North Carolina
Infant-Toddler Program
Guide to Reimbursement Procedures

For Children's Developmental Services Agency (CDSA) Use Only

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Early Intervention Section
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North Carolina
Infant-Toddler Program

Guide to Reimbursement Procedures

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General Guidance for CDSA Codes and Definitions

Overview

The purpose of this section is to serve as a guide to Children's Developmental Services Agencies (CDSA) staff for reporting and billing for services. All policies of the *North Carolina Infant-Toddler Program Policy Manual* must be followed. NC Division of Health Benefits (DHB) provides the CDSAs guidance through Clinical Coverage Policy # 8J. CDSA staff should consult DHB's web site at https://medicaid.ncdhhs.gov/. Codes found in this document have been approved for CDSA staff. Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) are included. Each CDSA staff provider must determine whether the service he or she has provided meets the definition of an approved procedure.

Unless defined otherwise, an encounter is a face-to-face interaction with a child, family member, or other professional to provide a clinical service. Any encounter reported using these codes must be substantiated in the record through an assessment report or comprehensive treatment, consultation, or progress note. The amount of time spent, and the units of time, as defined by the procedure, must be documented in the record.

All CDSA services are provided under the direction of an attending medical professional. Signed service orders are required prior to initiation of clinical services. Targeted Case Management (TCM) and evaluation services are provided under standing orders from the CDSA medical professional. The Standing Order document should be maintained in each CDSA's Operational Manual. Orders for clinical services must be child-specific and correspond to a service listed on the Individualized Family Service Plan (IFSP). Child-specific orders are maintained in each child's record. Orders for all treatment services must be signed and dated by a physician, physician assistant or nurse practitioner prior to initiating treatment. A licensed psychologist may sign orders for special instruction.

If required, prior approval must be obtained before the service start date. Prior approval for evaluations completed by CDSA staff is not required by Medicaid because CDSAs are exempt from Carolina Access regulations related to evaluations. Treatment must follow prior approval requirements. Some private insurance companies may require prior approval for evaluations. Reimbursement for some services is subject to Medicaid procedures for prior approval after a limited amount of treatment has been provided. The CDSA clinician providing a service is responsible for obtaining prior approval when required.

Some procedure codes are time-dependent, and others are event-based. Attention must be paid to rules that apply to each procedure code to ensure that documentation requirements are met. Clinical documentation and billing records must reflect actual service provision dates. Only services provided by the same provider to the same child on the same day using the same code may be added together.

For evaluations or treatments provided by multiple CDSA clinicians using time-based codes, the total time for units of all CDSA staff involved may not exceed total face-to-face time with the child. Only one discrete service at a time is reimbursable. For joint evaluation, total time for time-based evaluation codes cannot exceed total time with the child. Timed services are usually documented in 15-minute units. Except for TCM, Medicaid will reimburse for face-to-face time only. Please refer to coding manuals for details for billing specific codes. Integrated assessment reports must be supported by clear documentation for each code reported. Multiple encounters to complete a service may be documented in an integrated report. The purpose, date, and time spent for each CDSA staff member's encounter must be clearly indicated.

Services may only be provided and coded by a CDSA staff member who is qualified to provide that service. Service documentation must include a diagnostic (ICD-CM) code.

Families are never charged for evaluations/assessments or TCM. Treatment services are provided on a sliding fee scale. An original legal signature with date of signature is required with appropriate clinical credentials for all services documented in the record. Licensure or certification credentials must be included. Although credentials may be entered electronically, original, legal signatures are required. Each CDSA is required to maintain a list of original signatures. Document all services in the record, regardless of billing status. If more than one CDSA clinician is involved in an evaluation, each clinician involved must sign documentation of his or her evaluation or the integrated report. If a summary is also completed, only the service/evaluation coordinator may sign the report. If more than one CDSA clinician is involved in providing a service in a single encounter, the primary clinician is responsible for writing and signing the progress note, listing all other clinicians involved. If two or more services are provided by multiple CDSA staff during a single encounter, each service requires a separate clinician's note with dated signature.

Audiology Diagnosis and Assessment (AUDA)

The following services are provided by a North Carolina licensed CDSA Audiologist, in accordance with the NC Licensure Act for Speech and Language Pathologists and Audiologists:

92551 – Pure tone screening, air only

92552 – Pure tone audiometry (threshold); air only

92553 – Pure tone audiometry (threshold); air and bone

92555 – Speech audiometry threshold;

92556 – Speech audiometry threshold; with speech recognition

92557 – Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)

92567 – Tympanometry (impedance testing)

92568 – Acoustic reflex testing; threshold

92569 – Acoustic reflex decay test

92579 – Visual reinforcement audiometry (VRA)

92582 – Conditioning play audiometry

92583 – Select picture audiometry

92585 – Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive

92588 – Evoked otoacoustic emissions; comprehensive or diagnostic evaluation

92590 – Hearing aid examination and selection; monaural

92591 – Hearing aid examination and selection; binaural

92592 – Hearing aid check; monaural

92593 – Hearing aid check; binaural

92594 – Electroacoustic evaluation for hearing aid; monaural

92595 – Electroacoustic evaluation for hearing aid; binaural

92626 – Evaluation of auditory rehabilitation status; first hour

92627 – Evaluation of auditory rehabilitation status; each additional 15 minutes

92630 – Auditory rehabilitation; pre-lingual hearing loss

92633 – Auditory rehabilitation; post-lingual hearing loss

Audiology Treatment (AUDT)

The following services are provided by a North Carolina licensed CDSA Audiologist, in accordance with the NC Licensure Act for Speech and Language Pathologists and Audiologists. (Refer to *NC Medicaid Clinical Coverage Policy #10A, Outpatient Specialized Therapies* at https://files.nc.gov/ncdma/documents/files/10A_9.pdf.) Audiology treatment services are subject to DMA prior approval policy. A new order is required at least every six months and upon expiration of the previous order in less than six months.

92507 – Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual

92508 – Treatment: group, two or more individuals

Educational /Developmental Diagnosis and Assessment (EDUA)

The following services are provided by a qualified and/or licensed CDSA early intervention professional (refer to https://files.nc.gov/ncdma/documents/files/8-J.pdf. They include evaluation of the child's functional learning abilities through assessment of the child's developmental level(s), learning strengths and needs, learning style and approach to pre-academic and academic tasks, readiness for a structured learning environment and ability to use assistive technology.

96110 – Developmental screening (e.g., developmental milestones survey, speech and language delay screen), with scoring and documentation, per standardized instrument

96112 – Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory, and/ or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour

+96113 – Each additional 30 minutes (list separately in addition to code for primary procedure). *(*Date of billing note in HIS must be *date of the evaluation.)*

T1023 – Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter.

Codes 96110, 96112, and 96130 may not be used on the same day for the same child. Total encounter time must be assigned to one code even if two CDSA staff members were involved in the delivery of the service. In such cases, one clinician should report the code as billable with total time for both clinicians. The other clinician may report his or her activity only, using the units of time for his or her portion of the assessment only (NTC: note to chart).

Evaluation and Management (E/M) Codes

E/M coding must follow the rules found in the CPT manual. Clear and specific documentation is required. E/M codes are mutually exclusive. E/M is provided by a physician, physician assistant, or nurse practitioner within the scope of practice. Service must conform to current professional expectations for the use of these codes. Time cannot be used to determine the level of E/M service except as described below. When counseling and/or coordination of care dominates more than 50% of the face-to-face encounter, time is considered the key or controlling factor to qualify for a level of E/M services.

Evaluation and Management: Office or Other Outpatient Assessment Services – New Patient (MEDAN)

For evaluation and management of a new patient, three key components are required: problem-focused history, problem- focused examination, and straightforward medical decision-making. A new patient is one who has not been seen by the CDSA for an E/M service within the past three years.

99201 – Requires all three of the following components (typically 10 minutes of face-to-face time with patient and/or family): Problem-focused history; Problem-focused examination; Straightforward medical decision-making

99202 – Requires all three of the following components (typically 20 minutes of face-to-face time with patient and/or family): Expanded problem-focused history; Expanded problem-focused examination; Straightforward medical decision-making

99203 – Requires all three of the following components (typically 30 minutes of face-to-face time with patient and/or family): Detailed history; Detailed examination; Medical decision-making of low complexity

99204 – Requires all three of the following components (typically 45 minutes of face-to-face time with patient and/or family): Comprehensive history; Comprehensive examination; Medical decision-making of moderate complexity

99205 – Requires all three of the following components (typically 60 minutes of face-to-face time with patient and/or family): Comprehensive history; Comprehensive examination; Medical decision-making of high complexity

Evaluation and Management: Office or Other Outpatient Assessment Services – Established Patient (MEDAE)

An established patient is one who has been seen by the CDSA for an E/M service within the past three years. This pertains to a self-referred client (by parent or other family member) or to a client referred by a CDSA provider.

99211 – (Typically five minutes spent performing or supervising these services): May not require the presence of a physician

99212 – (Typically 10 minutes of face-to-face time with patient and/or family): Requires two of these key components: Problem-focused history; Problem-focused examination; Straightforward medical decision-making

99213 – (Typically 15 minutes of face-to-face time with patient and/or family): Requires two of these key components: Expanded problem-focused history; Expanded problem-focused examination; Medical decision-making of low complexity

99214 – (Typically 25 minutes of face-to-face time with patient and/or family): Requires two of these key components: Detailed history; Detailed examination; Medical decision - making of moderate complexity

99215 – (Typically 40 minutes of face-to-face time with patient and/or family): Requires two of these key components: Comprehensive history; Comprehensive examination; Decision-making of high complexity

Evaluation and Management: Office or Other Outpatient Assessment Consultations – New (MEDAN) or Established Patient (MEDAE)

These codes may only be used for clients referred by a non-CDSA provider (physician or other professional source not the parent or other family member). The CDSA medical provider must document the request, the individual who made the request, the need for the consultation, opinion and services performed or ordered, and follow-up communication with the referral source. The referral source's name and agency must be documented. Follow-up visits in the consultant's office are reported using office visit codes for established patients (99211-99215).

99241 – (Typically 15 minutes of face-to-face time with patient and/or family) – Requires all three of these key components: Problem-focused history; Problem-focused examination; Straightforward medical decision- making

99242 – (Typically 30 minutes of face-to-face time with patient and/or family) – Requires all three of these key components: Expanded problem-focused history; Expanded problem-focused examination; Straightforward medical decision-making

99243 – (Typically 40 minutes of face-to-face time with patient and/or family) – Requires all three of these key components: Detailed history; Detailed examination; Medical decision-making of low complexity

99244 – (Typically 60 minutes of face-to-face time with patient and/or family) – Requires all three of these key components: Comprehensive history; Comprehensive exam; Medical decision-making of moderate complexity

99245 – (Typically 80 minutes of face-to-face time with patient and/or family) – Requires all three of these key components: Comprehensive history; Comprehensive examination; Medical decision-making of high complexity

The following codes may be used alone or in conjunction with any of the preceding E/M codes:

92551 – Pure tone hearing screening

92567 – Tympanometry

Evaluation and Management – Treatment – Established Client (MEDT)

E/M is provided by a physician or physician assistant within the appropriate scope of practice.

99211 – (Typically five minutes spent performing or supervising these services): May not require the presence of a physician

99212 – (Typically 10 minutes of face-to-face time with patient and/or family): Requires two of these key components: Problem-focused history; Problem-focused examination; Straightforward medical decision-making

99213 – (Typically 15 minutes of face-to-face time with patient and/or family): Requires two of these key components: Expanded problem-focused history; Expanded problem-focused examination; Medical decision-making of low complexity

99214 – (Typically 25 minutes of face-to-face time with patient and/or family): Requires two of three of these key components: Detailed history; Detailed examination; Medical decision-making of moderate complexity

99215 – (Typically 40 minutes of face-to-face time with patient and/or family): Requires two of these key components: Comprehensive history; Comprehensive examination; Decision-making of high complexity

Nursing Assessment (NURA)

The following services are provided by a CDSA Registered Nurse (RN) who has completed expanded role training ("Guilford" training) within the scope of the North Carolina Nurse Practice Act.

NURA may include:

99211 – Office or other Outpatient visit (E/M), typically five minutes – established patient only: This can only be used when a physician does not see the child on the same visit.

The following codes may be used alone or in conjunction with any nursing or physical diagnosis and assessment codes:

92551 – Pure tone hearing screening, air only

92567 – Tympanometry (impedance testing)

96110 – Developmental testing: limited, with interpretation and report

Nursing Treatment and Consultation (NURT)

The following services are provided by a CDSA Registered Nurse (RN) within the scope of the North Carolina Nurse Practice Act:

99211 – Office or other Outpatient visit - established patient, five minutes

92551 – Pure tone hearing screening, air only

Nutrition Diagnosis and Assessment (NUTRA)

Services are provided by a CDSA Nutritionist/Dietitian registered with the American Dietetic Association's Commission on Dietetic Registration or licensed by the NC Board of Dietetics/Nutrition. (Refer to *NC Medicaid Clinical Coverage Policy #1I, Dietary Evaluation and Clinical Counseling* at https://files.nc.gov/ncdma/documents/files/1-I_1.pdf for billing limitations.) Bill all units even if over the limit and let Medicaid deny. (Refer to *EPSDT Policy Instructions* at https://files.nc.gov/ncdma/documents/files/epsdtpolicyinstructions.pdf) Rebill under non-covered services.

97802 – Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes

If Medicaid is billed, children must be referred to the Women, Infants, and Children Program (WIC) if not currently participating.

Nutrition Treatment and Consultation (NUTRT)

Services are provided by a CDSA Nutritionist/Dietitian registered with the American Dietetic Association's Commission on Dietetic Registration or licensed by the NC Board of Dietetics/Nutrition. (Refer to *NC Medicaid Clinical Coverage Policy #1I, Dietary Evaluation and Clinical Counseling* at https://files.nc.gov/ncdma/documents/files/1-I_1.pdf for billing limitations.) Bill all units even if over the limit and let Medicaid deny. (Refer to *EPSDT Policy Instructions* at https://files.nc.gov/ncdma/documents/files/epsdtpolicyinstructions.pdf) Rebill under non-covered services.

97803 – Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes

If Medicaid is billed, children must be referred to the Women, Infants, and Children Program (WIC) if not currently participating.

Occupational Therapy Diagnosis and Assessment (OTA)

The following services are provided by a CDSA Occupational Therapist (OT) working within the scope of the NC Occupational Therapy Practice Act.

97165 – Evaluation of occupational therapy; 30 min

97166 – Evaluation of occupational therapy; 45 min

97167 – Evaluation of occupational therapy; 60 min

97168 – Re-evaluation of occupational therapy; 30 min

97762 – Checkout for orthotic/prosthetic use, established patient, each 15 minutes

97750 – Physical performance test or measurement; e.g. musculoskeletal, functional capacity with written report, each 15 minutes

92610 – Evaluation of oral and pharyngeal swallowing function

Occupational Therapy Treatment and Consultation (OTT)

The following services are provided by a CDSA Occupational Therapist working within the scope of the NC Occupational Therapy Practice Act. If physical therapy (PT) and occupational therapy (OT) treatment are delivered to the child on the same day, discrete codes for each must be recorded, and limits for service combinations must be considered. As with any service, assure that any prior approval requirements are met.

97010 – Application of a modality to one or more areas; hot or cold packs; does not require direct (one-on-one) contact by the provider

97032 – Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes; requires direct (one-on-one) contact by the provider

97110 – Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility; requires direct (one-on-one) contact by the provider

97112 – Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception for sitting and/or standing activities, each 15 minutes; requires direct (one-on-one) contact by the provider

97113 – Aquatic therapy with therapeutic exercises, each 15 minutes; requires direct (one-on-one) contact by the provider

97124 – Massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion), each 15 minutes; requires direct (one-on-one) contact by the provider

97140 – Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes; requires direct (one-on-one) contact by the provider

92526 – Treatment of swallowing dysfunction and/or oral function for feeding

97530 – Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

97533 – Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by provider, each 15 minutes

97535 – Self-care/home management training (e. g, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct (one-to-one) contact by provider, each 15 minutes

97542 – Wheelchair management/propulsion training, each 15 minutes

97761– Prosthetic training, upper and/or lower extremities, each 15 minutes; requires direct (one-on-one) contact by the provider

97762 – Checkout for orthotic/prosthetic use, established patient, each 15 minutes

Physical Therapy Diagnosis and Assessment (PTA)

The following services are provided by a CDSA Physical Therapist licensed by the NC Board of Physical Therapy Examiners:

97161 – Evaluation of physical therapy; 20 min

97162 – Evaluation of physical therapy; 30 min

97163 - Evaluation of physical therapy; 45 min

97164 – Re-evaluation of physical therapy; 20 min

97762 – Checkout for orthotic/prosthetic use, established patient, each 15 minutes

97750 – Physical performance test or measurement e.g. musculoskeletal, functional capacity with written report, each 15 minutes

Physical Therapy Treatment (PTT)

The following services are provided by a CDSA Physical Therapist licensed by the NC Board of Physical Therapy Examiners. If Physical Therapy (PT) and another specialized therapy treatment are delivered to the child on the same day, discrete codes for each must be recorded. (Refer to *NC Medicaid Clinical Coverage Policy #10A, Outpatient Specialized Therapies* at https://files.nc.gov/ncdma/documents/files/10A_9.pdf.) As with any service, assure that prior approval requirements have been met.

97010 – Application of a modality to one or more areas; hot or cold packs; does not require direct (one-on-one) contact by the provider

97032 – Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes; requires direct (one-on-one) contact by the provider

97110 – Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility; requires direct (one-on-one) contact by the provider

97112 – Neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception, for sitting and/or standing activities each 15 minutes; requires direct (one-on-one) contact by the provider

97113 – Aquatic therapy with therapeutic exercises, each 15 minutes; requires direct (one-on-one) contact by the provider

97116 – Gait training (includes stair climbing), each 15 minutes; requires direct (one-on-one) contact by the provider

97124 – Massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion), each 15 minutes; requires direct (one-on-one) contact by the provider

97140 – Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes; requires direct (one-on-one) contact by the provider

97530 – Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

97533 – Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by provider, each 15 minutes

97535 – Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes

97542 – Wheelchair management/propulsion training, each 15 minutes; requires direct (one-on-one) contact by the provider

97761 – Prosthetic training, upper and/or lower extremities, each 15 minutes; requires direct

(one-on-one) contact by the provider

Psychological Diagnosis and Assessment (PSYA)

The following services are provided by a CDSA Psychologist licensed by the NC Psychology Board in accordance with the NC Psychology Practice Act. When billing insurance, data analysis and report-writing can be included in the billable time if completed on the same day as the evaluation. **Only face-to-face time is billable to Medicaid.**

Services must include formal assessment, in accordance with the American Psychological Association Standards for Educational and Psychological Testing (1985), Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (1990), and Ethical Principles of Psychologists and Codes of Conduct (2002):

96110 – Developmental screening (e.g., developmental milestones survey, speech and language delay screen), with scoring and documentation, per standardized instrument

96112 – Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory, and/ or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour

+96113 – Each additional 30 minutes (list separately in addition to code for primary procedure)

96116 – Neurobehavioral status exam (clinical assessment of thinking, reasoning, and judgment, e.g., acquired knowledge, attention, language, memory, planning, and problem solving, and visual spatial abilities), per hour including face-to-face time, time interpreting the test results and time preparing the report - for use by certified neuropsychologists only

+96121 – Each additional hour (list separately in addition to code for primary procedure)

96130 – Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour

+96131 – Each additional hour (list separately in addition to code for primary procedure)

96132 – Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(*s) when performed; first hour.

+96133 – Each additional hour (list separately in addition to code for primary procedure)

96136 – Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, **two or more tests**, any method, first 30 minutes

+96137 – Each 30 additional minutes (list separately in addition to code for primary procedure)

H0031– Mental Health Assessment by Non-Physician, each 15 minutes, direct, face-to-face time *(See Social Work section)*

T1023 –Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter

Codes 96110, 96112, and 96130 may not be used on the same day for the same child. Total encounter time must be assigned to one code even if two staff members were involved in the delivery of the service. In such cases, one clinician should report the code as billable with total time for both clinicians. The other clinician may report their activity only, using the units of time for their portion of the assessment only.

Psychological Treatment (PSYT)

The following services are provided by a CSDA Psychologist licensed by the NC Psychology Board in accordance with the NC Psychology Practice Act. Twenty-six unmanaged visits per calendar year are allowed without prior approval. Prior approval is required for these services beyond the 26-visit limit.

90832 – Psychotherapy, 30 (16-37) minutes

90834 – Psychotherapy, 45 (38-52) minutes

90837 – Psychotherapy, 60 (53+) minutes

90846 – Family psychotherapy without child (patient) present

90847 – Family psychotherapy with child (patient) present

+90785 – interactive complexity (add-on code)

Social Work Assessment and Diagnosis (SWA)

The following services are provided by a CDSA Licensed Clinical Social Worker (LCSW). LCSWs provide services in accordance with the Ethical Guidelines of the Social Worker Certification Act (General Statutes of North Carolina, Chapter 90B) and the NASW Code of Ethics.

H0031 – Mental Health Assessment by Non-Physician – each 15 minutes, direct, face-to-face time

Services may include testing, interviewing and observations to assess the following:

- Family social history, which may include identifying information, family composition, home environment, child-care arrangements, daily routine, transportation, financial or legal issues and involvement in community support programs
- Social/emotional development and/or adaptive behavior which may include the child’s emotional development within the family, ability to interact with peers and in community settings, ability to respond to verbal and non-verbal cues, and self- help skills and behavior.
- Child and family functioning which may include parents’ understanding of previous testing (diagnosis), parents’ perspective of child’s strengths and needs, parents’ expectations for the CDSA evaluation, parenting skills and need for supportive services, family dynamics including parent-child relationship and/or family’s response to and ability to use assistive technology (AT).

96110 – Developmental testing; limited (e.g. Developmental Screening Test II, Early Language Milestone Screen) with interpretation and report

96112 – Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory, and/ or executive functions by standardized

developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour

+96113 – Each additional 30 minutes (list separately in addition to code for primary procedure)

T1023 – Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter

Codes 96110 and 96111 may not be used on the same day for the same child. Total encounter time must be assigned to one code even if two CDSA staff members were involved in the delivery of the service. In such cases, one clinician should report the code as billable with total time for both clinicians. The other clinician may report his or her activity only, using the units of time for his or her portion of the assessment only (NTC: note to chart).

Social Work Treatment (SWT)

The following services are provided by a CDSA Licensed Clinical Social Worker (LCSW). LCSWs provide services in accordance with the Ethical Guidelines of the Social Worker Certification Act (General Statutes of North Carolina, Chapter 90B) and the NASW Code of Ethics.

Services may include individual or family therapies to ameliorate identified emotional and/or behavioral dysfunction, promote healthy child and family relationships and functioning, and/or assist the family in coping with and managing an identified disability. Within this therapeutic context, services may also include providing instruction to the child or family. The encounter must be face-to-face with the child and/or family and conform to the CPT or HCPCS code definition to be billable.

90846 – Family psychotherapy without child (patient) present

90847 – Family psychotherapy with child (patient) present

+90785 – interactive complexity (add-on code)

Special Instruction (Early Intervention Community-Based Rehabilitative Services (CBRS))

Service orders must be signed prior to service provisions by a physician, physician assistant, nurse practitioner, or licensed psychologist. CDSA Special Instruction (Community-Based Rehabilitative Services) staff must be a:

- Licensed psychologist, as defined in 10A NCAC 27G.0104(16);
- Licensed Clinical Social Worker (LCSW) as defined in 10A NCAC 27G.0104(10);
- Licensed Marriage and Family Therapist as defined in 10A NCAC 27G.0104(18);
- Certified Infant, Toddler and Family Specialist (ITFS)

Special instruction includes a range of coordinated services to correct, reduce, or prevent further deterioration of identified deficits in the child’s mental or physical health in areas of identified deficit. Deficits are identified through comprehensive screening, assessments, and evaluations. Special instruction services must be face-to-face encounters, medically necessary, within the CDSA staff member’s scope of practice and intended to maximize reduction of identified disability(ies) or deficit(s) and restoration of a recipient to his or her best possible functional level. Services include direct hands-on treatment with the child and collaboration with and instruction to parents and caregivers in assisting in

identifying, planning, and maintaining a regimen to improve functioning. Services may be provided in home, child care center, or other natural environments. In consultation with the IFSP team, the CDSA ITFS will work with caregivers on planning and developing individualized intervention strategies to extend opportunities to learn and practice skills in everyday activities in natural environments. The ITFS will demonstrate and teach intervention strategies to caregivers and collaborate with other professionals as needed. The ITFS also provides emotional support to caregivers.

Services involving family or caregivers must be directed to meeting the child's treatment needs. Services must be ordered by and under the direction of a physician or licensed practitioner of the healing arts. The order must specify which level of special instruction is to be provided (i.e., professional or paraprofessional) and must precede the service. A copy of the order must be filed in the child's central record at the CDSA.

Special instruction services include the following range of services, also referred to as early intervention (EI) services, to be provided to all eligible children for whom services are medically necessary:

- Cognitive: This refers to the acquisition, organization, and ability to process and use information. Example goals include: developing strategies for the child to understand cause and effect, object permanence, concepts of in and out, differentiating shapes and colors, associating movement with sound, and establishing awareness of self and control of the environment; developing strategies to improve the child's visual tracking, eye contact; responding to reprimands and tone of voice; following simple directions.
- Communication: This includes verbal and non-verbal expressive and receptive communication skills. Example goals include: increasing word comprehension; using suggested strategies to facilitate or enhance oral motor development for making sounds and words; implementing behavioral strategies to improve communication.
- Social/Emotional Skills refers to interpersonal relationship abilities. This includes interactions and relationships with parent(s) and caregivers, other family members, adults, and peers, as well as behavioral characteristics. Example goals include: helping caregivers understand and respond to the child's behaviors; development of strategies to set limits and manage the child's problems, developing strategies to help organize behaviors before they become uncontrollable while providing opportunities for normal active exploration.
- Adaptive Development: This refers to the ability to function independently within the environment and the child's competency with daily living activities. Example goals include: increasing acceptance of different food textures; accepting and handling utensils for self-feeding; developing or enhancing oral motor development for proper sucking or chewing; developing strategies to stimulate independent play; introducing concepts, developing strategies for self-care in play.
- Physical (gross and fine motor): This refers to abilities with tasks requiring large and small muscle coordination, strength, stamina, flexibility, and motor development. Example goals include: modifying or adapting sensorimotor experiences to learn new activities; facilitating or enhancing positioning for optimal functioning; handling techniques and postural control to enable successful movements and interactions.

H0036-HI-Professional EI: Individual, per 15 minutes

Speech/Language Diagnosis and Assessment (SPEA)

The following services are provided by a North Carolina licensed CDSA Speech and Language Pathologist in accordance with the NC Licensure Act for Speech and Language Pathologists and Audiologists. Services may include testing and/or clinical observation as appropriate.

92521 – Evaluation of speech fluency (e.g., stuttering, cluttering)

92522 – Evaluation of speech sound production (egg, articulation, phonological process, apraxia, dysarthria)

92523 – Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (egg, receptive and expressive language)

92523/52 – Evaluation of speech only

92524 – Behavioral and qualitative analysis of voice and resonance

92610 – Evaluation of oral and pharyngeal swallowing function

The following codes may be used alone or in conjunction with any of the preceding service codes:

92551 – Pure tone screening, air only **

92567 – Tympanometry, impedance testing

The licensure board has said: "Fixed-intensity, pure tone audiometric screening performed **within the content of an individual speech-language evaluation/assessment is within the scope of practice of licensed speech-language pathologists.”

Speech/Language Treatment (SPET)

The following services are provided by a North Carolina licensed CDSA Speech and Language Pathologist in accordance with the NC Licensure Act for Speech and Language Pathologists and Audiologists. As with any service, assure that prior approval requirements have been met. (Refer to *NC Medicaid’s Clinical Coverage Policy #10A, Outpatient Specialized Therapies* at https://files.nc.gov/ncdma/documents/files/10A_9.pdf.)

92507 – Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual

92508 – Treatment: group, two or more individuals

92526 – Treatment of swallowing dysfunction and/or oral function for feeding

97530 – Therapeutic Activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance) – each 15 minutes

Targeted Case Management (TCM)

Background

The Center for Medicare and Medicaid Services (CMS) is the federal agency that regulates and oversees all state medical assistance programs (Medicaid), including North Carolina's Division of Health Benefits (DHB). Targeted Case Management (TCM) is a Medicaid-defined service that is provided to defined target groups in the state plan. TCM is defined generally as services that assist individuals eligible under the state plan in gaining access to needed medical, social, educational, and other services. The intent of case management is to assist the individual in gaining access to needed services, consistent with the requirements of the law and regulations administered by the states.

TCM is provided by a qualified CDSA early intervention professional who meets requirements listed in DHB's clinical coverage policy for CDSAs. (Refer to https://files.nc.gov/ncdma/documents/files/8-J.pdf.)

TCM Definition (from *NC Medicaid's CDSA Clinical Coverage Policy #8J*): Case Management services include: assessment and periodic reassessment to determine types and amounts of services needed; development and the implementation of an individualized case management service plan with the client; consistent with SSA 1902 (a)(23), coordination and assignment of responsibilities among staff and service agencies; and monitoring and follow-up to ensure that services are received and are adequate for the client's needs.

An order must be signed and dated by the physician, physician assistant, nurse practitioner, or licensed psychologist initiating the service. Standing orders are allowed for TCM. (Refer to *Medicaid TCM Special Bulletin* at https://files.nc.gov/ncdma/documents/Providers/Bulletins/archives/2005/0705_SpecBull_DDTargetedCaseMgmt.pdf. Although all TCM activities must be documented in the record, the writing of the service notes is not considered a TCM activity. Targeted case management services may begin at the time of referral to the CDSA. Case management activities provided at different times during a day can be cumulated at the end of the day if each separate activity is documented in the service note. Case management services are to be billed in 15-minute units. Case management services must be provided throughout the assessment/evaluation/eligibility process. Service coordination activities (including those billed as TCM) must be provided to any child referred to the Infant-Toddler Program, from the time of referral throughout service delivery.

Considerations for Billing TCM

Targeted Case Management (TCM) coverage for children less than three years old begins at the time of referral to the Infant-Toddler Program. (Refer to *DMA's 2005 NC Medicaid Special Bulletin on TCM* at https://files.nc.gov/ncdma/documents/Providers/Bulletins/archives/2005/0705_SpecBull_DDTargetedCaseMgmt.pdf.)

After ITP eligibility is determined and enrollment is established, all services must be provided as outlined in the IFSP.

If there is a known payor for any services provided by a CDSA staff member, then that payor should be pursued.

Medicaid Coverage Requirements for TCM

DMA's 2005 Special Medicaid Bulletin on TCM states that Medicaid covers services defined as TCM when:

1. The service is medically necessary.
2. The service is individualized, specific, and consistent with symptoms of or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs.
3. The service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
4. The service may be provided to CAP MR/DD waiver recipients.

TCM Service Components

Assessment

This component includes activities that focus on needs identification. Activities include assessment of the recipient to determine the need for any medical, educational, social, and other services. Specific assessment activities include: taking recipient history, identifying the needs of the recipient, and completing related documentation.

It also includes gathering information from other sources such as family members, medical providers, and educators, if necessary, to form a complete assessment of the recipient.

Care Planning

This component builds on the information collected through the assessment phase and includes activities such as ensuring the active participation of the recipient or the recipient's representative and working with him/her and others to develop goals and identify and document a course of action to respond to the assessed needs of the recipient. The goals and actions in the IFSP should address medical, social, educational, and other services needed by the recipient.

Referral and Linkage

This component includes activities that help link recipients to the medical, social, educational providers, and /or other programs and services identified in the IFSP that will provide needed services. For example, making referrals to providers for needed services and scheduling appointments may be considered Targeted Case Management. Referral or arrangements for medical treatment, physical or psychological examinations or evaluations are billable case management activities. Coordination of care between Targeted Case Management providers for MR/DD and Mental Health/Substance Abuse professionals is critical when there is a co-occurring disorder present.

Monitoring/Follow-up

This component includes activities and contacts that are necessary to ensure the IFSP is effectively implemented and adequately addressing the needs of the recipient. The activities and contacts may be with the recipient, family members, providers, or other entities. These may be as frequent as necessary to help determine such things as (1) whether services are being furnished in accordance with the recipient's IFSP, (2) the adequacy of the services identified in the IFSP, and (3) changes in the needs or status of the recipient. This function, with the consent of the recipient and/or representative, includes making necessary adjustments in the IFSP and service arrangements with providers.

T1017HI - Targeted Case Management, per 15 minutes

General Guidance for the Authorization and Billing

Overview

The fee, billing, and reimbursement requirements and procedures apply to the Children's Developmental Services Agencies and enrolled Infant-Toddler Program service providers. Certain specific provisions were developed in accordance with Part C of the Individuals with Disabilities Education Act (IDEA) and include the following:

- fees for child find, screening, evaluation, assessment, service coordination, Individualized Family Service Plan (IFSP) development, and implementation of procedural safeguards and other administrative activities related to the Infant- Toddler Program may not be charged directly to parents, although Medicaid and private insurance will be billed if the child is covered, with written parental authorization.
- when fees are charged to parents for certain services, a sliding fee scale that takes into consideration the size of the family and income must be used, and
- the inability of the parents of an eligible child to pay for services, as determined by the sliding fee scale, will not result in the denial of services to the child or the child's family.

Fee Categories for Infant-Toddler Program Services

The Infant-Toddler Program has three distinct categories of services in regard to fees. These services are either:

- required and provided at no direct charge to the parent;
- required but fees may be charged to the parent, or
- recommended services which are not required and for which fees may be charged to the parent.

Services Required and Provided at No Direct Charge to the Family

Early Identification

Screening Evaluations

Assessments Service Coordination

Although the following are not listed as services under the Infant-Toddler Program, the family cannot be charged for activities related to:

- administrative and coordinative activities related to the development, review, and evaluation of the Individualized Family Service Plan, or
- implementation of procedural safeguards, and other administrative activities related to the Infant-Toddler Program.

Fees for services required and provided at no direct charge to the parent may not be charged directly to the parent, although Medicaid and private insurance will be billed if the child is covered, with written parental authorization.

Services Required but May Be Charged to the Family

Assistive Technology Services and Devices
Audiology Services
Community Based Rehabilitative Services
Family Counseling and Therapy
Health Services Medical Services
Nursing Services
Nutrition Services
Occupational Therapy
Physical Therapy
Psychological Services
Respite*
Social Work Services
Speech-Language Therapy
Transportation*
Vision Services

Parents may be billed for all the above services; however, the North Carolina Infant-Toddler Program Sliding Fee Schedule must be applied when determining the amount for which the parent is responsible. The Children's Developmental Services Agencies and enrolled Infant-Toddler Program service providers are required to use the Infant-Toddler Program Sliding Fee Scale. If the only provider available for a service is a provider who is not an enrolled Infant-Toddler Program service provider, the Children's Developmental Services Agency may:

- enroll the service provider as an Infant-Toddler Program service provider;
- provide the service itself, or
- negotiate with the service provider to apply the family's assigned percentage on the Infant- Toddler Program Sliding Fee Scale to the Infant-Toddler Program Reimbursement Rate, less any insurance payment, to determine the family fee, and bill the Infant-Toddler Program for the difference, up to the Infant-Toddler Program Reimbursement Rate.

If an enrolled Infant-Toddler Program service provider is available, but the parent chooses to have someone else provide the service, the Children's Developmental Services Agency is under no obligation to make the service available on a sliding fee scale and payment for the entire fee is the responsibility of the parent.

Recommended Services Which are Not Required and for Which Fees May Be Charged to the Family

Refer to the NC ITP Parent Handbook, page 5, at http://beearly.nc.gov/data/files/pdf/PHBK%20FINAL.pdf for recommended services.

TCM and Evaluation Documentation Requirements

DMA's July 2005 Special Medicaid Bulletin on TCM states that a service order for TCM for individuals with developmental disabilities must be completed by a physician, licensed psychologist, physician assistant, or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided. *DMA's September 2016 Special Medicaid Bulletin on Attending, Rendering, Ordering, Prescribing or Referring Providers and National Provider Identifier* requires the appropriate National Provider Identifier (NPI) of any ordering or referring physician or other professional to be specified on any claim for payment. This includes all services outlined in an IFSP, including evaluations. NC ITP has declared that CDSA physicians will serve as the ordering physician for evaluations performed by CDSA staff. For evaluations to be performed by ITP contract providers, the providers are responsible for obtaining a Service Order from the recipient's primary care physician (or acceptable interim provider). Standing orders for TCM and evaluations have been issued by CDSA physicians and are currently found in the operations manual at each local CDSA. These standing orders are valid from the date of signature. They need to be updated when there is a change in supervising physician at the CDSA.

Additionally, the case management provider must maintain case records for a *minimum of five years,* and the records must describe all contacts with and on behalf of the recipient. NC ITP case records are a combination of paper form, Health Information System electronic form, and scanned PDF form stored electronically by the local CDSA.

The case record, *at a minimum,* must also contain documentation of the following: [Note that these are typically in the child's record, and no additional record needs to be maintained or developed.]

1. The recipient's full name and birth date on each page of the record.
2. The name of the provider agency and the credentials and name of the person providing direct services to the recipient.
3. The place of service delivery.
4. The date of service.
5. The nature, extent, and duration/length of the case management services in minutes ***or*** units.
6. The records of referrals to providers and programs.
7. A copy of the completed prior approval (PA) form with PA number, when appropriate.
8. A copy of the physician's order for treatment services.

   Note: The signed order date must precede the treatment dates.
9. A copy of each test performed or summary listing of all test results and written evaluation report.
10. A copy of the IFSP with clearly defined goals and measurable baselines.
11. Progress notes signed by the case manager (including professional credentials) that describes:
    a. achievements or measurable progress towards goals identified in the IFSP,
    b. description of services performed, and
    c. service monitoring evaluations.
12. Claims for reimbursement.

Confirming and Documenting Acceptance as Medicaid Client

The North Carolina Administrative Code (NCAC) (10A NCAC 22J .0106) states that a patient or patient's representative may request acceptance as a Medicaid patient by any of the following methods:

1. Presenting the patient's Medicaid card or presenting a Medicaid number either orally or in writing;
2. Stating either orally or in writing that the patient has Medicaid coverage; or
3. Requesting acceptance of Medicaid upon approval of a pending application or a review of continuing eligibility.

Any of the methods listed in NCAC may be documented in a chart note. In the initial contact with the family, explanation of the ITP program should include identification of services to be provided and the request for the Recipient ID. Documentation to confirm patient acceptance as a Medicaid client should include one of the methods outlined in NCAC. Although confirmation may involve verification of the Recipient ID by other means or at a later date, document verbal notification of coverage or request for acceptance on approval of pending application.

Medicaid Billing Timelines

DHB's *NCMMIS Provider Claims and Billing Assistance Guide* states that all Medicaid claims except inpatient claims and nursing facility claims must be received by Electronic Data Systems (EDS) within 365 days of the first date of service to be accepted for processing and payment.

Retroactive coverage may be approved for up to three calendar months prior to the month of the application if the applicant meets all eligibility conditions in the retroactive period. Medicaid will pay for covered services received during the retroactive period if all other Medicaid guidelines are met.

Financial Procedures

Sliding Fee Scale (SFS) Determination

Determination of Family Unit Size

ITP Definition of Family Unit

The family unit is the group of individuals whose information is used to determine family unit size for application to the SFS. Members of the family unit with income are required to submit documentation of income to the CDSA Business Office to verify family unit income used to calculate the SFS percentage.

First, establish adults with income who would be included in the family unit. Adults in the household, typically the parents of the eligible child, are those that satisfy the following criteria:

1. Those related to the child by blood, marriage, or adoption;
2. Those living in the same household with the child; and
3. Those adults who have responsibility for the child's financial support.

NOTE: Step-parents should not be counted as part of the family unit and have their income

included as part of the sliding fee scale calculations unless the child is identified as a dependent on the tax form. Then a step-parent are counted as part of the family unit.

In addition to the parents and the eligible child, to be considered part of the family unit, other qualifying household members (other children and adult relatives in the home) must:

1. Be the eligible child's brother, sister, half-brother, half-sister, step brother, step sister, foster brother, foster sister; or a descendant of any of them; and meet at least one of these additional conditions:
   a. Currently under age 19 and younger than the identified parents; or
   b. Under age 24, a full-time student, and younger than the identified parents; or
   c. Any age if permanently and totally disabled;
2. NOT have provided more than half of his or her own support for the year and lived with the family for more than 6 months;
3. NOT be a qualifying dependent of any other taxpayer (family)

Exceptions for Temporary Absences

Household members who are absent from the home for a temporary absence may be counted as part of the family unit. A temporary absence may occur for special circumstances such as military service, education, business, vacation, or illness. It must be reasonable to assume that the absent person will return to the home after the temporary absence.

Ward of the State

Children under DSS custody or those living in a foster home or institution are considered a family unit of one since they do not live in the household with a relative who has financial responsibility for the child. If the child has any income of his or her own, that income alone would be counted. Even if a relative is appointed as the child's legal guardian, the relative should not be counted as a family member under this definition. Legal guardianship implies that the guardian handles the child's financial matters, not that he or she must support the child financially.

Procedures for Determination of Family Unit Size

Collection of family unit size information is the first step required to establish a family's SFS percentage.

Service Coordination Staff:

- Collect all family unit size information at the initial contact with the family in all situations; except in situations where the SFS percentage may be established by verified participation in one of the State's Medicaid, Social Security Income (SSI), or Women, Infants, and Children (WIC) programs.
- Collect and record family unit information on Section D of the *Financial Data Collection Form*.
- The name, relationship, and current age information must be completed for all members of the household that meet the ITP definition of family unit.

  Children in foster care (but not in DSS custody) are included in the family unit size
- Family members reported as having income should be identified first and indicated by making a checkmark in the box following the age in the current age column.

- Complete Sections A, B, C, and D of the *Financial Data Collection Form*.
  If WIC contact is needed, the CDSA should obtain a signed release (*Authorization to Release Form*) from the family allowing us to contact WIC. The release must specify the information to be gathered. The release must be in place prior to making any contact attempts. Record contact name and phone number used for verification of SSI or WIC program participation in Section B of the *Financial Data Collection Form*.
- Have the family sign the form to certify family information provided is accurate as well as indicating they understand the reasons for the ITP requesting the social security number of the financially responsible adult.
- Inform the family that a completed copy of the *Financial Data Collection Form* will be mailed/provided to them from the Business Office.
- Submit the signed original *Financial Data Collection Form* to the Business Office as soon as it is completed. No copies should be made after it is submitted to the Business Office unless made by the Business Office.

Business Office Staff:

- Make final determination on the verified family unit size based on review of all information.
- In cases where family unit information is in question, verify family unit information supplied on the *Financial Data Collection Form* with family information on intake, tax, or other documents submitted as part of income verification procedures. For example, adjustments may be needed if a family member is added (birth/adoption) or is lost (death) after the federal income tax return is filed.
- Request additional documentation as needed, including the social security number of the financially responsible adult if not available from tax forms submitted by the family.
- Record SFS and Monthly Maximum Cap decisions in Section E of the *Financial Data Collection Form*.
- Mail/provide a copy of the completed signed *Financial Data Collection Form* to the family once all income verification, SFS calculations, and Monthly Maximum Cap information is completed.
- Maintain *Financial Data Collection Form* only in the client's financial file in the Business Office to protect the private information according to state regulations.

Verification of Income

Verification of Other State Program Participation Methods

Current program participation in Medicaid, SSI, or WIC by anyone in the family unit establishes the family SFS percentage at 0%. No additional income verification is needed during the time a family is eligible for any of these programs. The income eligibility levels of these programs are consistent with the ITP-defined inability to pay guideline of 200% of federal poverty guideline (FPG) or below. If a family is subsequently found not to be eligible for Medicaid, SSI, or WIC, follow standard verification of income procedures guided by instruction under the "When there is a Lapse in Medicaid, SSI or WIC Eligibility" section below.

Verification of Income Methods

The most recent federal income tax form must be used if a federal income tax form was completed the prior year. This may include tax returns from two or more applicable family members, if filed separately. The adjusted gross income (AGI) can be located on federal tax form 1040 Line 7 [for tax years prior to 2018 – 1040 line 37, 1040A Line 21, 1040EZ Line 4]. A summary from tax preparation software may be used so long as the information needed to determine the family unit, SFS percentage and the maximum monthly cap, is present. AGI is defined by the Internal Revenue Service and is gross income adjusted downward by specific deductions, but not including standard and itemized deductions. When tax forms are current, they must be used to determine a family's adjusted gross income for use with the SFS. A copy of the income-supporting documents must be obtained and kept in the financial file to support the current SFS determination.

- If family states tax forms do not represent their current financial situation, a copy of one of the alternate methods, in addition to the most-recently filed tax forms, are required to compare and verify current financial situation.
- If tax forms are not available for review, an alternate ITP approved method will be used to determine family unit income for use with the SFS. The alternate method will allow for a set 3% deduction from the verified gross income as described on the following page.

Alternate ITP-Approved Verification of Income Methods

The methods listed below for verification of income should **only** be used if a family member did not file a federal income tax return the prior year, or they are unable to provide the necessary tax documents.

Alternate Method A: Use current year W-2(s), allow the 3% deduction to determine the family unit AGI income for use with the SFS.

Alternate Method B: Use pay stubs from the most recent two months' pay periods. Annualize the gross income indicated on the payment documents and allow the 3% deduction to determine the family unit income for use with the SFS.

Alternate Method C: Use statement signed by the employer(s) regarding gross salary and wages. The statement should indicate an annualized wage based on the current level of income. If it doesn't, the Business Office is to annualize the gross income provided on the employer-signed salary and wage statement and allow the set 3% deduction to determine the family unit income for use with the SFS.

If a family states that they have no income, and no member of the ITP family unit has filed a federal tax form, current year pay stubs, or an employer letter; then a signed letter from the family certifying their income (or lack of income) is required. When a family reports no income, they should be encouraged to apply or re-apply for Medicaid.

Veterans Affairs (VA) benefits, SSI and Child Support are all non-taxable, therefore should not be considered as income to the family.

Methods for Submitting Required Verification Documents

Families must provide appropriate and complete documentation required for income verification prior to establishing an SFS percentage. Families may submit required income verification documentation to the CDSA Business Office contact by the following methods:

- Hand delivery of originals or a copy
- Mail or fax
- Hand delivery of a copy using a confidential method via an Early Intervention Service Coordinator

With documentation of the circumstances, the CDSA Business Officer may approve an alternate means of submitting the required income information.

When Required Documentation is Not Submitted

A family may choose not to participate in the sliding fee scale program by choosing not to provide the required information for income verification, or a family may fail to submit the required information by the date specified on the notice. If the family fails to submit the required information by the date specified, their SFS percentage will be established at 100% until adequate information is provided. The family would still be billed for early intervention services as outlined in ITP policy, and their cost would be established as 100% of chargeable services. Other funding source such as private insurance can be used.

When the SFS is determined at 100% due to failure to provide the required financial information for verification, the CDSA staff should document important facts in the client record around the circumstances involved when the family chooses not to provide information or there is a refusal or a delay in providing the necessary information to determine SFS percentage.

When There is a Lapse in Medicaid, SSI, or WIC Eligibility

If a child's Medicaid eligibility has lapsed, the SFS percentage must be reviewed using family size and income verification. The family must receive notification of a financial review request and all procedural safeguards must be followed prior to any change in SFS percentage taking effect. In instances of lapsed eligibility, the CDSA Business Office should initiate income verification based on the following guidelines. First, notify the family in writing as soon as the lapse in Medicaid, SSI or WIC is identified. The notification letter should identify the purpose and request the needed family action to avoid additional income verification activities if possible. Notification and requested action should include the following points.

- The CDSA is aware of a lapse in the child's Medicaid, SSI, or WIC enrollment status.
- The current SFS percentage (0%) was established based on enrollment in the Medicaid, SSI, or WIC program.
- The financially responsible parent/guardian is to be given 14 business days from the date of the written notification to re-establish enrollment for the program or to verify re-application for the program.
- If action is not taken or the re-application does not restore program enrollment, income verification is required.

If no action has been taken by the 15th business day following written notification or re-application does not restore program enrollment, standard income verification procedures should be initiated.

The family must be provided a deadline date for submitting the required income verification documents using the *Family Notification for Verification of Income & FAQ on Costs for ITP Services*.

If, subsequently, the family re-establishes enrollment in Medicaid, SSI, or WIC, their SFS percentage will remain at 0%. If the family does not provide the required documents by the date set in the notice, their SFS will be established at 100%, until the required documentation is provided for income verification, as would occur for any family not providing the required documentation. An IFSP review must take place to notify the family of changes in the cost of the early intervention services, and all procedural safeguards must be followed prior a change in the SFS percentage taking effect.

Procedures for Verification of Income

Verification of income is the second step required to establish a family's SFS percentage.

Service Coordination Staff:

- Notify family at initial contact of the income verification process even in situations where the SFS percentage may be established by other State program participation, such as Medicaid, SSI or WIC.
- Assure this information is shared with family immediately following the referral to give timely notice to the family. This notification may be completed through a mail contact to ensure the family receives a timely and written notice. The notice must also be reviewed with the family at the initial contact.
- Provide notification using the *Family Notification for Verification of Income & FAQ on Costs for ITP Services* and explain required income and insurance documents that are needed for that family must be submitted to the Business Office. The notification will be provided containing the date upon which required family documents must be received at the Business Office.
- Review with the family the established method for verification of income and alternate methods so the family understands what information is required to be submitted. The service coordinator must explain the consequence of not providing the income information to the Business Office contact by the stated deadline.
- Inform families that if their Medicaid enrollment is **not** verified, they will be required to submit the documentation indicated in the *Family Notification for Verification of Income & FAQ on Costs for ITP Services.*
- Refer all income-related questions to the CDSA Business Office contact. Beyond referring questions, service coordination staff may only transport a family's income-supporting documents, using a confidential method, to the CDSA Business Office.
- Refer families to the copy of the *Financial Data Collection Form* that will be mailed/provided to the family from the CDSA Business Office for information on their current SFS percentage or Monthly Maximum Cap level.

Business Office Staff:

- Verify income for all families, who have not been verified as participating in one of the State's Medicaid, Social Security Income (SSI), or Women, Infants, and Children (WIC) programs.
  - When applicable, verify participation in one of the State's Medicaid, Social Security Income (SSI), or Women, Infants, and Children (WIC) programs and document it in Section B of the *Financial Data Collection Form.*

- ♦ After verifying eligibility status for Medicaid recipients, Medicaid policy details and other private insurance policy information, as applicable, as well as the family's established SFS percentage must be recorded on the *Insurance Information Worksheet*.
- ♦ Verify participation in SSI or WIC, in cases where the family does not have Medicaid using the information from Section B of the *Financial Data Collection Form* or request a certification statement from the family.

- ▪ Determine and document required SFS information and Monthly Maximum Cap in Section E of the *Financial Data Collection Form* when current program participation is verified.
  - ♦ *If unable to verify Medicaid or* other *program participation*, communicate with service coordination staff to initiate standard income verification procedures.

- Make phone contacts as needed with the family or Early Intervention Service Coordinator to facilitate income verification efforts.
- Assure needed adjusted gross income (AGI) and gross income information is recorded for each member in the family unit with income.
  - ▪ This applies except in situations where the SFS percentage has been established by verified participation in one of the State's Medicaid, Social Security Income (SSI), or Women, Infants, and Children (WIC) programs, as they are at 0%.
- Calculate monthly gross income information to determine the monthly maximum cap level.
- Record all required source and income information in Section E of the *Financial Data Collection Form*.
- Use the verified family unit size and family adjusted gross income information to determine the SFS percentage using the current *ITP Sliding Fee Scale Matrix Table*.
- Record verified family unit size and family AGI in Section E of the *Financial Data Collection Form.*
- Record the SFS percentage on the *Insurance Information Worksheet* to communicate the SFS percentage and insurance information to the Early Intervention Service Coordinator and applicable ITP contract providers.
- The CDSA Business Office must mail/provide a completed copy of the *Financial Data Collection Form* to the family once it is completed to share written information on SFS determination and established Monthly Maximum Cap level with the family.
- Maintain all copies of income verification documents in the financial record during the time the documents support the current SFS percentage.
- The *Financial Data Collection Form* and all income-supporting documents must be retained, and all updated copies maintained in the financial record. The *Financial Data Collection Form*, like all other ITP forms, is retained in accordance with State record retention policy.
- Ensure that any income verification information requested by the family is returned to the family once a copy is made.

Annual Re-Verification of Income

Annual Re-Verification of Income for Enrolled Families

A family maintains the right to request a re-verification of income at any time. The ITP *requires* that family income information be re-verified by the CDSA Business Office annually at the time of the family's annual IFSP review. The CDSA Business Office must have procedures:

- To monitor the date of the last income verification for each family.
- To initiate the annual re-verification process at the direction of the CDSA Business Officer.

Although the processes are separate, for some families, an annual income re-verification process due at the time of the annual IFSP review may overlap in the same time with the effective date of the SFS update. Staff should align these two processes to support the family and reduce multiple processes as applicable. Staff should not align the processes for all families, as the reason for each is distinct.

The *Family Notification for Verification of Income & FAQ on Costs for ITP Services* must be used to notify families of the documents and the deadline required for submitting information for the income re-verification process. A new *Financial Data Collection Form* must be used to record information for income re-verification. The CDSA Business Office must determine the family's updated SFS percentage and Monthly Maximum Cap based on the income documents received. If the family does not submit the required documentation by the deadline, the SFS percentage should be established at 100% until the required documentation is received.

If changes to the SFS percentage or Monthly Maximum Cap result from the re-verification process, the Early Intervention Service Coordinator must notify the family of the change in costs for early intervention services at an IFSP review prior to the new SFS information taking effect. *Any* time the SFS percentage is changed, all procedural safeguard requirements must be followed in notifying the family of potential changes to cost for early intervention services before changes go into effect.

Procedures for Annual Re-Verification of Income for Enrolled Families

Service Coordination Staff:

- Notify the family of the required annual re-verification process.
- Deliver the *Family Notification for Verification of Income & FAQ on Costs for ITP Services* with date required for submitting re-verification documents.
- Complete *Financial Data Collection Form* as needed to update family unit information.
- Following re-verification, schedule an IFSP review meeting and complete the IFSP Service Delivery page with updated information, if there are updates to SFS percentage, and provide all procedural safeguards related to informed consent.
- Update any applicable service authorizations within two (2) business days of the IFSP review.
- Provide a copy of the updated *Insurance Information Worksheet* to notify current providers of any SFS percentage or insurance change within two (2) business days of the IFSP review.
- Refer families to the copy of the *Financial Data Collection Form* that will be mailed/provided to the family from the Business Office for information on their current SFS percentage or Monthly Maximum Cap level.

Business Office Staff:

- The Business Office initiates the annual review process by requesting the Early Intervention Service Coordinator to notify the family an annual review is required.
- The Business Office must supply the date required for submitting documents to be listed on the *Family Notification for Verification of Income & FAQ on Costs for ITP Services*.
- Receive the requested re-verification documents from the family and verify the information to determine an updated SFS percentage and monthly maximum cap for ITP services.
- Communicate the updated information to the service coordinator as soon as it is determined.
- The CDSA Business Office must mail/provide a completed copy of the *Financial Data Collection Form* to the family once it is completed to share written information on SFS determination and established Monthly Maximum Cap level with the family.

Monthly Maximum Cap

Purpose of Monthly Maximum Cap

As stated in the *NC ITP System of Payments Notifications*, a family's monthly cost share for services consented to on the IFSP should not exceed 5% of the family's monthly gross income. The CDSA Business Office will inform the family of their maximum cap amount. This cap establishes the maximum out-of-pocket cost a family should pay for all ITP services in any month while the child is enrolled in the program. In cases where a family has multiple children enrolled in the ITP, the monthly maximum cap applies to ITP costs for the family. AT equipment can be factored into the monthly gross cap and is calculated in the month the payment was authorized by the vendor.

Monitoring of the monthly maximum cap is the responsibility of the family. They are required to pay enrolled providers up front and can document the total amount paid each month for ITP services. When a family reports the overpayment to the CDSA, the Business Office should verify charges for the month in question and request documentation from the parents to support the amount of reimbursement requested. Reimbursement for services paid is based on the month the service was received, not the month the invoice was paid.

The reimbursement for the monthly maximum cap will be administered through the CDSA Business Office with verified expenses being reimbursed to the family. The family will be reimbursed for the verified amounts paid above the monthly cap for ITP services provided. For non-recurring monthly maximum cap overages, there is no HIS adjustment made and the family must continue to pay the family portion for any additional payments due to the service provider.

In situations where a family will continue to exceed the monthly maximum cap, the CDSA Business Office may adjust the family's SFS to keep the family from continuously going over their cap. However, this should be done with careful consideration and CDSAs should contact the EI Section office to discuss the details of the case.

Required Supporting Documentation

- List of all ITP service dates and ITP services that occurred within the month
- Copy of EOB(s), invoices, and receipts for the above services
- Service Delivery Page of the IFSP

Procedures for Business Office

- Verify all information provided by the parent
- Complete the *ECAC Reimbursement of Family Payments Made for IFSP Services* form
- CDSA Business Officer signs the form and forwards it to Winston-Salem CDSA
- Winston-Salem CDSA will send the reimbursement directly to the family

Financial Review and Hardship Adjustment

The Financial Review and Hardship Adjustment Application procedures provide a way for families to request a specific review of their hardships encountered that may significantly affect their ability to pay for ITP services. Hardship categories are defined as loss of home; loss of employment or income; and extensive current year medical costs.

Loss of Home (abrupt, unplanned displacement from the established permanent residence):

- Destruction (insurance claim of total loss or significant loss requiring family to move)
- Bank repossession (bank documentation)
- Eviction from rental property

Loss of Employment or Income:

- Unemployment information is subtracted from the documented lost wages to figure the actual loss of income.
- Notice from employer
- In absence of other verification, family may submit a letter including previous employer name, contact information, date of change in employment, and the amount of income lost. If the CDSA can verify the information, this may be used to document need.
- A hardship adjustment for a self-employed parent, like all others, should take into consideration the original amount of income verified and used in determining the SFS percentage. There may be unique challenges to verifying income loss from self-employed parent(s). In situations where verification procedures are in question, please contact your EI Branch office staff who can discuss the specific situation with you to consider the hardship adjustment application.

Extensive Out-of-Pocket Medical Costs:

- Total out-of-pocket expenses must meet or exceed the current AGI percentage utilized by the Internal Revenue Service, as well as meet the IRS definition of allowable medical expenses. For the current AGI percentage and definition of allowable medical expenses, please refer to *Instructions for Schedule A* on the IRS website (irs.gov).
- Medical costs refer to payments made for medical bills in the current calendar year, and not paid from spending account claimed in the prior year income tax form calculation of AGI, not including the cost of ITP services.
- Explanation of Benefits (EOB), current invoice, and receipt of payments made to document a

medical service was provided to a member of the identified family unit and that payment for that service was made in the current calendar year.

Required Supporting Documentation

To complete the application process, the CDSA Business Office must:

- verify the required supporting documentation submitted with the family's application;
- verify when all required supporting documentation is received; and
- put this date on the application form as the date application was completed.

The CDSA should obtain a signed release (*Authorization to Release Form*) from the family allowing us to contact the employer, if applicable. The release must specify the information to be gathered. The release must be in place prior to making any contact attempts.

The CDSA has 30 days from the date of receipt of the completed application to decide on the requested adjustment. Examples of required supporting documentation for each category are listed below. The CDSA Business Office may request additional supporting documentation, if needed.

Adjustment Decision Required Components

a. Date the adjustment decision is recommended
b. New SFS percentage
c. New monthly maximum cap, if applicable
d. Date of next required financial review, not to exceed 9 months

Note: If no adjustment is recommended, provide a short summary of basis of the decision.

Adjustment Decision Guidelines

All adjustment decisions must be reviewed and signed by the CDSA Director. The adjustment decision timeline set for next review date must be followed. An additional hardship request may occur with a new application process, if needed, following the review. Typically, adjustments should be made for 6 to 9 months with consideration of the next scheduled annual review period. CDSAs should follow the suggested guidelines based on each category when making an adjustment decision. The adjustment decision will be implemented as of the date the family is notified and signs the IFSP review page. The IFSP review must include all procedural safeguards related to notice of the change to the cost of the ITP services, and the adjustment decision will apply to service charges after the date the family signs the IFSP review. The following must happen after an adjustment decision is made:

- Update any service authorizations,
- Notify all providers of the families change in SFS, using the *Insurance Information Worksheet*, and
- Document the adjustment decision timeline set for next review date.

Loss of Home:

- Adjust SFS percentage to 0% for approved timeframe, not to exceed 9 months.

Loss of Employment or Income:

- Adjust AGI by established income loss, and re-calculate SFS based on adjusted AGI, for approved timeframe, not to exceed 9 months.

Extensive Out-Of-Pocket Medical Costs:

- Reduce AGI by the total amount of documented, current year, out-of-pocket medical expenses paid. Re-calculate SFS based on reduced AGI for approved timeframe, not to exceed 9 months.

Procedures for Financial Review and Hardship Adjustment

Service Coordination Staff:

- Ensure families are aware of the Financial Review and Hardship Adjustment Request process when providing the *Family Notification for Verification of Income & FAQ on Costs for ITP Services*. If family would like more information, provide the FAQ on Financial Review and Hardship Adjustment and/or the *Financial Review and Hardship Adjustment Application*.
- Assist the family as needed in explaining the FAQ on Financial Review and Hardship Adjustment and/or completing the *Financial Review or Hardship Adjustment Application*. The service coordinator should:
  - help the family in identifying a specific category on the application and
  - assist family in identifying the required supporting documentation to be submitted to the Business Office.
- Schedule the IFSP review meeting as soon as possible after the decision or within two weeks of approval date.
- Update any applicable service authorizations within two (2) business days of the IFSP review.
- Provide an updated *Insurance Information Worksheet* to notify IFSP team providers of any SFS percentage and/or consent to use insurance and insurance detail changes within two (2) business days of the IFSP review.
- Refer families to the copy of the *Financial Data Collection Form* that will be mailed/provided to the family from the Business Office for information on their current SFS percentage or Monthly Maximum Cap level.
- Be aware of the review timeline set in the adjustment decision and communicate with the CDSA Business Office regarding the re-verification process as needed.

Business Office Staff:

- Receive the *Financial Review and Hardship Adjustment Application* form to ensure the supporting documentation is sufficient for verification.
- Record the date of the completed application on the *Financial Review and Hardship Adjustment Application* is received.
- Inform the family in a letter of the date the application was received as complete with all required supporting documentation as determined by the Business Office. The Director should sign this letter notifying the family the complete application has been received and that a decision will be made in 30 days.
- Notify the Early Intervention Service Coordinator of the date the *Financial Review and Hardship*

Adjustment Application was verified as completed.

- Review the application and supporting documentation to make an adjustment recommendation to the CDSA Director within 10 business days of receiving the completed application.
- Track the next required financial verification process required by the adjustment decision. The CDSA Business Office will track the new required date of financial re-verification that was established by the adjustment decision.
- Inform the Early Intervention Service Coordinator when the financial verification process should begin in order to follow the review requirements set in the adjustment decision.
- The CDSA Business Office must mail/provide a completed copy of the *Financial Data Collection Form* to the family once it is completed to share written information on SFS determination and established Monthly Maximum Cap level with the family.
- Upon approval of the SFS adjustment by the CDSA Director, the Financial Investigation screen in HIS should be updated to document any changes to SFS. The effective date of the SFS change is the date the IFSP Review Page is signed.

CDSA Director:

- Sign the letter notifying the family the complete application has been received.
- Approve or revise the recommendation made by the CDSA Business Office.
- Communicate in a written letter the final decision to the financial officer, the service coordinator, and the family within 20 days of receiving the completed application.

Insurance Identification

Identifying Insurance Information

Established Methods for Verification of Medicaid Benefits

Refer to the current DHB's *NCMMIS Provider Claims and Billing Assistance Guide* in the section on verifying eligibility to determine available methods for verification of a client's Medicaid eligibility status. The provider of the early intervention service, whether the CDSA or community provider, is responsible for verification of the family's Medicaid eligibility and/or insurance coverage.

Established Methods for Insurance Identification

The *Insurance Information Worksheet* is used to collect information on client plan benefits, limitations, and other coverage effects and to communicate the family's instruction on consent to use Medicaid and private insurance, as well as the established SFS percentage to ITP providers.

When consent to use insurance is provided, insurance information must be identified to:

- identify if the insurance plan is an available funding source for early intervention services,
- identify the requirements needed to access the funding source, and
- assist the family in making provider selections as needed.

There are three primary ways to identify insurance benefits and each should be tried in the following order when consent to use insurance has been provided: by the web, by phone and by quote from an insurance representative.

1. Web-based insurance company resources
   - Identify benefits by using basic subscriber information and/or by accessing an automated system and requesting a fax.
2. Phone contacts to the insurance company
   - Call the benefits verification department of the insurance carrier using the phone number found on the back of the insurance identification card.
   - Use the general phone number for the insurance company provided by the family if you do not have the card information.
3. Insurance company representative
   - Benefit identification is not a guarantee of payment. The insurance representative may provide a quote of plan benefits. Final determination regarding reimbursement will be made when the insurance company reviews the actual claim.
   - Key points for communicating with insurance representatives.
     a. Identify yourself as a provider and make the request to identify benefit coverage.
     b. Provide the name, policy number, date of birth, and/or other information requested to locate the policy.
     c. Request *all* fields required from the *Insurance Information Worksheet* i.e.; the effective date of policy; out of network benefits, etc.; the in/out network benefits may include differences in copayment, coinsurance, deductible, covered services, etc. It is important to get all the information on the worksheet completed, when available.
     d. Request the address where claims should be sent each time to *confirm* the correct address. Many insurance carriers have separate claims-paying facilities and information on the card may not be the most updated.
     e. If needed, make a call to the family or communicate with the service coordinator to assist in having family gather needed insurance information when company will not discuss with potential provider or will only provide certain details to the subscriber.

Procedures for Insurance Identification

Service Coordination Staff:

- With parental consent, initiate the process of identifying insurance coverage or other funding sources with the family at the initial visit. The service coordinator must ask the family to identify any public or private insurance coverage for the referred child.
- Record any insurance information reported by the family (Medicaid and private insurance policy information as applicable) from the insurance card(s). Insurance plan information must be filled in on the *Insurance Information Worksheet*.
- When consent for use of insurance is provided, notify family members of their

responsibility to provide a copy of the insurance policy subscriber card to the Business Office as stated on the *Family Notification for Verification of Income & FAQ on Costs for ITP Services* document.

- When consent for use of insurance is provided, indicate family consent to use insurance was provided on the *Insurance Information Worksheet* next to the SFS percentage information to be shared with ITP providers.
- The *Insurance Information Worksheet* will be used as a resource when informing the family of how the cost of early intervention services on the IFSP will be determined, and for sharing established SFS percentage information as well as consent instruction on use of insurance and insurance policy information with ITP providers.
- Submit the **original** *Insurance Information Worksheet* to the CDSA Business Office.

Business Office Staff:

- Identify the insurance plan details based on the information provided from service coordinator on the *Insurance Information Worksheet*, or from the copy of the insurance policy subscriber card provided by the family.
- Research all available coverage details needed for completing the *Insurance Information Worksheet*.
- Use established methods to determine which early intervention services are covered plan benefits to identify prior approval requirements or service limitations, or any other information needed to implement ITP fees and billing policy.
- Use the *Insurance Information Worksheet* to record the details collected from the plan website or phone contacts with the insurance company or the subscriber.
- Complete the *Insurance Information Worksheet* prior to the planned initial IFSP meeting to communicate the family's established SFS percentage and insurance plan details to the service coordinator for use at the meeting.
- Ensure the service coordinator has a copy of the *Insurance Information Worksheet* in a timely manner. The *Insurance Information Worksheet* will be used as a resource when informing the family of how the cost of early intervention services on the IFSP will be determined, and for sharing established SFS percentage information as well as consent instruction on use of insurance and insurance policy information with ITP providers.

Consent and Notification of Financial Policy

NC ITP Forms Documenting Informed Consent

Consent for Eligibility Evaluation and/or Child Assessment

The *Consent for Eligibility Evaluation and/or Child Assessment* form presents a place for a family to provide or decline written consent for:

1. The ITP to carry out the Eligibility Evaluation and/or the Child Assessment.
2. The ITP provider to bill private insurance and/or Medicaid for the Eligibility Evaluation and/or Child Assessment and related service coordination activities as applicable for prior to the

initial IFSP development.

As part of notification required for informed consent, families will also be asked to indicate by initialing that they:

1. Received a copy of the *NC ITP System of Payments Notifications* and that the notifications related to billing private and public insurance benefits have been explained to them and that they understand them.
2. Understand ITP policy provides that evaluation, assessment, and service coordination activities are provided at no cost to all families, regardless of consent for billing private insurance/Medicaid.

IFSP Agreement and Review

The *IFSP Agreement and Review* page presents a place for a family to provide or decline written consent for:

1. The NC ITP and service providers to provide the NC ITP services identified on the IFSP and to carry out all the activities as reviewed on the IFSP.
2. The *IFSP Agreement and Review* page also presents a place for a family to provide or decline written consent for the NC ITP provider to bill private insurance and/or Medicaid on record for the child for all for the early intervention services as identified on the IFSP including increases in the frequency, length, duration, or intensity. There is also option for consenting with specific exceptions documented.

As part of notification required for informed consent, families will also be asked to indicate by initialing that they:

1. Received a copy of the *NC ITP System of Payments Notifications* and that the notifications related to billing private and public insurance benefits have been explained to them and that they understand them.
2. Have provided insurance information on record for the child is current and accurate.
3. Understand if their child is covered by private insurance and Medicaid, private insurance must be billed first, before Medicaid benefits can be accessed.

NC ITP Documents used in Notification of Financial Policy

The provision of notification of financial policy and child and family rights required to be provided during consent activities is documented on the *Consent for Eligibility Evaluation and/or Child Assessment* form and the *IFSP Agreement and Review* page based on the services that are being planned. The parent/guardian must sign and date these completed forms in order to acknowledge notification and understanding of the information and to provide their written consent.

NC ITP System of Payments Notifications

The *NC ITP System of Payments Notifications* document is composed of ten categories of policy/notifications that must be explained to the family when consent is being sought for early intervention services and/or use of insurance. The ten categories of policy/notifications include:

- Section I: **ITP SLIDING FEE SCALE (SFS)** is a notification that ITP fee and billing policy uses the SFS to determine ability or inability to pay for ITP services and reference to the program

website for the ITP SFS and Fee Schedules.

- Section II: **"NO COST" SERVICES** is a notification of services that are provided at no cost to families in our ITP policy.
- Section III: **"CHARGEABLE" SERVICES** is a notification that all ITP services other than those specified as "no cost" may be charged to the family and that the SFS percentage will determine the family's cost share.
- Section IV: **INCOME VERIFICATION/ SFS DETERMINATION** is notification of the ITP policy and rights related to income verification and determining the family cost share, and the family's rights related to costs and fees.
- Section V: **HARDSHIP ADJUSTMENT** is notification that a family may apply at any time for consideration of a hardship adjustment if their financial situation changes or they are impacted by extraordinary medical expenses.
- Section VI: **CONSENT FOR USE OF PRIVATE INSURANCE AND MEDICAID** is notification of ITP Policy regarding consent and use of private insurance and costs of services.
- Section VII: **MEDICAID** is notification of specific policy and rights related to Medicaid.
- Section VIII: **PRIVATE INSURANCE** is notification of specific policy and rights related to use of private insurance.
- Section IX: **CDSA FEE COLLECTION POLICY** is notification of specific policy related to CDSA collection of amounts due to ITP services providers.
- Section X: **REASON ITP REQUESTS SOCIAL SECURITY NUMBER** is notification of privacy practice and the reason the ITP will request the social security number of the financially responsible adult of the children enrolled in the ITP.

When to Complete Consent Forms and Notification of Financial Policy

The *Consent for Eligibility Evaluation and/or Child Assessment* form is completed at the initial visit when consent is being requested for Eligibility Evaluation or any other time consent is being requested for Child Assessment. The *NC ITP System of Payments Notifications* and any applicable *Child and Family Rights* must be provided each time consent is requested.

IFSP Agreement and Review page is completed at the established times for annual or other required IFSP reviews. The *NC ITP System of Payments Notifications* and any applicable *Child and Family Rights* must be provided each time consent is requested for early intervention services. Consent must be obtained prior to billing Medicaid and private insurance for any early intervention services on the IFSP; each time there is a change to the family's Sliding Fee Scale percentage; and each time consent for services is required due to an increase (in frequency, length, duration, or intensity) in the provision of services in the child's IFSP. The signature date is the effective date for all consents or directives authorized by the family, unless denoted by *Request Restriction on Use and Disclosure of Health Information*.

Procedures for Consent Forms and Notification of Financial Policy

Service Coordination Staff:

- For the Eligibility Evaluation, use the *Consent for Eligibility Evaluation and/or Child Assessment*

form to request family consent for service and use of insurance.

- Use the *Insurance Information Worksheet* to begin to collect insurance information when consent to use insurance is provided.
- Communicate with the CDSA Business Office to ensure specific information on insurance policy detail and the established family SFS percentage is collected and included on the *Insurance Information Worksheet* prior to consent notifications and requesting consent at the IFSP meeting.
- Communicate with the CDSA Business Office to ensure insurance information collected on the *Insurance Information Worksheet* may be used during notification.
- Use the *Insurance Information Worksheet* to communicate the determined SFS percentage and any identified plan details with the family when explaining the cost of early intervention services.
- Inform the family of ITP fees and billing policy related to the services being planned using the *NC ITP System of Payments Notifications* document whenever consent is requested.
- Notify families of their agreements per the signing statements on either the *Consent for Eligibility Evaluation and/or Child Assessment* form or the *IFSP Agreement and Review* page depending on which services consent is being requested.
- Review the insurance coverage at each IFSP review to ensure all information is accurate and no changes are required to ensure accurate notification of family financial responsibilities to the ITP.
- Ensure the family receives a copy of the completed *Financial Data Collection Form* when requested by the family.
- Ensure all IFSP service providers receive a copy of the *Insurance Information Worksheet* and most-current IFSP prior to their initiation of IFSP services to inform them of the family's established SFS percentage information, insurance policy information, and the family's consent instruction on use of insurance.
- Ensure the *Financial Data Collection Form* is **NOT** shared with community service providers; this form contains sensitive information and once completed should only be submitted to the CDSA.

Business Office Staff:

- Provide the Early Intervention Service Coordinator with the determined Monthly Maximum Cap information needed prior to the IFSP meeting (*Financial Data Collection Form)*.
- Provide the Early Intervention Service Coordinator with the completed *Insurance Information Worksheet* including any specific family information, and the determined SFS percentage prior to the IFSP meeting.
- Collaborate with the Early Intervention Service Coordinator during the income verification process (i.e., gathering family unit size, income verification, and identifying insurance coverage) to ensure all information needed is available to inform the family of their financial responsibility.

- If the appropriate information has not been supplied by the family or is not made available in a timely manner by the family, the SFS will be established at 100%. This should be documented on the *Financial Data Collection Form* and maintained in the financial record. When entering this information into HIS, Financial Investigation form, under Income-Validation option, select #7 Insufficient/ No Information Provided by Family.
- Complete the *Insurance Information Worksheet* any time the Early Intervention Service Coordinator notifies the CDSA Business Office of a change to the family's insurance coverage or there is a change in the family's SFS percentage.

Privacy Policy

Family Education Rights and Privacy Act (FERPA)

The Family Education Rights and Privacy Act (FERPA) is a federal law that protects the privacy of children and parents who receive services from the ITP. Information concerning a child or family member is confidential and must not be exchanged among service providers without written authorization from the parent, except under special circumstances where this release is allowable by law such as a health or safety emergency, under court order, or as an allowable child find activity. The agency, however, may release confidential information to its own employees who have a legitimate need for access to the information.

CDSA Fee Collection Policy

Expected Payment Terms

The CDSA must inform the family how it will collect fees due by the family. Family fees are due thirty (30) days from the initial invoice date and will be invoiced monthly by the provider of the early intervention service. The service provider is expected to bill available insurance first for early intervention services within the guidelines of the ITP fee and billing policy.

Family fees are collected by the provider of the early intervention service after insurance has been billed and appropriate family cost has been determined through the application of the SFS percentage to the base charge. ITP community providers should develop and follow fee and billing practices related to invoicing and debt collection that are in line with the NC ITP Policy and Procedure Manual.

Insurance Payments Made to the Subscriber

The ITP will invoice the family for the amount the insurance plan transferred to the subscriber for reimbursement of the early intervention service when a family has authorized consent to bill insurance and the insurance plan has paid the subscriber directly (transferred liability) for the service. This will be identified on the letter with the invoice and the family SFS percentage **will not** apply to the balances in which the liability was transferred by the insurance company.

If the liability was transferred to the family, the ITP may bill the family to collect the insurance plan reimbursement for the early intervention service. Families are notified of this when reviewing the *NC ITP System of Payments Notifications*.

Requesting the Social Security Number of the Responsible Adult

To fully comply with the North Carolina General Statutes (N.C.G.S. 105A-3 and N.C.G.S. 147-86.21), the NC ITP must request the social security number of the financially responsible adult for families that participate in our program. This is solely to comply with debt collection procedures and should NOT

be shared with ITP providers. The social security number will be used only for this purpose and will not be distributed for any other reason, except required by law.

If a guarantor refuses to provide the social security number of the financially responsible adult, services must still be provided as prescribed by the NC ITP. The CDSA Business Office should document “refused to provide” on the *Financial Data Collection Form* and follow ITP collection procedures, including referral for outstanding debts to the Attorney General’s office and collections agency.

Outstanding Balances

The account aging process begins from the date the initial invoice is sent. If insurance was authorized to be billed, the EOB should be processed appropriately prior to transferring amounts due to family pay. The family pay outstanding balances must be managed monthly according to the 30-60-90-day schedule as appropriate. CDSA Business Office staff must send invoices and past due notices to families on a standard 30-60-90-day schedule.

Summary of Standard Operating Procedure for Outstanding Balances owed to NC ITP

Sliding Fee Scale Balance	Insurance Reimbursement Sent to Subscriber
Bill Insurance/Review Explanation of Benefits (EOB)	Bill Insurance/Identify Liability Transferred from EOB
Send Initial Invoice for SFS Balance Due	Phone Call 1st notification of issue
Invoice/30 Day Past Due Letter 1	Invoice/30 Day Past Due Letter 1
Invoice/60 Day Past Due Letter 2	Phone Call 2nd notification of issue
Prepare PWN to terminate services (if applicable)	Invoice/60 Day Past Due Letter 2
Phone Call 1	Prepare PWN to terminate services (if applicable)
Invoice/90 Day Past Due Letter 3 (final notice)	Invoice/90 Day Past Due Letter 3 (final notice)
Report to DPH Budget Office	Report to DPH Budget Office

Note: Contract CDSAs should follow the protocol of their parent agencies regarding actions on outstanding balances.

Outstanding Balance Payment Arrangements

Families should be instructed to send payment to the CDSA by mail or bring the payment to the Business Office. If payment is not received in a timely manner and the family contacts the CDSA to discuss the payment of balances due, the CDSA Business Office may develop a reasonable default payment plan. If full payment or other arrangements to develop or amend a payment plan are not made after the 90 days past due notice, the CDSA must report the account to the DPH Budget Office to begin further collection efforts administered by the Other Accounts Receivable Section of the Controller’s Office.

Once the account is submitted to the DPH Budget Office for collections, it will be processed and sent to the Other Accounts Receivable Section of Controller’s Office for reporting to the North Carolina Attorney General’s Office as a past due account. If required, it may be turned over to the North Carolina Department of Revenue as a delinquent account subject to the Debt Setoff Collection against Individual Income Tax Refunds Policy.

Reasonable Payment Plans

If a family contacts the CDSA Business Office with extenuating circumstances related to their ability to pay past due account balances, the Business Office must discuss the financial situation with the family. The CDSA Business Office may arrange a payment plan with the family if requested by the family. The

terms must be documented and have a target date set for full payment of the debt owed. If the family discontinues making payments on an established payment plan the account should be turned over to the collection process initiated through the DPH Budget Office and administered by the Other Accounts Receivable Section of the Controller's Office. **Note:** Contract CDSAs should follow the protocol of their parent agencies regarding actions on outstanding balances.

Discontinuation of Chargeable Services for Non-Payment

Services identified as provided at no cost to the family **cannot** be discontinued; only those identified as services subject to family cost may be discontinued for non-payment of family fees. Once an account has reached seventy-five (75) days past due (from the date of initial invoice), the CDSA Business Office staff must notify the Early Intervention Service Coordinator to provide notice of pending chargeable service discontinuation for non-payment of fees. The Early Intervention Service Coordinator must schedule an IFSP meeting and follow all procedural safeguard requirements. The meeting should be scheduled for a date following the ninety (90) day past due point established by the CDSA Business Office.

It must be documented in the record that the meeting was scheduled to discontinue chargeable services due to non-payment of fees. If the family makes payment or establishes a payment plan with the CDSA Business Office, service may continue per the IFSP. If the family does not make payment or defaults on payment plan arrangements, the chargeable services must be discontinued for non-payment and documented as such in the record. Discontinued services may be reinstated if full payment of all past due fees is made within three months of the date services were discontinued. If greater than three months has passed since discontinuation of the services, the IFSP team must re-assess needed services and an IFSP review must establish the need for services.

Discontinuation of chargeable services for non-payment applies to all chargeable services listed on the IFSP, regardless of:

- balance origination (SFS family cost or insurance payments made to the subscriber)
- the service associated with the past-due balance
- whether the service is provided by a combination of CDSA clinician or ITP contract provider

Procedure Guidelines for CDSA Fee Collection Policy

Service Coordination Staff:

- Inform the family of the CDSA collections policy during the review of the *NC ITP System of Payments Notifications* with the family.
- Inform the family, at the initial contact, that the ITP will request the social security number of the financially responsible adult using Section C of the *Financial Data Collection Form*.
- Notify the family that chargeable services will be discontinued if their account becomes greater than 90 days past due. The CDSA Business Office will notify the Early Intervention Service Coordinator in these situations when the account reaches 75 days past due.
- Follow all procedural safe guards when discontinuing chargeable services due to non-payment of fees.

Business Office Staff:

- Record the social security number (SSN) of the financially responsible adult in Section E of the *Financial Data Collection Form*.
- Obtain the SSN of the financially-responsible adult if not available from the tax documents submitted to verify income
- Invoice families monthly based on ITP Fee, Billing and Reimbursement policy.
- Notify the Early Intervention Service Coordinator when a family's account becomes greater than 75 days past due.

Authorizing Assistive Technology

Overview

Refer to North Carolina Infant-Toddler Program Assistive Technology Policy for general information regarding AT funding.

Assistive Technology is a service required to be made available by the NC Infant Toddler Program. To be eligible to access any assistive technology device or service through the Infant- Toddler Program, a child must:

- be enrolled in the Infant-Toddler Program or have an Interim Individualized Family Service Plan (IFSP); and
- have identified on their IFSP the need to use assistive technology services and devices as described in this policy.

AT Services and Devices

Assistive technology services are services that assist in the selection, development, and training in the use of an assistive technology device. Assistive technology services include:

a. evaluation of the needs of a child with a disability, including a functional evaluation of the child's customary environment;
b. purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for children with disabilities;
c. selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
d. coordinating and using other therapies, interventions, or services with assistive technology devices such as those associated with existing education and rehabilitation plans and programs;
e. training and technical assistance for a child with a disability or, if appropriate, that child's family, and
f. Training and technical assistance for professionals (including individuals providing early intervention services) or other individuals who may provide services to or are otherwise substantially involved in the major life functions of individuals with disabilities.

Assistive Technology Devices include any items, pieces of equipment or product systems whether acquired

commercially off the shelf, modified, or customized, that are used to increase, maintain, or improve the functional capabilities of children with disabilities. The term does not include a medical device that is surgically implanted, including a cochlear implant, or the optimization (e.g. mapping), maintenance, or replacement of that device.

Some assistive technology items must be customized and purchased per child and are therefore considered exceptions to loaning for the Infant Toddler Program. The decision-making protocols detailed in the IFSP process section of this procedure must be followed for all assistive technology including these exceptions to loaning. For the assistive technology listed below by category, the sliding fee scale and family cost participation policies will apply. The Infant-Toddler Program uses a sliding fee scale to determine a family's ability or inability to pay for services. A family determined to be unable to pay for early intervention services, based on the sliding fee scale, will not have a cost for assistive technology devices or services and will not be denied access to these services. The family's portion is calculated based on, and the Infant-Toddler Program will pay vendors no more than, the current Medicaid rate for a device or service and the family's sliding fee scale percentage at the time consent was given on the IFSP. If there is not a Medicaid rate for the device, the Manufacturer's Suggested Retail Price will apply. As with all other required services, the Infant-Toddler Program is the payor of last resort. *(For additional information, see NC Infant-Toddler Program Fees, Billing, and Reimbursement Policy.)*

Forms to be used for Assistive Technology:

- NC ITP Assistive Technology Funding Authorization
- Vendor approval to proceed

Transportation and Respite

Introduction

Transportation and respite are supports that assist parents in meeting the outcomes on the Individualized Family Service Plan (IFSP). These supports are identified by the IFSP team as being needed by the parent in order to receive the services listed on the IFSP and authorized by the IFSP team.

General Procedures for Transportation and Respite

Reimbursement for transportation and respite is contracted through the Winston-Salem CDSA Business office. The Winston-Salem CDSA Business office directly reimburses families who have paid for these services. To be reimbursed, the services must be listed on the child/family IFSP and authorized in writing by the CDSA in the area where the child/family lives. The Winston-Salem CDSA Business office will reimburse parents directly for transportation and respite services.

The following guidelines apply to the reimbursement of transportation and respite to families:

- Authorization for respite and transportation reimbursement must be submitted by the local CDSA before parents can be reimbursed by the Winston-Salem CDSA.
- The Winston-Salem CDSA will provide reimbursement to family members for respite and transportation expenses within two weeks of receiving authorization and approval from CDSAs.
- Rates for these services are determined by the Early Intervention Section, Division of Child and Family Well-Being.

- The amount reimbursed to each family is determined based upon a sliding scale applied to the standardized rate for each authorized reimbursement transaction to families. The sliding scale is based upon family size and income.
- Transportation reimbursement is based on travel reimbursement rates for state employees. Other types of authorized transportation (bus fare, taxi fares) require a receipt and the sliding scale will be applied to the total amount of the receipt.

Transportation Requirements

Transportation and related costs include the cost of travel (e.g., mileage reimbursement, or travel by taxi, common carrier, or other means) and other costs (e.g. tolls and parking expenses) that are necessary to enable a child eligible under the NC Infant-Toddler Program and the child's family to receive early intervention services.

1. Transportation must be listed on the Individualized Family Service Plan and clearly indicate the provision of transportation (who, when, how, costs, etc.).
2. The Early Intervention Service Coordinator (EISC) authorizes and invoices reimbursement for transportation specific to the child using the *NC ITP Transportation Reimbursement Authorization* & *Invoice* form.
   a. This form is completed monthly.
   b. The EISC completes Sections 1 & 2 of the form for approval by the CDSA Business Officer prior to the provision of service.
   c. The EISC then forwards a copy of the form to the family.
   d. The family completes Section 3 and submits the completed form and receipts, as appropriate, to their EISC at the appropriate CDSA.
   e. EISC submits the completed form to the CDSA Business Officer.
   f. The CDSA Business Officer completes Section 4 and mails the form with an original signature to the payment source (Winston-Salem CDSA). A copy is provided to the EISC for the child's chart and a copy is retained in the reimbursement file.
   g. The EISC is responsible for maintaining and updating the form as needed.
   h. Instructions for completing each section of the form are specified on page 2 of the form.

Respite Requirements

Respite Services are time-limited, intermittent family supports that enable parents to participate in or receive other early intervention services in order to meet the outcomes on the child's and family's Individualized Family Service Plan. Examples include the parent participating in sign language classes in order to assist the child in developing communication skills, meeting with a psychologist to design appropriate behavioral management strategies when the child is exhibiting inappropriate behavior, attending Individualized Family Service Plan meetings and reviews, and obtaining counseling or psychological services for himself.

1. Respite services must be listed on the Individualized Family Service Plan and linked to a specific outcome for the child or family. As with all Infant-Toddler Program services, the Individualized Family Service Plan team must consider the use of natural supports to meet the respite needs of the child

and family. Infant-Toddler Program funds for respite will be used only when there is no other resource for this service.

2. Reimbursement for respite is limited to thirty-two (32) hours per year. The year begins the first time respite is listed on the Individualized Family Service Plan.
3. The EISC authorizes and invoices reimbursement for respite using the *NC ITP Respite Reimbursement Authorization* & *Invoice* form.
   a. This form is completed monthly.
   b. The EISC completes Section 1 & 2 for approval by the CDSA Business Officer prior to the provision of respite.
   c. The EISC signature in Section 2 indicates review of the information to ensure it corresponds to the current IFSP and family's Sliding Fee Scale percentage.
   d. The CDSA Business Officer completes Section 2, keeping a copy for the reimbursement file and returning the original to the EISC for the child's record.
   e. The EISC then forwards a copy of the form to the family and reviews the directions with them for completing Section 3. The parent selects a respite provider and arranges for the delivery of respite.
   f. The family completes Section 3 after receiving respite and submits the form to their EISC at the appropriate CDSA.
   g. The EISC submits the invoice to the CDSA Business Officer.
   h. The CDSA Business Officer completes Section 4, mailing the form with original signature to the payment source (Winston-Salem CDSA). A copy is forwarded to the EISC for the child's records and a copy is retained in the reimbursement file.
   i. The EISC is responsible for maintaining and updating the form as needed.
   j. Instructions for completing each section of the form are specified on page 2 of the form.

General Guidance for NC Infant-Toddler Program Payments

Overview

NC Tracks is the authorization and payment system used by all state-operated Children's Developmental Services Agencies (CDSAs) as the mechanism for reimbursing enrolled Infant-Toddler Program (ITP) Providers for services rendered. NC Tracks processes are governed by CHAPTER 45 - GENERAL PROCEDURES FOR PUBLIC HEALTH PROGRAMS, SUBCHAPTER 45A - PAYMENT PROGRAMS, SECTION .0100 – GENERAL PROVISIONS state statutes. Services are authorized by the CDSA for children in the North Carolina Infant-Toddler Program (ITP) who are not eligible for Medicaid and for services not covered by Medicaid. Services that are currently covered by the program through NC Tracks include physical therapy services, occupational therapy services, speech and language therapy services, community based rehabilitative services (CBRS), audiology, and case consultation and education services (CC&E) and other required ITP services. CDSAs have entered into formal service agreements with qualified providers of the

above services to assure that all the services listed on the child's Individualized Family Service Plan (IFSP) are provided expeditiously to children in the Infant-Toddler Program within the required timelines.

The Early Intervention Service Coordinator (EISC) is the individual responsible for completing each ITP Prior Authorization Request Form, hereinafter referred to as "the authorization form," and submitting them to be entered in NC Tracks. In the Infant-Toddler Program, services are officially and legally authorized at the IFSP meeting. The authorization form is the tool used to convey what has been duly authorized on the IFSP to the NC Tracks system in a quantitative manner. Each completed authorization form establishes the mechanism for designated ITP Providers to be reimbursed for services rendered. Once an approval has been generated by the NC Tracks system, the ITP Provider then enters the claims into NC Tracks for payment of services rendered.

Basic Authorization and Payment Flow

- Once the IFSP meeting has been held, the EISC is responsible for promptly completing an authorization form for each service covered by ITP and listed on the IFSP. (CC&E is the only authorized service that is not written on the IFSP, but still requires a completed authorization form.)
- No Authorization will be given for services not listed on the IFSP, except for CC&E, and not originated by the EISC.
- If a specialized therapy service is listed on the child's IFSP, the provider of the service is responsible for obtaining any prior approval required by private insurance. *(See Processing Authorizations section in this document for more detail).*
- A separate authorization form must be completed for each distinct covered service. Each authorization is then submitted for data entry into the NC Tracks system.
- If the authorization is complete and accurate, it is entered in NC Tracks.
- The CDSA will keep the original copy of the approved authorization in the client's chart. ITP Providers should not wait to receive the approval before beginning the service, as this may cause undue and unnecessary delays in the provision of services. It is important to remember that the IFSP is the official, legal authorization for all ITP services.
- In general, if a child has insurance coverage and billing to the insurance can occur per parent permission, ITP Providers are required to bill private insurance prior to billing the ITP program through NC Tracks and prior to billing families who are responsible for out-of-pocket fees for chargeable services. The basic sequence of events for ITP Providers is as follows:

  1. The authorized service is provided;
  2. Insurance is billed (with parent permission);
  3. Insurance responds with payment or denial;
  4. The ITP Provider may then bill the family (as applicable) and the NC ITP, following all procedures outlined in the North Carolina ITP Manual (See Fees, Billing and Reimbursement Policy).

     ITP Providers must bill family in a timely manner with consideration of insurance payment or denial.
  5. With the other payer information submitted as part of the claim, NC Tracks then calculates the amount due to the provider, based on the ITP Reimbursement Rate, less any applicable parent

fees due, based on the family's sliding fee percentage assigned by the CDSA.

- ITP Providers submit their claims directly through the NC Tracks Provider Portal for payment.
- Based on the information entered from the ITP Prior Authorization Request, NC Tracks will process the claim by either reimbursing the provider, or by denying payment because of improper submission, omission, or error. Claims that are not completed properly are denied.
- ITP Providers are responsible for the collection of any applicable fees from the family. The ITP is not authorized to pay providers for any uncollected fees.
- The enrolled provider should follow their established collection policy, which must be in line with all ITP policies and the CDSA Fee Collection Policy (see page 37), when attempting to collect fees owed by the family. Once services have been discontinued due to nonpayment, or the family is no longer enrolled in the program, the ITP enrolled provider should follow their own procedures related to debt collection.

Completing ITP Prior Authorization Requests

EISCs are strongly encouraged to enter information electronically, both to save time and paper, as well as to ensure legibility on authorization forms.

Processing Authorizations: All authorization forms must be routed through the CDSA Business Office for approval prior to entry into NC Tracks.

Turnaround time for entry of authorizations into NC Tracks is set by each individual CDSA. When the authorization submitted for entry into NC Tracks is complete, legible, and correct, the service is approved, the information is authorized, and confirmation numbers are generated by the system in real time. Again, ITP Providers should not wait to receive an approved authorization before starting services for the child.

It is paramount that EISCs remember to check with families for the child's Medicaid status as well as insurance coverage on a regular basis. Authorization forms submitted for entry into NC Tracks for a service covered by Medicaid for a child found to be eligible for Medicaid will generate a denial.

EISCs should take special care to assure that all authorization forms are properly completed to prevent unnecessary delays in the authorization process, which may subsequently require corrective paperwork and cause delays for the provider in being reimbursed.

Authorization forms must be submitted separately by service authorized by provider.

Case Consultation and Education (CC&E) Case Consultation and Education is a service reimbursable to professional-level staff who are certified as Infant-Toddler-Family (ITF) Specialists or licensed practitioners, such as physical, occupational, speech and language therapists. This service applies to children from birth to three years old and their families who have been determined eligible for the North Carolina Infant-toddler Program. It is a child-specific service and is limited to early intervention activities that are not covered by Medicaid and other health insurance plans, unless otherwise specified (see bullet number three). CC&E includes elements that are most valued by early intervention practitioners - supporting the provision of services in the child's natural environment, encouraging participatory service planning for the child, and promoting collaboration with other service providers to help a child meet the goals on the IFSP. All CC&E services must be authorized by the CDSA for enrolled ITP Providers to be reimbursed. CC&E services and supporting documentation will be monitored on an ongoing basis by the CDSA to ensure compliance.

- Participation in IFSP meetings, including transition planning meetings. This service includes assisting the parent and EI Service Coordinator in goal-setting and determining outcomes, discussing service needs, and making recommendations in the planning process. This is a time-based service, billable to the CDSA (in 15-minute increments) for the time spent participating in the meeting. This service must be provided face-to-face with the family of the child, the Service Coordinator, and with other service providers as appropriate.
- Consultation and collaboration with families and service providers regarding the child and family's needs. This service includes time spent by the ITP Provider in consultation with parents, the EI Service Coordinator, and other service providers, focusing on the needs of the child and family. This service encompasses consultation and collaboration that is outside the scope of any unit cost covered services. This is a time-based service, billable to the CDSA (in 15-minute increments) for the time spent providing this service. This service must be provided face-to-face with the child, family, collateral, and/or other service providers.
- Initiation of a therapy service or completion of a discipline-specific assessment by an ITP Provider at the request of the CDSA, when there has been a delay in obtaining prior 3rd party authorization or a service order. These services encompass a one-time intervention or assessment activity that has been recommended by the IFSP team, but, which is not reimbursable to the provider via Medicaid or private insurance, as authorization has not yet been obtained. This is a time-based service, billable to the CDSA (in 15-minute increments) for
- the time spent providing this service. This service must be provided face-to-face with the child and family. It is preferable, but not required, for the service coordinator to be present. Use of CC&E for this purpose should be infrequent and only as a last resort to ensure compliance and/or timely service delivery to a child.
- Assistive Technology activities not otherwise covered by Medicaid. This service includes face-to face time with collateral (not child) and/or other involved service providers by licensed PT/OT/SLP/Audiologists, CSHS-rostered staff, educators, and staff privileged to provide special instruction in investigating proper devices and procuring specialized equipment for a child. This would include choosing the appropriate equipment and securing funding for AT devices, creating, adapting, and programming AT devices to meet the needs of the child. This is a time-based service, billable to the CDSA (in 15-minute increments) for the time spent performing the service.
- Nutrition Services (not otherwise covered by Medicaid). This service includes face-to-face time with collateral (not child) and/or other involved service providers by a licensed nutritionist securing equipment, supplements, or funding to support the nutritional needs of a child. This would include working with providers and WIC to obtain specialized formulas for families, as well as obtaining special feeding equipment. This is a time-based service, billable to the CDSA for the time spent (in 15-minute increments) performing the service.

Reimbursement: Reimbursement will be provided to the enrolled ITP Provider through a claim entered in NC Tracks.

- Face-to-face time with child, parent, collateral, or other provider is required.
- One unit = $ 20.69 per 15 minutes, with a maximum authorization limit of 16 units (4 hours) per child, per individual ITP provider discipline, per authorization period.

Documentation and Claims Processing:

- CC&E is authorized by the CDSA through invitation to and participation in IFSP meetings or approved delivery of a service. Authorization for CC&E will be submitted to NC Tracks by the state-operated CDSA within ten days of the provider's attendance at the IFSP meeting or provision of an approved service.
- To receive payment, the ITP Provider must submit all claims for CC&E to NC Tracks at the end of each month, but no later than the 10th of the following month. The assigned code for CC&E will be CCE. Contract CDSAs will implement similar procedures at their sites.
- CC&E documentation for provider participation in IFSP meetings is captured by EI Service Coordinator's documentation of attendance in the service record.
- CC&E documentation for provider provision of an approved service is documented by the provider's progress/billing note.

Limitations: Maximum Allowable CC&E Reimbursement:

- CC&E is limited to a maximum allowable reimbursement per child, per ITP Provider discipline, per authorization period (based on the 6-month IFSP cycle) for CC&E.
- This maximum is four (4) hours or sixteen (16), 15-minute units per child, per ITP Provider discipline, per authorization period.
- In rare circumstances and depending on the needs of the child/family, if the need for CC&E reimbursement is greater than the maximum amount authorized, then the ITP Provider may submit a written request to the CDSA, outlining the need for the increased time, along with the number of additional units requested. The CDSA will make the final decision in approving or denying the requested additional hours of CC&E services, based on the rationale and justification provided by the ITP Provider, and depending on the availability of funds. The ITP Provider will be notified of the decision within 14 days of the CDSA's receipt of the request for additional coverage. If approved, authorization will then be sent to NC Tracks by the CDSA.

Claims Processing

Each CDSA has a unique identification number in NC Tracks associated with each approved ITP Prior Authorization. ITP Provider claims paid against prior authorizations automatically link the claims payments to the authorizing CDSA center (52xx). Payments are based on Medicaid's reimbursement rates.

Billing Insurance and Parent Fees: All ITP Providers are responsible for filing, following up on, and collecting insurance payments (with written parental consent), as well as collecting any applicable fees from the family for services provided. If the family is subject to private pay, the ITP Provider may bill the family for chargeable services after insurance has paid (or denied payment), based on the assigned sliding fee scale percentage applied to the ITP Reimbursement Rate Schedule, which is the base rate for all family fees. ITP Providers are responsible for following all the policies and procedures outlined in NC ITP's *Fees, Billing & Reimbursement* policy.

There are only three exceptions to the requirement of ITP Providers having to file insurance prior to submitting claims through NC Tracks for payment:

- Filing with private insurance for CBRS services is not required.
- Family would not allow their insurance to be billed; and

- CC&E claims.

ITP Providers must enter the amount paid by the insurance company when entering claims and be able to provide a copy of the EOB if/when requested. Providers should never enter parent fees collected. NC Tracks will calculate the payment due to the provider, if any, based on the insurance payments received by the provider, assigned base rate (lower of Medicaid rate or insurance), and the assigned sliding fee scale percentage applied to chargeable services on the ITP Reimbursement Rate Schedule to prevent overpayment to the ITP Provider. If the insurance plan covers the service, payment by the insurance plan and any assigned family charge is considered payment in full. The defined assigned family charge would be subject to the family SFS percentage. Medicaid rate is the established base rate when:

- Client does not have private insurance coverage
- Insurance denial due to out of network status
- Insurance has reached maximum benefits (service no longer covered)
- Insurance contractual rate is higher than Medicaid rate

ITP claims must be received within one year after the date of service. However, ITP Providers should routinely submit their claims after the service was rendered, or as soon as possible after they receive payment or denial from a child's insurance company and subsequently bill parent fees in a timely manner. Unnecessary late claims submission causes significant budgeting, fiscal planning, and tracking problems for the CDSAs, and it is crucial that ITP Providers submit all claims in a timely manner. Corrected claims or payment adjustments must be received within 1 year after date of service.

NC Tracks Reports

There are several NC Tracks reports that are available to CDSA Business Officers and other designated staff. These reports are available in NC Tracks Operations portal (Report2Web) and XTND to assist CDSAs in managing funds, projecting expenditures, analyzing encumbrances, and monitor ITP Providers claims payments. The reports are created weekly after each checkwrite approval for the DPH programs.

NC Tracks Report2Web General Reports

- NCAS Expenditures Report FR 181-R0010
- Payment Activity Controls Total Report FR 33400-R0040

NC Tracks Report2Web Check Cycle Report

- Check Register - FR88200-R140
- Final MMIS Payment Register - FR 33400-R0010 EFT's
- Final MMIS Payment Register - FR 33400-R0010 Checks
- NCAS Claims Interface Expenditures Reports – FR18110-R0010

XTND Interface Reports

- DHRWHA SIM DPH NCTRK CHECK WR WK - Weekly Check Interface
- DHRWHA SIM DPH NCHK N-CHECK WK – Weekly Non-Check Interface
- DHRWHA NSIM DPH NCTRK CHECK WKLY – Weekly Check Interface

General Guidance for the CDSA Provider Agreement

Overview

The CDSA is the primary provider of eligibility determination services and targeted case management services for the catchment area and will continually rely upon Infant Toddler Program Providers (ITP Providers) in the community to deliver direct community-based services through agreements and referrals. ITP Providers may include public or government agencies, for profit and not for profit corporations, independent practitioners, and sole proprietors.

The CDSA Provider Agreement is the agreement used with CDSA-approved providers who provide Early Intervention services to children in the NC Infant-Toddler Program. CDSAs enter into formal provider agreements with qualified providers of required Early Intervention services in order to assure that services listed on the Individualized Family Service Plan (IFSP) are provided expeditiously in a manner that is developmentally appropriate and consistent with the family's routines and priorities.

Service Providers

The Children's Developmental Services Agencies are responsible for recruiting and enrolling through written agreement qualified public or government agencies, for profit and not for profit corporations, independent practitioners, and sole proprietors as Infant-Toddler Program service providers. The Children's Developmental Services Agency determines if a service provider meets the qualifications to be an Infant-Toddler Program Provider. The Enrolled ITP Provider status is effective for one (1) year with two optional renewals based on the service provider's continued good standing. At the end of the third year, the service provider must resubmit the appropriate documentation to the Children's Developmental Services Agency for renewal of qualified status. (Providers who enter into a written service provider agreement with the Children's Developmental Services Agency are also designated in the local directory as an Enrolled Infant-Toddler Program Provider.) Only enrolled service providers will be recommended to parents for the delivery of Infant-Toddler Program services.

Process for Enrolling Providers of Early Intervention Services

Upon making contact with the CDSA, the potential provider will be given information about the qualification and application process. Once the CDSA approves the potential provider as a qualified applicant, the provider may proceed with application. The application paperwork includes: Provider Agreement, Attachment 1, and accompanying documentation.

Once the CDSA determines the application paperwork is complete and sufficient, the provider and CDSA will review and sign the **ITP Provider Agreement**, **Local ITP Services Plan/Agreement Amendment Form**, and any applicable certifications. The **ITP Provider Agreement Attachment** contains the rights and responsibilities of the CDSA, the rights and responsibilities of the ITP Provider, and the assurances of both parties. Providers also are expected to read and refer to the **Infant Toddler Program Policies and Procedures** (www.beearly.nc.gov) for information and guidance.

If the provider is currently providing services through a Provider Agreement with another CDSA, the potential CDSA should contact the current CDSA to obtain a copy of the Provider's application. In this case,

the Provider only needs to submit a Signature Warranty, Local ITP Services Plan/Agreement Amendment Form and ITP Provider Roster with accompanying documentation to the CDSA to which the provider is applying.

Continuing Enrollment of Providers of Early Intervention Services

Once a provider is qualified by a CDSA, the provider maintains the qualified status for three years unless their Provider Agreement is terminated by a CDSA due to non-compliance. If a Provider remains in good standing throughout the first year, the CDSA will invite the Provider to continue the Provider Agreement for another year through an Agreement Amendment. A Provider in good standing can continue the Provider Agreement through amendment for two consecutive years to complete a three-year cycle as an ITP Provider. Once this three-year cycle concludes, the Provider must complete the entire qualification and application process, as they did when they first became providers with a CDSA.

The annual amendment is done by completing the **Local ITP Services Plan/Agreement Amendment Form**. The **Change Request Form** should also be completed if contact or Provider Roster information needs to be updated at the time of the amendment. In this case, appropriate accompanying documentation should accompany the **Change Request Form**.

Once the Provider Agreement has lapsed or terminated, the Provider may not bill for any ITP services.

Resolving Compliance Issues

When an ITP Provider enters into the Provider Agreement with the CDSA, both parties and their representatives are expected to understand and carry out the terms and conditions of the Agreement. First and foremost, CDSAs and ITP Providers should work together in developing good relationships and implement practices that will prevent the occurrence of non-compliance on the part of both parties.

In order to fulfill lead agency responsibilities and monitoring requirements for the Infant-Toddler Program, CDSAs are charged with assuring that the terms and conditions of this Agreement are carried out by the ITP Providers in their catchment area. If there are concerns that the Provider is not following ITP policy and/or Provider Agreement assurances, CDSAs should refer to the current Provider Agreement and contact the Early Intervention Branch Operations Unit.

ITP Providers should follow the steps of the Dispute Resolution Policy (www.ncdhhs.gov/itp-beearly) if they have concerns about the CDSA meeting its obligation to the provider or if they disagree with a non-compliance issue identified by the CDSA.

Contact Information

CDSAs should contact the Early Intervention Section Operations Unit for questions related to the Provider Agreement process and implementation. CDSAs should contact the Early Intervention Section Quality Improvement Unit for questions and requests for technical assistance and support related to State Performance Plan compliance or performance indicators.

Helpful Resources

North Carolina Infant-Toddler Program Policies and Procedural Guidance:
https://www.ncdhhs.gov/divisions/child-and-family-well-being/north-carolina-infant-toddler-program-nc-itp/nc-itp-staff

North Carolina Infant-Toddler Program Forms with Instructions:
https://www.ncdhhs.gov/divisions/child-and-family-well-being/north-carolina-infant-toddler-program-nc-itp/nc-itp-staff/forms-publications

NC Tracks Billing Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

DMA July 2005 Special Medicaid Bulletin on TCM:
https://files.nc.gov/ncdma/documents/Providers/Bulletins/
archives/2005/0705_SpecBull_DDTargetedC aseMgmt.pdf

DMA April 2008 Special Bulletin on Early and Periodic Screening and Diagnostic Testing (EPSDT):
https://files.nc.gov/ncdma/documents/files/epsdtpolicyinstructions.pdf

DMA Dietary Evaluation and Counseling Clinical Coverage Policy # 1I:
https://files.nc.gov/ncdma/documents/files/1-I_1.pdf

DMA Physical Rehabilitation Equipment and Supplies Clinical Coverage Policy #5A:
DMA May 2008 Special Medicaid Bulletin on NP I :
https://files.nc.gov/ncdma/documents/files/5A-1_1.pdf

DMA Orthotics and Prosthetics Clinical Coverage Policy #5B:
https://files.nc.gov/ncdma/documents/files/5B_1.pdf

DMA Hearing Aid Services Clinical Coverage Policy #7:
https://files.nc.gov/ncdma/documents/files/7.pdf

NC Medicaid CDSA Clinical Coverage Policy #8J:
https://files.nc.gov/ncdma/documents/files/8-J.pdf

NC Medicaid Outpatient Specialized Therapies Clinical Coverage Policy #10A
https://files.nc.gov/ncdma/documents/files/10A_9.pdf

DMA Independent Practitioner Clinical Coverage Policy #10B:
https://files.nc.gov/ncdma/documents/files/10-B_0.pdf

DHB Provider Library:
https://medicaid.ncdhhs.gov/providers/medicaid-bulletins
https://files.nc.gov/ncdma/documents/Providers/Bulletins/archives/2008/0508SpecBull.pdf