United Behavioral Health/Optum to administer ABA services for children under three (3) include: Harvard Pilgrim Health Care, United Healthcare, selected GIC plans, Connecticare, and Oxford. Initial eligibility and benefit verification should start with contact information and phone numbers on the member's card (unless otherwise specified) specifically stating that the service is for "enhanced Autism benefits".

- Key information by insurer is summarized below. EI providers who have contracted with insurers will have received some of this information directly.

Massachusetts Insurer Guidelines

AETNA

ABA /Autism services for children under three (3) will be handled as an extension of Early Intervention services using the CPT Code H2019. The SE modifier is not required.

Prior authorizations for EI/ABA services are not required if the services provided are medically necessary services included under the ABA program for Early Intervention.

If there are issues or concerns contact the Aetna Provider Service Center and specifically indentify the service as EI/ABA-Autism services for a child under age 3.

Providers should note the Reference Number (REF) for any phone calls when verifying benefits. Providers should make note of the date the call was placed to confirm benefits and ask the customer service representative for the REF number for the phone call transaction. This will also assist if there are problems with the verification process.

For questions refer to the member's ID card for the toll-free Member Services or the Aetna Behavioral Health phone number.

BLUE CROSS/ BLUE SHIELD OF MASSACHUSETTS

To initiate the process, contact Provider Services at 1-(800) 451- 8123 to verify ABA/Autism benefits and eligibility. Once verified, contact the Prior Authorization Clinical Coordination area at 1- (800) 444-2426 for the Assessment (H0031). Prior authorization of services is required.

The BCBA evaluating the member must meet criteria specified by BC/BS of MA. Supervision is limited to one hour increments.

For out of state plans contact Blue Card at 1-(800) 676-2583 for benefits and eligibility information, as well as authorizations for out of state members.

To facilitate claims processing it is important that EI providers bill ABA/Autism Services on a separate claims form from EI Services or transmit claims separately as specified by the insurer. There could be a co-pay depending upon the account to which the member subscribes.
At this time it is not required that a family member be present but the ABA has to occur in the home or an office or agency (not in childcare).

For questions regarding Network Management Services call 1-(800) 316-BLUE (2583). Additional resources are available through the BlueLinks for Providers website at www.bluecross.com/provider

Massachusetts Insurer Guidelines (Continued)

BEACON HEALTH STRATEGIES
www.beaconhealthstrategies.com

BMC HEALTH NET/ COMMERCIAL (NOT MASSHEALTH MCO)

BMC has a very limited commercial product that does not fall under their MCO. Integrated EI/ABA services are administered through Beacon Health Strategies.

Provider line: 1-(800) 900-1451

www.BMCHP.org

CIGNA HEALTH CARE AND GREAT WEST

EI/ABA-Autism Services will be reimbursed as an extension of EI Services using the CPT Code H2019. Providers are encouraged to use the SE modifier (although it is not required) to aid in indentifying that the services are for EI/ABA-Autism.

A prior authorization of services is not required.

Matthew Bancroft at 1 (888) 244-6264 #1 76461 or Matthew_Bancroft@cigna.com should be the contact if there are issues or problems.

FALLON COMMUNITY HEALTH PLAN- COMMERCIAL (NOT MASSHEALTH MCO)

FCHP will begin covering integrated EI-ABA/Autism Services for contracted providers as of 12/15/12. Coverage for non-contracted providers will be effective 10/1/12 and providers will be reimbursed at a “usual & customary” rate determined by FCHP.

A prior authorization is required.

In billing for ABA Services use CPT Code H2019 with the SE modifier. Contracted providers will be reimbursed at the rate of $ 61.52.

Both claims submissions and prior authorizations will be handled through FCHP. FCHP, not Beacon Health Strategies, will maintain management of the ABA service request by the EI providers.
www.fchp.org/providers

Massachusetts Insurer Guidelines (Continued)

HARVARD PILGRIM HEALTH CARE

United Behavioral Health/Optum administers this service for HPHC.

EI/ABA services through Health Plans Inc. (under the HPHC umbrella) will be administered by Health Plans Inc.

Health Plans Inc.

Providers should call the Customer Service number at Health Plans Inc. to confirm coverage for EI and autism spectrum disorders. The general number is 1-800-532-7575. If the group has a dedicated Customer Service line, the provider will be transferred to the proper place. The Customer Service number is also on the Health Plans Inc. member ID card.

Customer Service personnel will verify the appropriate plan document to determine whether ABA coverage is available. Health Plans Inc. plan documents do not specifically address the terms “applied behavioral analysis” or “autism spectrum disorders”. However, these services are generally covered or excluded under the same terms as “developmental delays, behavioral disorders, and/or learning disabilities”, so providers should use these terms when making inquiries.

HNE- HEALTH NEW ENGLAND - COMMERCIAL (NOT MASSHEALTH MCO)

Integrated EI-ABA/Autism services require prior authorization by Health New England. For questions regarding the prior authorization process call HNE’s Health Services Department at 1- (800) 842-4464 ext 5028.

Claims for services must be billed using the CPT Code H2019 with the SE modifier or they will be denied.

HNE will not require that parents be present at every ABA visit in the daycare setting for members receiving services.

Information regarding EI/ABA services is available through the HNE Provider Portal on their website. www.hne.com.

Massachusetts Insurer Guidelines (Continued)

NEIGHBORHOOD HEALTH PLAN (NHP) - COMMERCIAL (NOT MASSHEALTH MCO)

NHP has finalized provider Payment Guidelines for EI/ABA Services effective 12/1/12.

EI/ABA-Autism Services will be reimbursed as an extension of EI Services using the CPT Code H2019 through NHP.

NHP will be the single point of entry for the authorization and payment for all EI/ABA services for children under three. NHP's clinical team will process all authorizations, and providers will be paid for authorized ABA services upon submission of a claim to NHP.

Prior authorizations for services are required

Questions can be directed to Provider Network Management at prweb@nhp.org
Customer Care Center (800) 462-5449

www.nhp.org/pages/providers_adminresources.aspx

TRICARE
www.tricare.mil

TUFTS HEALTH PLAN *(effective 10/25/14)*

For coverage determination questions contact the Service Coordinator in the Mental Health Department at 1- (800) 208-9565.

A prior authorization must be obtained. If services are authorized they will be valid for 12 months or until the member's third birthday.

Tufts has changed its reporting requirements, for children under 3 receiving autism services, to the following:

a) Parent(s) and/or Guardian(s) involvement in the training of behavioral techniques must be documented in the Member's medical record and is critical to the generalization of treatment goals to the Member's environment.

Tufts has also indicated that their Provider Services area at (888) 884-2404 should be the first line for providers with questions.
Send all requests and supporting documentation to:

Mental Health Dept.
Tufts Health Plan
705 Mount Auburn St.
Watertown, Ma. 02472

OR fax to (617) 673-0314.

Massachusetts Insurer Guidelines (Continued)

UNICARE STATE INDEMNITY PLAN

Beacon Health Strategies administers this service.

UNITED BEHAVIORAL HEALTH/OPTUM

United Behavioral Health will engage EI providers using a Letter of Agreement (LOA.) Codes and reimbursement rates will be added to the EI Provider file on their systems. Coverage will be based upon the period forward of the letter of agreement. United Behavioral Health will use the following coding and reimbursement rate.

CMS Service Code: H2019
Modifier: SE
Rate: $15.38 per 15 minutes or $61.52 per hour.
Prior authorizations are required

Instructions for EI Providers for all United Behavioral Health/Optum children with an autism diagnosis:

1. Call the number on the back of the member's card to verify benefits and eligibility.
2. If an enhanced autism benefit is verified, then they need to ask for a transfer to the "enhanced autism dedicated clinical team."
3. The Autism Clinical Team will then coordinate the needed paperwork with the EI provider to authorize care at the in-network level directly to the EI Provider.
4. Once paperwork is completed and authorizations are provided, the EI Provider can submit claims to UBH/Optum through the process defined below.

The following language will be included in the Letters of Agreement that we secure with the EI Providers.

Provider agrees to submit complete clean claims (on CMS-1500 claim form) and all supporting information necessary to process such claims, by faxing to **1-855-835-6130** no later than ninety (90) days from the date of completion of the services or the authorized treatment episode, whichever occurs first. Provider agrees to complete the claim form as a Group and enter the Group name, address, and TIN information in sections 25, 31, 32, and 33.

If providers are still having difficulties contact Elizabeth (Betty) Rubin at (860) 582-0013 or email elizabeth.rubin@optum.com.

Behavioral Network online resources: www.ubhonline.com

Massachusetts Insurer Guidelines (Continued)

UNITED HEALTHCARE OF NEW ENGLAND

EI/ABA Autism services are administered through United Behavioral Health/Optum.