RHODE ISLAND MEDICAL ASSISTANCE CLAIMING REIMBURSEMENT GUIDEBOOK for

EARLY INTERVENTION SERVICES

September 2008

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I. INTRODUCTION AND BACKGROUND

I.1 Purpose of This Claiming Guide

This *Rhode Island Medicaid Assistance Claiming Reimbursement Guidebook for Early Intervention Services,* developed by the Rhode Island Department of Human Services (DHS), contains information to assist State-certified Early Intervention (EI) providers and specialty providers in Rhode Island with EI direct services claiming. This Guide is intended for all EI and specialty provider staff. DHS may provide additional information for this Guide in the future.

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I.2 Medicaid

Medicaid is a Federal/State assistance program established in 1965 as Title XIX of the Social Security Act. State Medicaid programs are overseen by the Centers for Medicare and Medicaid Services (CMS) within the U.S. Department of Health and Human Services. State Medicaid programs are jointly funded by the Federal and State governments and are administered by each individual State to assist in the provision of medical care to income eligible children and pregnant women, and to eligible individuals who are aged, blind, or disabled. Medicaid programs pay for services identified in a plan, called the Medicaid State Plan, some of which are mandated by the Federal government and others that are optional and determined to be covered by each State.

Medicaid recipients usually pay no part of the cost of covered medical expenses, although recipient cost-sharing is sometimes required. Medicaid eligibility is limited to individuals who fall into specified categories. The Social Security Act identifies over 25 different eligibility categories for which Federal funds are available. These categories can be classified into five broad coverage groups:

- Children
- Pregnant women
- Adults in families with dependent children
- Individuals with disabilities
- Individuals 65 and over

For more information on Medicaid, please refer to www.cms.hhs.gov/medicaid .

I.3 Medical Assistance in Rhode Island

Medical Assistance in Rhode Island is administered by the Rhode Island Department of Human Services (DHS), following authorization from the Rhode Island General Assembly.

Families and children in Rhode Island may become eligible for Medicaid by applying to DHS for coverage through the following: RIte Care, RIte Share, Supplemental Security Income (SSI), Katie Beckett, Adoption Subsidy and the Mental Retardation/Developmental Disability (MR/DD) Waiver. The majority of children covered by Rhode Island Medicaid are enrolled in a managed care program through RIte Care. Most children with special health care needs (CSHCN) receive their coverage through eligibility from SSI, Katie Beckett, Adoption Subsidy, or the Mental Retardation/Developmental Disability (MR/DD) Waiver.

Starting in September 2003, families whose children are eligible for Medicaid through SSI, Katie Beckett, Substitute Care or Adoption Subsidy *and* who do not have other insurance coverage have the choice of enrolling in a RIte Care Health Plan or fee-for-service Medicaid. Children with Special Health Care Needs are enrolled in RIte Care with Neighborhood Health Plan of Rhode Island. Those children who are eligible through SSI, Katie Beckett or Adoption Subsidy and who have other insurance coverage remain in fee-for-service Medicaid, which is secondary to their commercial insurance.

EI services provided to children enrolled in RIte Care, whether or not they are children with special health care needs, are billed directly to the RIte Care Health Plans. EI services provided to children enrolled in RIte Share are billed directly to the insurer. If the insurer appropriately denies the EI provider's claim for reimbursement, the EI provider may seek reimbursement by DHS for services by submitting a claim to the Medicaid fiscal agent for Rhode Island, EDS. (Please see Attachment E.) EI services provided to children in Medicaid fee-for-service are billed directly to EDS.

EI and specialty provider staff may assist families with applications for Medical Assistance (MA). As Medicaid benefits for children are identical regardless of the basis for their Medicaid eligibility, the following are broad guidelines to use when helping a family apply for MA:

- **RIte Care** – Eligibility is based on family income. Refer by calling 462-5300 or by calling the local DHS offices or download an application for RIte Care from the DHS web site at www.dhs.ri.gov

- **RIte Share** – Families, whose income falls within certain Federal guidelines that have access to employer-sponsored insurance (ESI), may be eligible for RIte Share. For more information call the RIte Share line at 462-0311.

- **SSI –** Eligibility is based on the child's disability *and* the family's income. Refer to the Social Security Administration (SSA) by calling 1-800-772-1213, by contacting a local SSA office or by accessing the Social Security web site at www.socialsecurity.gov

- **Katie Beckett –** Three elements are considered when determining if a child age birth to 18 years old is eligible for Katie Beckett. These are (1) a disability determination, (2) a level of care determination and (3) the child's income and resources. Refer to the DHS website at www.dhs.ri.gov for an application.

I.4 The Role of Early Intervention

Section 631 of Part C of the Individuals with Disabilities Act (IDEA, or 20 USC 1431 *et. seq.*) provides formula grants to States and territories to assist in maintaining and implementing statewide systems of coordinated, comprehensive, multidisciplinary, interagency programs of Early Intervention (EI) services for infants and toddlers up to age three with disabilities and their families.

In Rhode Island, the EI system is designed to meet the needs of infants and toddlers eligible for EI and their families, as early as possible. The purpose of the EI system is to support families' capacity to enhance the growth and development of children birth to 36 months who have developmental challenges. Eligible children may have certain diagnosed conditions, delays in their development, or be experiencing circumstances, which are likely to result in significant developmental problems, particularly without intervention.

EI services are designed to serve children younger than three years of age who are experiencing developmental delays in one or more of the following areas: cognitive, physical, communicative, social/emotional or adaptive development skills.

Certified EI providers must ensure that families have access to the services required by IDEA, when such services are identified within the context of the child's Individual Family Service Plan (IFSP). The services required by IDEA include the following: assistive technology device, assistive technology service, audiology, family training/counseling/home visits, health services, medical services only for diagnostic or evaluation purposes, nursing services, nutrition services, occupational therapy, physical therapy, psychological services, service coordination services, social work services, special instruction, speech-language pathology, transportation and related costs, and vision services.

I.5 Medicaid the Payer of Last Resort

Under Medicaid law and regulations, Medicaid is generally the payer of last resort. A third party – any individual, entity or program – may be liable to pay all or part of the costs for medical assistance for Medicaid-covered services. The U.S. Congress intended that Medicaid pay for health care only after a beneficiary's other health care resources were accessed.[1] Even though services provided through IDEA are exempt from the free care principle, EI providers must

[1] Health Care Financing Administration. *Medicaid and School Health*, 1997.

comply with third-party liability (TPL) policies. What this means for EI providers in Rhode Island is they must submit a claim to a third-party insurer other than Medicaid if there is one available. If the provider receives an appropriate denial of payment from the third-party insurer for the claim, then the provider can submit a claim to Rhode Island Medical Assistance for payment. There are some exceptions to the provisions of Medicaid as the payer of last resort that allows Medicaid to be the primary payer to another Federal or Federally funded program and these include Medicaid-covered services listed on a Medicaid eligible child's IFSP. Medicaid will pay primary to IDEA.[2]

Federal regulatory requirements for TPL are explicated in Subpart D of 42 CFR 433. It should be noted that Section 433.139 (c) provides: "If the probable existence of third party liability cannot be established or third party benefits are not available to pay the recipient's medical expenses at the time the claim if filed, the agency must pay the full amount allowed under the agency's payment schedule."

As Addendum A shows, insurers in the State of Rhode Island must cover EI services up to $5,000 annually; such coverage may not be subject to deductibles or coinsurance requirements. Addendum B lists the insurer contacts, with which EI providers may deal concerning participation and other matters. Addendum C describes the process for resolving disputes and complaints with the insurers. These commercial insurance-related policies, procedures, and materials are provided as a courtesy for EI providers. EI providers should contact the insurers directly for the most up-to-date policies, procedures, and materials.

I.6 EI Provider Participation Requirements for Rhode Island Medical Assistance

In order to participate in Rhode Island Medical Assistance, EI providers must meet two basic requirements. First, EI providers must be certified by the State according to the *Early Intervention Certification Standards – September 1, 2005*. These certification standards may be found at:

http://www.dhs.state.ri.us/dhs/famchild/ei_forms/ei_cert_standards05.pdf

Second, providers must have a participation agreement with the Rhode Island Medical Assistance fiscal agent, EDS, and meet other requirements established by EDS. Addenda D and E describe these requirements.

[2] *Ibid.*

I.7 Early Intervention Medicaid Reimbursable Services

EI providers may submit claims for the following EI services provided:

- Assistive Technology (Device and Services)
- Audiology
- Family Training/Counseling
- Health Services
- Medical Services (Diagnosis and Evaluation)
- Nursing Services
- Nutrition Services
- Occupational Therapy
- Physical Therapy
- Psychological Services
- Service Coordination Services
- Social Work Services
- Special Instruction
- Speech-Language Pathology
- Transportation
- Translator/Interpreter
- Vision Services
- Other Services – Developmental Monitoring Services
- Other Services – Evaluation Assessment and Plan Development
- Other Services – Supervisory/Managerial Codes
- Other Services – Training and Development

The subsequent chapters of this Guide describe each of these services in terms of:

- IDEA definition
- Billable activities
- Current Procedural Terminology (CPT) definition
- Notes

Addendum B provides a concise summary of this information

It should be noted that it is the responsibility of the EI provider to collect and verify insurance coverage and to request reimbursement accordingly. The Services Rendered Form (SRF) is used to document all billable services (except file management) for a child. The IFSP indicates which services (by category) the child and family will receive. It is important that each service recorded on an IFSP match what is recorded and billed for on an SRF. For example, if Special Instruction is listed on the IFSP, then only one of the service codes listed under Special Instruction should be listed on the SRF.

Other guidelines for billing include the following:

- Maximum units of service are per day, unless otherwise noted.

- Only one claim per child per code (up to the maximum allowed) can be submitted for reimbursement per day. If a service is provided twice in one day for a child (e.g., service coordination) the sum is what should appear on the request for reimbursement. Two providers cannot bill for the same service for the same day for the same child, unless one is billed through a specialty provider.

- Individual child/family co-treatments are allowed when clinically appropriate. Documentation must support the services provided by each staff person.

- All services are covered prior to the child's 3rd birthday

- Minimum criteria for staff providing services are listed for each code. Please refer to the *Early Intervention Certification Standards* regarding personnel standards and definitions for service coordinators and qualified professionals.

- All Services Rendered Forms (SRFs) must be retained in the child's record. Complete records for Medicaid claiming purposes must be retained for seven (7) years according to State law.

- State law requires a child's private/commercial insurance to be billed first. Providers must submit claims to the appropriate insurance carrier based on the child's insurance. Denials and/or co-payments from insurance companies can then be submitted to EDS for reimbursement as the payer of last resort (See Addendum D).

- Prepaid services (such as parent consultant services) should be indicated on an SRF utilizing the code 990.

- All services must be identified on the Individual Family Service Plan (IFSP) or interim IFSP in order to submit claims for reimbursement, except those services which are not required to be identified on the IFSP including all codes with the Federal Category L, W, T, I, and Z (exception to this is one Z code-developmental monitoring, which should be identified on the IFSP as Other Service - Developmental Monitoring).

- Early Intervention is designed to provide services and supports to families and their children in their natural environments. For some children, it makes sense to provide services in a segregated setting for a period of time. If a service will not be provided in the natural setting the majority of the time, then a plan must be developed for providing the service in a natural environment, that must include: a statement of why the outcome cannot be achieved in the child's natural environment, a description of how the activities or strategies will be applied to the child's daily activities and routines and a detailed plan for moving the activities/strategies into the child's natural environment.

- "Placements" or "settings" are not reimbursable through Early Intervention. Staff must be present for the duration of the visit in order to be a reimbursable service.

Group Services:

- Groups are to be billed per child, not per staff member. Groups are considered a group if there are at least two (2) children in the group. (It is not considered a group if the only two children in the group are siblings) Reimbursement is only allowed for the children in attendance on that day.

- Considerations for Groups: IFSP teams should consider the individual outcomes for the child and family. If a group service makes sense, a location that is typical/natural for the family should be the first choice. If this is not possible, then the team must consider how the child will be able to carry over what he/she is learning in the group can be carried over to his/her natural setting. Who will provide support in the carryover, when will this be done, and how will this happen are considerations the team must make. The provision of special instruction within a setting is reimbursable, but tuition or fees for a placement or setting are not reimbursable.

II. ASSISTIVE TECHOLOGY (DEVICE AND SERVICES)

Service Description as defined in Sections 632(4) of IDEA 2004:

"Assistive technology device" means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, used to increase, maintain, or improve the functional capabilities of children with disabilities.

"Assistive technology service" means a service that directly assists a child with disabilities in the selection, acquisition or use of an assistive technology device, and includes:

- Evaluation of a child's needs, including a functional evaluation of the child in the child's customary environment
- Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by children with disabilities
- Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices
- Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitative plans and programs
- Training and technical assistance for a child with disabilities or, if appropriate the child's family
- Training and technical assistance for professionals (including individual providers of EI services) or other individuals who provide services to or are substantially involved in major life functions of individuals with disabilities

Billable Activities:

Procedure Codes listed below are for Assistive Technology (Device and Services)

Procedure Codes	Federal Category	Description	Unit of Service	Max Units	Rate	Minimum Criteria
97535	A	Assistive Technology Service	15 min	20	$ 25.74	Qualified Professional
T5999	A	Assistive Technology Device	N/A	1	As billed	As appropriate

Definition according to the American Association's 2006 Current Procedural Terminology (CPT) Professional Edition.

97535 Self-care/home management training (eg. 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.

Definition according to the MAG Mutual Healthcare Solutions, Inc.'s 2006 HCPCS Professional Edition

T5999 Supply, Not Otherwise Specified

Notes

- Assistive device should be entered on an IFSP (service page) in the following manner:
  Services: Assistive technology
  Provider: The person who will explain the device to the parent
  Location: N/A
  Method: I (assuming the device is for one child)
  Frequency: Once in 6 months
  Intensity:0
  Initiation Date: Date parent can expect to receive the device
  Duration: 6 months
  Timely Services Justification: Community Schedule

- Assistive device should be entered on a SRF and entered into the data system in the following manner:
  Provider: The person who will explain the device to the parent
  Services: T5999
  Location: N/A
  Minutes: 1 unit (= 15 min)
  Payer of Service: Child's insurance

- Services must be entered on the IFSP and on a SRF and entered into the data system as stated above. To be paid, providers must follow these guidelines and send the invoice and any other necessary paperwork to the Medicaid fiscal agent.

III. AUDIOLOGY

Service Description as defined in Sections 632(4) of IDEA 2004:

"Audiology" includes:

- Identification of children with audiological impairment using criteria and appropriate audiologic screening techniques;
- Determination of the range, nature, and degree of hearing loss and communication functions by use of audiological evaluation procedures;
- Referral for medical and other services necessary for habilitation or rehabilitation of children with auditory impairments;
- Provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training, and other services;
- Provision of services for prevention of hearing loss; and
- Determination of the child's need for individual amplification, including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating effectiveness of those devices.

Billable Activities:

Procedure Codes listed below are for Audiology Services

Procedure Codes	Federal Category	Description	Unit of Service	Max Units	Rate	Minimum Criteria
92557	B	Comprehensive audiometry threshold evaluation	30 min	3	$ 99.00	Licensed Audiologist
V5008	B	Hearing Screening	15 min	6	$ 30.89	Qualified Professional
V5010	B	Assessment for hearing aid	15 min	6	$ 30.89	Licensed Audiologist

Definition according to the American Association's 2006 Current Procedural Terminology (CPT) Professional Edition.

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

Definition according to the MAG Mutual Healthcare Solutions, Inc.'s 2006 HCPCS Professional Edition

V5008 Hearing Screening

V5010 Assessment for Hearing Aid

Notes

- Providers should only utilize the above codes when provider agency or contracted agency is providing this service. Service coordination of auditory services should be listed on the IFSP on page 13 and billed as Service Coordination [See Chapter XII].

IV. FAMILY TRAINING/ COUNSELING

Service Description as defined in Sections 632(4) of IDEA 2004:

"Family training" "counseling" and **"home visits"** means services provided, as appropriate, by social workers, psychologists, and other qualified personnel to assist the family of an eligible child in understanding the special needs of the child and enhancing the child's development.

Billable Activities:

Procedure Codes listed below are for Family Training/Counseling Services

Procedure Codes	Federal Category	Description	Unit of Service	Max Units	Rate	Minimum Criteria
96152	C	Developmental Intervention with Child	15 min	6	$ 30.89	Qualified Professional
96154	C	Developmental Intervention with Child and Family	15 min	6	$ 30.89	Qualified Professional
96155	C	Developmental Intervention with Family	15 min	6	$ 30.89	Qualified Professional
S9446	C	Developmental Intervention Group	15 min	6	$ 15.44	Service Coordinator

Definition according to the American Association's 2006 Current Procedural Terminology (CPT) Professional Edition.

96152 Health and behavior intervention, each 15 minutes, face-to-face; individual

96154 Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)

96155 Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)

Definition according to the MAG Mutual Healthcare Solutions, Inc.'s 2006 HCPCS Professional Edition

S9446 Patient Education, Not Otherwise Classified, Non-Physician Provider, Group, Per Session

Notes

- Developmental Intervention Group may be utilized to cover cost of sending family to a class/educational session, such as A Starting Point or Hanen. Bill appropriate amount of units to cover cost of the session. Setting for parent education is N/A. It may also be utilized for a parent and child group.

- Sign language and cued language training should be billed under family training/ counseling services.

V. HEALTH SERVICES

Service Description as defined in Sections 632(4) of IDEA 2004:

"Health Services" means services necessary to enable a child to benefit from other EI services during the time the child is receiving the other EI services. The term includes such services as clean, intermittent catheterization, tracheotomy care, tube feeding, the changing of dressings or colostomy collection bags and other health services; and consultation by physicians with other service providers concerning the special health care needs of eligible children that will need to be addressed in the course of providing other EI services.

The term does not include services that are:

- Surgical in nature (e.g., cleft palate repair, surgery for club foot or the shunting of hydrocephalus); or purely medical in nature (such as hospitalization for management of congenital heart ailments, or the prescribing of medicine or drugs for any purpose).

- Devices necessary to control or treat a medical condition.

- Medical health services (such as immunization and regular "well baby care") that are routinely recommended for all children.

Billable Activities:

Health Services are for the coordination of medical services necessary or required in order for the children to participate in the Early Intervention program. This area may overlap with other billable services, such as nursing or service coordination.

VI. MEDICAL SERVICES (DIAGNOSIS OR EVALUATION)

Service Description as defined in Sections 632(4) of IDEA 2004:

"Medical services only for diagnostic or evaluation purposes" means services provided by licensed physicians to determine a child's developmental status and need for EI services.

Billable Activities:

Procedure Codes listed below are for Medical Services (Diagnosis or evaluation)

Procedure Codes	Federal Category	Description	Unit of Service	Max Units	Rate	Minimum Criteria
90801	E	Psychiatric evaluation	50 min	1	$ 150.00	MD
99367	E	Medical Conference by a Physician	30 min	4	$ 36.04	MD

Definition according to the American Association's 2006 Current Procedural Terminology (CPT) Professional Edition.

90801 Psychiatric diagnostic interview examination

99367 Medical team conference with interdisciplinary team of health care professionals, with patient and/or family not present, 30 minutes or more, by a physician.

VII. NURSING SERVICES

Service Description as defined in Sections 632(4) of IDEA 2004:

"Nursing services" includes:

- Assessment of health status for the purpose of providing nursing care, including identification of patterns of human response to actual or potential health problems
- Provision of nursing care to prevent health problems, restore or improve functioning and promote optimal health and development
- Administration of medications, treatments, and regimens prescribed by a licensed physician

Billable Activities:

Procedure Codes listed below are for Nursing Services

Procedure Codes	Federal Category	Description	Unit of Service	Max Units	Rate	Minimum Criteria
T1002	F	RN services	15 min	6	$ 25.74	Licensed RN

Definition according to the MAG Mutual Healthcare Solutions, Inc.'s 2006 HCPCS Professional Edition

T1002 RN Services, Up to 15 Minutes

VIII. NUTRITION SERVICES

Service Description as defined in Sections 632(4) of IDEA 2004:

"Nutrition services" includes:

- Conducting individual assessments in: nutritional history and dietary intake; anthropometric, biochemical, and clinical variables; feeding skills and feeding problems; and food habits and food preferences
- Developing and monitoring appropriate plans to address nutritional needs of eligible children based on assessment finding
- Making referrals to appropriate community resources to carry out nutrition goals

Billable Activities:

Procedure Codes listed below are for Nutrition Services

Procedure Codes	Federal Category	Description	Unit of Service	Max Units	Rate	Minimum Criteria
S9470	G	Nutritional Counseling, dietitian visit	30 min	3	$ 51.48	Licensed Dietitian/ Nutritionist

Definition according to the MAG Mutual Healthcare Solutions, Inc.'s 2006 HCPCS Professional Edition

S9470 Nutritional Counseling, Dietitian Visit

IX. OCCUPATIONAL THERAPY

Service Description as defined in Sections 632(4) of IDEA 2004:

"Occupational therapy" includes services to address functional needs of a child related to: adaptive development, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings and include:

- Identification, assessment, and intervention
- Adaptation of the environment and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote acquisition of functional skills
- Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability

Billable Activities:

Procedure Codes listed below are for Occupational Therapy

Procedure Codes	Federal Category	Description	Unit of Service	Max Units	Rate	Minimum Criteria
97003	H1	Occupational Therapy Evaluation	30 min	3	$ 61.78	Licensed OT
97150 GO	H	Occupational Therapy Group	30 min	3	$ 30.89	Licensed OT
97150 GO HM	H	Occupational Therapy Group – COTA	30 min	3	$ 25.64	COTA
97530	H	Occupational Therapy	15 min	6	$ 30.89	Licensed OT
97530 HM	H	Occupational Therapy - COTA	15 min	6	$ 25.64	COTA

COTA= Certified Occupational Therapy Assistant

Definition according to the American Association's 2006 Current Procedural Terminology (CPT) Professional Edition.

97003	Occupational therapy evaluation
97150	Therapeutic procedure(s), group (2 or more individuals)
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes

Modifier Description(s)

GO	Outpatient Occupational Therapy Service
HM	Less than Bachelor's Degree Level

X. PHYSICAL THERAPY

Service Description as defined in Sections 632(4) of IDEA 2004:

"Physical therapy" includes services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. These services include:

- Screening, evaluation, and assessment of infants and toddlers to identify movement dysfunction
- Obtaining, interpreting, and integrating information appropriate to program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems
- Providing individual and group services or treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems

Billable Activities:

Procedure Codes listed below are for Physical Therapy

Procedure Codes	Federal Category	Description	Unit of Service	Max Units	Rate	Minimum Criteria
97001	J1	Physical Therapy Evaluation	30 min	3	$ 61.78	Licensed PT
97110	J	Physical Therapy	15 min	6	$ 30.89	Licensed PT
97110 HM	J	Physical Therapy – PTA	15 min	6	$ 25.64	Certified PTA
97150 GP	J	Physical Therapy Group	30 min	3	$ 30.89	Licensed PT
97150 GP HM	J	Physical Therapy Group - PTA	30 min	3	$ 25.64	Certified PTA

PTA= Physical Therapy Assistant

Definition according to the American Association's 2006 Current Procedural Terminology (CPT) Professional Edition.

97001	Physical therapy evaluation
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97150	Therapeutic procedure(s), group (2 or more individuals) (Group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one patient contact by the physician or therapist).

Modifier Description(s)

GP	Outpatient Physical Therapy Service
HM	Less than Bachelor's Degree Level

XI. PSYCHOLOGICAL SERVICES

Service Description as defined in Sections 632(4) of IDEA 2004:

"Psychological services" includes:

- Administering psychological and developmental tests and other assessment procedures
- Interpreting assessment results
- Obtaining, integrating, and interpreting information about child behavior and child and family conditions related to learning, mental health, and development
- Planning and managing a program of psychological services, including psychological counseling for children and parents, family counseling, consultation on child development, parent training, and education programs

Billable Activities:

Procedure Codes listed below are for Psychological Services

Procedure Codes	Federal Category	Description	Unit of Service	Max Units	Rate	Minimum Criteria
90802	K	Diagnostic interview	50 min	1	$ 130.00	* SEE BELOW
90810	K	Individual Psychotherapy	30 min	3	$ 73.74	* SEE BELOW
96111	K	Psychological Developmental Testing	60 min	5	$ 95.00	Psychologist

* Psychiatrist, Psychologist, Psychiatric Nurse, Marriage & Family Therapist (MFT), Licensed Independent Clinical Social Worker (LICSW), & Licensed Mental Health Counselor

Definition according to the American Association's 2006 Current Procedural Terminology (CPT) Professional Edition.

90802 Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication.

90810 Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
(For EI purposes – May also be provided in the home)

96111	Developmental testing**:** extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report.

XII. SERVICE COORDINATION SERVICES

Service Description as defined in Sections 632(4) of IDEA 2004:

"Service coordination services" means assistance and services provided by a service coordinator to an eligible child and child's family that is in addition to the functions and activities as specified in "service coordination"

"Service Coordination" means the activities carried out by a service coordinator to assist and enable a child eligible under Part C and the child's family to receive the rights, procedural safeguards, and services authorized under the State's Early Intervention System. Service coordination is an active, ongoing process that involves:

- Assisting parents of eligible children in gaining access to the EI services and other services identified in the individualized family service plan
- Coordinating the provision of EI services and other services (such as medical services for other than diagnostic and evaluation purposes) that the child needs or is being provided
- Facilitating the timely delivery of available services
- Continuously seeking the appropriate services and situations necessary to benefit the development of each child being served for the duration of the child's eligibility

Specific service coordination activities include:

- Coordinating the performance of evaluations and assessments
- Facilitating and participating in the development, review, and evaluation of individualized family service plans
- Assisting families in identifying available service providers
- Coordinating and monitoring the delivery of available services
- Informing families of the availability of advocacy services
- Coordinating with medical health provider
- Facilitating the development of a transition plan to preschool services, if appropriate

Each eligible child and the child's family must be provided with one service coordinator who is responsible for:

- Coordinating all services across agency lines
- Serving as the single point of contact in helping parents to obtain the services and assistance they need
- Service Coordinators may be employed or assigned in any way permitted under State law as long as it is consistent with Part C requirements. Service Coordinators must be persons
    - Trained and practicing in a profession most immediately relevant to the child's or family's needs (or who is otherwise qualified to carry out all applicable responsibilities), who will be responsible for the implementation of the IFSP and coordination with other agencies and persons
    - Professionals who have demonstrated knowledge and understanding about: eligible infants and toddlers; Part C of the Individual with Disabilities Education Act and the regulations; the nature and scope of services available under the State's Early Intervention System, the system of payments for those services and other pertinent information
    - The State's policy and procedures for implementation of EI services must be designed and implemented to ensure service coordinators are able to carry out the above listed functions and services on an interagency basis

Billable Activities:

Procedure Codes listed below are for Service Coordination Services

Procedure Codes	Federal Category	Description	Unit of Service	Max Units	Rate	Minimum Criteria
T1016	L	Case Management	15 min	8	$18.02	Service Coordinator
T1016 TG	W	Transition Planning	15 min	8	$25.74	Service Coordinator

Definition according to the MAG Mutual Healthcare Solutions, Inc.'s 2006 HCPCS Professional Edition

T1016 Case Management, each 15 minutes

Modifier Description(s)

TG Complex/High Tech Level of Care

Notes

- A service coordinator must be assigned to all families and is responsible for the implementation of the IFSP and coordination with other agencies and persons.
- Service Coordination should be provided to families as needed and is not required on the IFSP service page.
- Transition planning is part of Service Coordination and must be provided to all families. It is not required on the IFSP service page.

XIII. SOCIAL WORK SERVICES

Service Description as defined in Sections 632(4) of IDEA 2004:

"Social work services" includes:

- Making home visits to evaluate a child's living conditions and patterns of parent-child interactions
- Preparing a social or emotional developmental assessment of the child within the family context
- Providing individual and family-group counseling with parents and other family members, and appropriate social skill-building activities with the child and parents
- Working with those problems in a child's and family's living situation (home, community or any center where EI services are provided) that affect the child's maximum utilization of EI services
- Identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from EI services

Billable Activities:

Procedure Codes listed below are for Social Work Services

Procedure Codes	Federal Category	Description	Unit of Service	Max Units	Rate	Minimum Criteria
90806	M	Social work (individual)	50 min	1	$ 123.56	LICSW*
90847	M	Social work (family)	50 min	1	$ 123.56	LICSW*

** Licensed Independent Clinical Social Worker

Definition according to the American Association's 2006 Current Procedural Terminology (CPT) Professional Edition.

90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient (For EI purposes - May be provided in the home)
90847	Family psychotherapy (conjoint psychotherapy) (with patient present)

XIV. SPECIAL INSTRUCTION

Service Description as defined in Sections 632(4) of IDEA 2004:

"Special instruction" includes:

- The design of learning environments and activities that promotes the child's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction
- Curriculum planning, including the planned interaction of personnel, materials, and time and space, that leads to achieving the outcomes in the child's individualized family service plan
- Providing families with information, skills, and support related to enhancing skill development of the child
- Working with the child to enhance the child's development

Billable Activities:

Procedure Codes listed below are for Special Instruction Services

Procedure Codes	Federal Category	Description	Unit of Service	Max Units	Rate	Minimum Criteria
97150	NA	Center Development Rehabilitation Group	30 min	3	$30.89	Qualified Professional
T1026	NA	Center Development Group	60 min	2	$ 61.78	Service Coordinator
H2015	NA	Comprehensive Community Support	15 min	6	$ 25.74	Qualified Professional
H2015 HN	NA	Comprehensive Community Support	15 min	6	$ 18.02	Service Coordinator

Definition according to the American Association's 2006 Current Procedural Terminology (CPT) Professional Edition.

97150	Therapeutic procedure(s), group (2 or more individuals). (Group therapy procedures involve constant attendance of the physician or therapists, but by definition do not require one-on-one patient contact by the physician or therapist).

Definition according to the MAG Mutual Healthcare Solutions, Inc.'s 2006 HCPCS Professional Edition

H2015	Comprehensive Community Support Services, Per 15 minutes
T1026	Intensive, Extended Multidisciplinary Services Provided in a Clinic setting to Children with Complex Medical, Physical, Medical and Psychosocial Impairments, Per Hour

Modifier Description(s)

HN	Bachelor's Degree Level
HQ	Group Setting

XV. SPEECH-LANGUAGE PATHOLOGY

Service Description as defined in Sections 632(4) of IDEA 2004:

"Speech-language pathology" includes:

- Identification of children with communicative or oropharyngeal disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills
- Referral for medical or other professional services necessary for habilitation or rehabilitation of children with communicative or oropharyngeal disorders and delays in development of communication skills
- Sign language and cued language training
- Provision of services for the habilitation, rehabilitation or prevention of communicative or oropharyngeal disorders and delays in development of communication skills

Billable Activities:

Procedure Codes listed below are for Speech-Language Pathology Services

Procedure Codes	Federal Category	Description	Unit of Service	Max Units	Rate	Minimum Criteria
92506	O1	Speech Evaluation	30 min	3	$ 61.78	***Licensed SLP
92507	O	Speech Service	30 min	3	$ 61.78	***Licensed SLP
92507 HN	O	Speech Service – SLPA	30 min	3	$ 51.28	SLPA
92508	O	Speech Group	30 min	3	$ 30.89	***Licensed SLP
92508 HN	O	Speech Group – SLPA	30 min	3	$ 25.64	SLPA

*** Licensed Speech, Hearing and Language Pathologist

Definition according to the American Association's 2006 Current Procedural Terminology (CPT) Professional Edition.

92506	Evaluation of speech, language, voice, communication, and/or auditory processing.
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals

Modifier Description(s)

HN	Bachelors Degree Level

Notes

- Sign language and cued language training should be billed under family training/ counseling services (See Chapter IV].

XVI. TRANSPORTATION

Service Description as defined in Sections 632(4) of IDEA 2004:

"Transportation and related costs" includes the cost of travel (e.g., mileage, or travel by taxi, common carrier or other means) and other costs (e.g., tolls and parking expenses) necessary to enable an eligible child and the child's family to receive other EI services.

Billable Activities:

Procedure Codes listed below are for Transportation and related costs

Procedure Codes	Federal Category	Description	Unit of Service	Max Units	Rate	Minimum Criteria
T2004	T	Transportation	One way	2	$ 10.30	N/A

Definition according to the MAG Mutual Healthcare Solutions, Inc.'s 2006 HCPCS Professional Edition

T2004 Non-Emergency Transport. Commercial Carrier, Multi-Pass

Notes

- Transportation in order to obtain another EI service is available to all families as needed. This must be indicated on an SRF with accompanying service. It is not needed on the IFSP services page.
- This code may be utilized to cover the cost of travel (taxis, or other commercial method) for parent and child to attend EI services when no other method of transportation is available (including a bus pass). This code does not cover staff travel expenses.

XVII. TRANSLATOR/INTERPRETER

Translator/Interpreter service is a service to ensure that families are fully able to participate in service delivery, provide consent and understand procedural safeguards. Information must be communicated to parents and families in their native language or other mode of communication of the family of the eligible child.

Billable Activities:

Procedure Codes listed below are for Translator/Interpreter Services

Procedure Codes	Federal Category	Description	Unit of Service	Max Units	Rate	Minimum Criteria
T1013	I	Translator/Interpreter	15 min	20	$14.00	N/A

Definition according to the MAG Mutual Healthcare Solutions, Inc.'s 2006 HCPCS Professional Edition

T1013 Sign Language or Oral Interpretive Services, Per 15 Minutes

Notes

- Translator/Interpreter service is available to all families as needed. This must be indicated on an SRF with accompanying service for interpreter services or a clear description of the family specific material requiring translation services. These services are not required on the IFSP service page.

XVIII. VISION SERVICES

Service Description as defined in Sections 632(4) of IDEA 2004:

"Vision services" means:

- Evaluation and assessment of visual functioning, including diagnosis and appraisal of specific visual disorders, delays, and abilities
- Referral for medical or other professional services necessary for habilitation or rehabilitation of visual functioning disorders, or both
- Communication skills training, orientation and mobility training for all environments, visual training, independent living skills training, and additional training necessary to activate visual motor abilities

Billable Activities:

Procedure Codes listed below are for Vision Services

Procedure Codes	Federal Category	Description	Unit of Service	Max Units	Rate	Minimum Criteria
V2799	V	Vision service (e.g. orientation and mobility)	15 min	6	$ 30.89	****SEE BELOW

**** Certified Orientation Mobility Specialist or certified special educator for the blind-partially sighted.

Definition according to the MAG Mutual Healthcare Solutions, Inc.'s 2006 HCPCS Professional Edition

V2799 Vision Services, Miscellaneous

XIX. OTHER SERVICES - Developmental Monitoring Services

Billable Activities:

Procedure Codes listed below are for Developmental Monitoring Code

Procedure Codes	Federal Category	Description	Unit of Service	Max Units	Rate	Minimum Criteria
96151	Z	Developmental Monitoring	15 min	4	$25.74	Qualified Professional

Definition according to the American Association's 2006 Current Procedural Terminology (CPT) Professional Edition.

96151 Re-assessment

Notes

- Developmental Monitoring is designed for eligible children and families who present evidence of a developmental delay and require developmental monitoring in order to determine appropriate services needed. Developmental monitoring involves systemic, periodic assessment (minimally every three months) of child development and family needs in order to determine the need for: (1) additional evaluations, (2) referrals to and linkages with existing community-based health, educational, or service programs, and (3) appropriate services.

- Other Service should be recorded on the IFSP and in the data system with Developmental Monitoring specified.

XX. OTHER SERVICES - Evaluation/Assessment & Plan Development

Billable Activities:

Procedure Codes listed below are for Evaluation/Assessment & Plan development Codes

Procedure Codes	Federal Category	Description	Unit of Service	Max Units	Rate	Minimum Criteria
96150	Z	Other Profession Evaluation	15 min	6	$30.89	Qualified Professional
H2000	Z	Comprehensive Multidisciplinary Evaluation	30 min	5	$123.56	Qualified Professionals (2 individuals)
H2011	Z	Interim IFSP	15 min	8	$17.50	Qualified Professional
S0316	Z	Progress Review	30 min	4	$51.48	Qualified Professional
S0316 HN	Z	Progress Review	30 min	4	$36.04	Service Coordinator
T1023	Z	Intake/Family Assessment	30 min	4	$36.04	Service Coordinator
T1023 TL	Z	Individual Family Service Plan (IFSP) Meeting	30 min	4	$51.48	Service Coordinator

Definition according to the American Association's 2006 Current Procedural Terminology (CPT) Professional Edition.

96150 Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psycho physiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient. Initial assessment.

Definition according to the MAG Mutual Healthcare Solutions, Inc.'s 2006 HCPCS Professional Edition

H2000 Comprehensive Multidisciplinary Evaluation

H2011 Crisis Intervention Services, Per 15 Minutes

S0316 Follow-Up/Reassessment

T1023 Screening To Determine The Appropriateness Of Consideration Of An Individual For Participant In A Specified Program, Project Or Treatment Protocol, Per Encounter.

Modifier Description(s)

HN	Bachelor's Level
TL	Early Intervention/Individualized Family Service Plan (IFSP)

Notes

- H2000 is the only code that requires two professionals. To record this in the system the second evaluator should be entered as a pre-paid service, utilizing the code 990. By using prepaid services the second evaluators productivity report will include pre-paid service minutes rather than zero minutes for the second evaluator.

- An Interim IFSP may be utilized for eligible children when an immediate need for services is required. An interim IFSP must include at least pages 1, 11, 12 and 15 of the IFSP. Page 11 (outcomes) must document the reason for immediate need for services.

- Progress reviews can occur at any time with consent of the parent, but are considered progress reviews when all of the outcomes and services are reviewed and are required at least every 6 months.

- An IFSP update is not a separate billable service-this could be reimbursed under Service Coordination [See Chapter XII].

XXI. OTHER SERVICES - Supervisory/Managerial Codes

Billable Activities:

Procedure Codes listed below are for Supervisory/Managerial Codes

Procedure Codes	Federal Category	Description	Unit of Service	Max Units	Rate	Minimum Criteria
H0046 HN	Z	Supervision	15 min	2	$12.50	Bachelor's Degree
H0046 HO	Z	Supervision	15 min	2	$15.00	Master's Degree
H0046 HP	Z	Supervision	15 min	2	$17.50	Doctoral Degree
H2016	Z	File Management	15 min per diem	465 (15 x 31 days)	$0.33	N/A

Definition according to the MAG Mutual Healthcare Solutions, Inc.'s 2006 HCPCS Professional Edition

H0046 Mental Health Services, Not Otherwise Specified

H2016 Comprehensive Community Support Services, Per Diem

Modifier Description(s)

HN Bachelors Degree
HO Masters Degree Level
HP Doctoral Level

Notes

- **File Management** –For all eligible/enrolled children, required paper and electronic documentation must be accurate and completed no more than 15 days after service is rendered. All paper documentation must be stored in an individual child record and all electronic documentation must be entered into the Rhode Island Early Intervention Case Coordination System. Providers should span bill this service for the month for each enrolled child. To enter this into the data system, the number of days needs to be converted to units - the number of days the child is enrolled in EI for that month times 15 minutes. The first IFSP review date must be consistent with the date file management is billed and services must be delivered as defined in the IFSP in a timely manner.

- **Supervision –**Clinical supervision is billed per child and is reimbursable at the rate allowed dependant upon the educational degree of the supervisor. Documentation must minimally consist of date of supervision, minutes of supervision, a brief summary of the topic (including child's name), and the signature of the supervisor and the person receiving supervision. An SRF is required for this service. The maximum allowed is 90 minutes per child per month and the documentation must be maintained on site in the child's file and available for DHS review.

  *Supervision as defined above does NOT:

  - Occur on a group basis, including staff meetings
  - Cover agency operation or billing practices
  - Cover personnel/disciplinary actions
  - Cover short (less than 15 minutes) unscheduled conversations between clinical supervisors and staff
  - Cover supervision needed to maintain certificate, license, or registration that is relevant to specialties

XXII. OTHER SERVICES - Training and Developmental

Training – The reimbursement allowed for training is intended to cover billable time lost for the purpose of staff development. Funding for training comes out of the Part C grant and is not a Medicaid covered service.

A maximum of 15 hours per FTE (pro-rated for part-time staff) is allowed per year (a training year is July 1 through June 30). A monthly staffing log must be submitted to the Sherlock Center in order to be reimbursed for training. Training required for keeping licenses/registrations or certificates or any training held after 6 p.m. or on weekends will not be reimbursed. Training must relate to clinical profession or EI practice for the purpose of staff development. Training must be pre-approved, and the application forms must be sent to the Sherlock Center, along with proof of attendance.

I. ADDENDUM A – ARTICLE 22

TITLE 27
Insurance

CHAPTER 27-18
Accident and Sickness Insurance Policies
SECTION 27-18-64

§ 27-18-64 Coverage for early intervention services. – (a) Every individual or group hospital or medical expense insurance policy or contract providing coverage for dependent children, delivered or renewed in this state on or after the effective date of this act [July 1, 2004], shall include coverage of early intervention services which coverage shall take effect no later than January 1, 2005. Such coverage shall be limited to a benefit of five thousand dollars ($5,000) per dependent child per policy or calendar year and shall not be subject to deductibles and coinsurance factors. Any amount paid by an insurer under this section for a dependent child shall not be applied to any annual or lifetime maximum benefit contained in the policy or contract. For the purpose of this section, "early intervention services" means, but is not limited to, speech and language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service plan development and review, nursing services, and assistive technology services and devices for dependents from birth to age three (3) who are certified by the department of human services as eligible for services under part C of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

(b) Subject to the annual limits provided in this section, insurers shall reimburse certified early intervention providers, who are designated as such by the Department of Human Services, for early intervention services as defined in this section at rates of reimbursement equal to or greater than the prevailing integrated state/Medicaid rate for early intervention services as established by the Department of Human Services.

(c) This section shall not apply to insurance coverage providing benefits for: (1) hospital confinement indemnity; (2) disability income; (3) accident only; (4) long-term care; (5) Medicare supplement; (6) limited benefit health; (7) specified disease indemnity; (8) sickness or bodily injury or death by accident or both; and (9) other limited benefit policies.

II. ADDENDUM B: EARLY INTERVENTION PROGRAM CODES, UNITS, RATES

Procedure Code	Federal Category	Description	Units of Service	Max Units	Rate	Minimum Criteria
97535	Assistive Technology	Assistive Technology	15	20	$25.74	Qualified Professional
T5999	Assistive Technology Devices	Assistive Technology Devices	N/A	1	As billed	As Appropriate
V5010	Audiology	Assessment for hearing aid	15	6	$30.89	Licensed Audiologist
V5008	Audiology	Hearing Screening	15	6	$30.89	Qualified Professional
92557	Audiology	Comprehensive audiometry threshold evaluation	30	3	$99.00	Licensed Audiologist
96154	Family Training/Counseling	Developmental Intervention with Child and Family	15	6	$30.89	Qualified Professional
96155	Family Training/Counseling	Developmental Intervention with Family	15	6	$30.89	Qualified Professional
96152	Family Training/Counseling	Developmental Intervention with Child	15	6	$30.89	Qualified Professional
S9446	Family Training/Counseling	Developmental Intervention Group	15	6	$15.44	Service Coordinator
99367	Medical Services	Medical Conference by a Physician	30	4	$36.04	MD
90801	Medical Services	Psychiatric evaluation	50	1	$150.00	MD
T1002	Nursing Services	RN Services	15	6	$25.74	Licensed RN
S9470	Nutrition Services	Nutritional counseling, dietitian visit	30	3	$51.48	Licensed Dietitian/Nutritionist
97003	Occupational Therapy	Occupational Therapy Evaluation	30	3	$61.78	Licensed OT
97530	Occupational Therapy	Occupational Therapy	15	6	$30.89	Licensed OT
97530 HM	Occupational Therapy	Occupational Therapy - COTA	15	6	$25.64	COTA
97150 GO HM	Occupational Therapy	Occupational Therapy Group – COTA	30	3	$25.64	COTA
97150 GO	Occupational Therapy	Occupational Therapy Group	30	3	$30.89	Licensed OT
96151	Other Services - Developmental Monitoring	Developmental Monitoring	15	4	$25.74	Qualified Professional
T1023 TL	Other Services – Evaluation/Assessment/Plan	IFSP Meeting	30	4	$51.48	Service Coordinator
T1023	Other Services – Evaluation/Assessment/Plan	Intake/Family Assessment	30	4	$36.04	Service Coordinator
H2011	Other Services –	Interim IFSP	15	8	$17.50	Qualified

Procedure Code	Federal Category	Description	Units of Service	Max Units	Rate	Minimum Criteria
	Evaluation/Assessment/Plan					Professional
S0316 HN	Other Services – Evaluation/Assessment/Plan	Progress Review	30	4	$36.04	Service Coordinator
S0316	Other Services – Evaluation/Assessment/Plan	Progress Review	30	4	$51.48	Qualified Professional
H2000	Other Services – Evaluation/Assessment/Plan	Comprehensive Multidisciplinary Evaluation	30	5	$123.56	Qualified Professionals (2)
96150	Other Services – Evaluation/Assessment/Plan	Other Professional Evaluation	15	6	$30.89	Qualified Professional
H0046 HN	Other Services - Supervisory/Managerial	Supervision	15	2	$12.50	Bachelor's Degree
H0046 HO	Other Services - Supervisory/Managerial	Supervision	15	2	$15.00	Master's Degree
H0046 HP	Other Services - Supervisory/Managerial	Supervision	15	2	$17.50	Doctoral Degree
H2016	Other Services - Supervisory/Managerial	File Management	15	465	$0.33	N/A
97001	Physical Therapy	Physical Therapy Evaluation	30	3	$61.78	Licensed PT
97150 GP HM	Physical Therapy	Physical Therapy Group - PTA	30	3	$25.64	Certified PTA
97150 GP	Physical Therapy	Physical Therapy Group	30	3	$30.89	Licensed PT
97110 HM	Physical Therapy	Physical Therapy –PTA	15	6	$25.64	Certified PTA
97110	Physical Therapy	Physical Therapy	15	6	$30.89	Licensed PT
90810	Psychological Services	Individual Psychotherapy	30	3	$73.74	See Psychological Services section
96111	Psychological Services	Psychological Developmental Testing	60	5	$95.00	Psychologist
90802	Psychological Services	Diagnostic interview	50	1	$130.00	See Psychological Services section
T1016	Service Coordination	Case Management	15	8	$18.02	Service Coordinator
T1016 TG	Service Coordination	Transition Planning	15	8	$25.74	Service Coordinator
90806	Social Work Services	Social Work (Individual)	50	1	$123.56	LICSW
90847	Social Work Services	Social Work (Family)	50	1	$123.56	LICSW
H2015	Special Instruction	Comprehensive Community Support	15	6	$25.74	Qualified Professional
H2015 HN	Special Instruction	Comprehensive Community Support	15	6	$18.02	Service Coordinator
T1026	Special Instruction	Center Development Group	60	2	$61.78	Service Coordinator
97150	Special Instruction	Center Development Rehabilitation Group	30	3	$30.89	Qualified Professional

Procedure Code	Federal Category	Description	Units of Service	Max Units	Rate	Minimum Criteria
92508	Speech-Language Pathology	Speech Group	30	3	$30.89	Licensed SLP
92507 HN	Speech-Language Pathology	Speech - SLPA	30	3	$51.28	SLPA
92508 HN	Speech-Language Pathology	Speech Group – SLPA	30	3	$25.64	SLPA
92506	Speech-Language Pathology	Speech Evaluation	30	3	$61.78	Licensed SLP
92507	Speech-Language Pathology	Speech	30	3	$61.78	Licensed SLP
T1013	Translator/Interpreter	Translator/Interpreter	15	20	$14.00	N/A
T2004	Transportation	Transportation	One Way	2	$10.30	N/A
V2799	Vision Services	Vision Service	15	6	$30.89	Certified Orientation Mobility Specialist or Certified Special Educator

CODES BY NUMBER

Code	Unit Rate	Unit	Max Units	Fed Category	Description
90801	$150.00	50 min	1	Medical Services	Psychiatric Evaluation
90802	$ 130.00	50 min	5	Psychological Services	Diagnostic Interview
90806	$ 123.56	50 min	1	Social Work Services	Social Work-Individual
90810	$ 73.74	30 min	3	Psychological Services	Individual Psychotherapy
90847	$ 123.56	50 min	1	Social Work Services	Social Work-Family
92506	$ 61.78	30 min	3	SLP	SLP Eval
92507	$ 61.78	30 min	3	SLP	Speech
92507 HN	$ 51.28	30 min	3	SLP	Speech-SLPA
92508	$ 30.89	30 min	3	SLP	Speech Group
92508 HN	$ 25.64	30 min	3	SLP	Speech Group-SLPA
92557	$ 99.00	30 min	3	Audiology	Comp. Audiomet. Thresh. Eval
96111	$ 95.00	60 min	5	Psychological Services	Psych – Developmental Testing
96150	$ 30.89	15 min	6	Other Serv-Ev/A/Pl	Other Professional Eval
96152	$ 30.89	15 min	6	Fam Trn/Counseling	Dev Intervention-Child
96154	$ 30.89	15 min	6	Fam Trn/Counseling	Dev Intervention-Child & Fam
96155	$ 30.89	15 min	6	Fam Trn/Counseling	Dev Intervention-Family
96151	$ 25.74	15 min	4	Other Services	Developmental Monitoring
97001	$ 61.78	30 min	3	PT	PT Eval
97003	$ 61.78	30 min	3	OT	OT Eval
97110	$ 30.89	15 min	6	PT	PT
97110 HM	$ 25.64	15 min	6	PT	PT - PTA
97150	$ 30.89	30 min	3	Special Instruction	Center Group-Rehab
97150 GO	$ 30.89	30 min	3	OT	OT Group
97150 GP	$ 30.89	30 min	3	PT	PT Group
97150 GO HM	$ 25.64	30 min	3	OT	OT Group- COTA
97150 GP HM	$ 25.64	30 min	3	PT	PT Group- PTA
97530	$ 30.89	15 min	6	OT	OT
97530 HM	$ 25.64	15 min	6	OT	OT - COTA
97535	$ 25.74	15 min	20	Assistive Technology	Assistive Technology Service
99367	$ 36.04	30 min	4	Medical Service	Med Conference-Physician
H0046 HN	$ 12.50	15 min	2	Other Services – Supervisory	Supervision-Bachelor's
H0046 HO	$ 15.00	15 min	2	Other Services – Supervisory	Supervision-Master's
H0046 HP	$ 17.50	15 min	2	Other Services – Supervisory	Supervision-Doctoral
H2000	$123.56	30 min	5	Other Serv- Eval/A/Pl	Multidisciplinary Eval
H2011	$ 17.50	15 min	8	Other Serv- Eval/A/Pl	Interim IFSP
H2015	$ 25.74	15 min	6	Special Instruction	Comprehen. Comm. Support
H2015 HN	$ 18.02	15 min	6	Special Instruction	Comprehen. Comm. Support
H2016	$ .33	15 min	465	Other Serv- Eval/A/Pl	File Management (per diem)
S0316	$ 51.48	30 min	4	Other Serv- Eval/A/Pl	Progress Review
S0316 HN	$ 36.04	30 min	4	Other Serv- Eval/A/Pl	Progress Review
S9446	$ 15.44	15 min	6	Fam Training/Counseling	Develop. Intervention Group
S9470	$ 51.48	30 min	3	Nutrition	Nutrition Counseling/Dietitian
T1002	$ 25.74	15 min	6	Nursing	RN Services
T1013	$ 14.00	15 min	20	Translator/Interpreter	Translator/Interpreter
T1016	$ 18.02	15 min	8	Service Coordination	Case Management
T1016 TG	$ 25.74	15 min	8	Service Coordination	Transition Planning
T1023	$ 36.04	30 min	4	Other Serv-Eval/A/Pl	Intake/Family Assessment
T1023 TL	$ 51.48	30 min	4	Other Serv-Eval/A/Pl	IFSP Meeting
T1026	$ 61.78	60 min	2	Special Instruction	Center Developmental Group
T2004	$ 10.30	1 way	2	Transportation	Transportation
T5999	As billed	N/A	1	Assistive Technology	Assistive Technology Device
V2799	$ 30.89	15 min	6	Vision Services	Vision Service
V5008	$ 30.89	15 min	6	Audiology	Hearing Screening
V5010	$ 30.89	15 min	6	Audiology	Assess for Hearing Aid

III. ADDENDUM C: SERVICES RENDERED FORM

ID: _____ **Last Name** _____ **First Name** _____ **MI** _____

DOB: _____/_____/_____ **Service Coordinator:** _____ **Insurance Coverage Change** ❑ Yes ❑ No

Service Date: _____/_____/____ **Cancellation:** ❑ No Show ❑ Cancel ❑ Provider Cancel	**Visit Participants:**	**Service Location:** ❑ Home ❑ Community ❑ Center based service ❑ EI group in community ❑ Phone call or Not applicable

Family Caregiver Update: What has happened since our last visit?	**Outcomes Addressed:**

Observations/Strategies/Notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Suggestions for follow up during daily routine:

Provider/Signature	**Service Code:**	**Minutes:**	**NEXT VISIT:**	**TIME:**
1._____ Date		_____		
2._____ Date		_____		
3._____ Date		_____		
4._____ Date		_____		

_____
Parent/ Guardian Signature Date

_____
Interpreter's Signature (if applicable) Date

Rev. 04/01/08

IV. ADDENDUM D: MEDICAID PROVIDER INFORMATION

Medicaid Provider Enrollment Packet

EDS is the fiscal agent for DHS and its Medical Assistance Program, and as the fiscal agent for DHS, is responsible for the enrollment, assignment of provider numbers, claims processing and reconciliation…
EDS can by reached by calling:

- 784-8100 for local and long distance calls
- 1-800-964-6211 for in-state toll calls or border community calls

Or by accessing its website https://www.dhs.ri.gov/secure/logon.do

Some of the information Early Intervention Agencies can request from EDS includes:

- Provider Enrollment Application
- Provider Agreement form
- W-9 Form
- Trading Partner Agreement Form (TPA)
- Provider Addendum 1 and Addendum 2
- Electronic Funds Transfer (EFT) Form
- Electronic Data Interchange Trading Partner Agreement (TPA)
- A copy of the HIPAA compliant Provider Electronic Solutions Software
- (PES)

The provider enrollment packet must be submitted to EDS and approved by DHS *before* an Early Intervention Agency submits claims for reimbursement. EDS will enroll each Early Intervention Agency, utilizing the National Provider Identifier (NPI) number assigned by the NPI Enumerator.

The National Plan and Provider Enumeration System (NPPES) is the contractor hired by CMS to assign and process the NPIs, to ensure the uniqueness of the health care provider, and generate the NPIs. Providers can apply at the following website: https://nppes.cms.hhs.gov/NPPES/Welcome.do

Electronic Data Interchange Trading Partner Agreement (TPA)

Effective October 16, 2003, all Medicaid providers, including Early Intervention Agencies, must utilize HIPAA compliant software. Providers in Rhode Island may use EDS' free software, Provider Electronic Solutions (PES), or software that has completed

HIPAA compliance testing with EDS. Another component for HIPAA compliance is an Electronic Data Interchange (EDI) Trading Partner Agreement.

Each billing provider, clearinghouse, or billing service that directly exchanges electronic data with EDS **must** complete and sign the Trading Partner Agreement (TPA). Once an Early Intervention Agency forwards a TPA to EDS, EDS will then forward an identification number and password to be used to access information on the DHS web portal. The web portal can be utilized to send claims, receive remittance advices, verify recipient eligibility verification, check on claims status, or to check a message center and to verify remittance payment.

RI Medicaid providers who utilize a Third Party (a billing company) to exchange data with EDS, must identify the transactions that the Third Party is authorized to perform on their behalf, and indicate consent by an authorized signature on the TPA. Providers who do not exchange electronic data directly with EDS are not required to complete a TPA.
If you have any questions about completing the TPA, please contact the EDI HIPAA Coordinator at (401) 784-3813.

Eligibility Verification

There are two processes for Medicaid Providers to verify recipient Medicaid eligibility. These include: (a) the Recipient Eligibility Verification System (REVS) maintained by EDS; and (b) the eligibility verification available through the DHS web portal. These processes generate an enrollment verification number for that date of service. Early Intervention Agencies should maintain this verification number as proof for eligibility on that date.

1. REVS
To verify eligibility through the REVS, an Early Intervention Agency needs its provider number, the dates of service being verified, (up to 365 days from date of service), and the recipient's Medical Assistance Identification (MID) number, which is usually the recipient's social security number.

How to access REVS via a Touch-Tone Phone:

- REVS phone allows providers 5 transaction per phone call
- Call or 1-401-784-8100 for local or long-distance calls
- Call 1-800-964-6211 for in-state toll or border state community calls

Entering and Receiving Information:

Security access is provided by the provider's 7 digit provider number

To enter a 7 digit provider number containing letter and numbers

- Press the asterisk key followed by two numbers representing the placement and position of letters on the touch-tone keypad.
- For example, A is entered by pressing *21, B is entered by pressing *22, C is entered by pressing *23, D is entered by pressing *31…
- Q is assigned *11
- Z is assigned *12
- Ending with the pound key (#)
- Provider number CF00001 is entered as: *23 *33 00001#
- Provider number EG00002 is entered as: *32 *41 00002#
- Provider number WD00003 is entered as: *91 *31 00003#

To enter dates of service

- MMDDYY format used followed by a pound key (#) e.g. March 31, 2004 is entered as 033104#
- # Key is used to enter current date as date of service

Use of pound (#) key

- Used to mark end of data just entered, e.g. provider number or date of service
- Used to tell system to reuse data previously entered for a specific prompt, e.g. recipient MID number
- Used to repeat a prompt

Use of asterisk (*) key

- Used to repeat a prompt at an options menu or main menu prompt
- Used to enter letters into the system
- Double asterisk (**) used to erase information entered incorrectly and to replace it with the correct information

2. DHS Web Portal Eligibility Verification System

Providers who want to utilize the DHS web portal to verify recipient eligibility must complete a Trading Partner Agreement with EDS through the portal. To access the web, providers need to use an assigned Identification (ID) number and password, and know the recipient's Medical Assistance ID (MID) number, usually a social security number. As with REVS, eligibility verification on the web portal may be accessed for a recipient up to 365 days from the date of service. If a provider's current TPA does not include eligibility verification, it can submit a Trading Partner Agreement ID Change/Add Form to add eligibility verification. To access the DHS web portal eligibility verification system providers need to:

- Complete a TPA and select 270 Eligibility Request and 271
- Eligibility Response
- Receive a Trading Partner ID and password from EDS

- Access the DHS web site at: www.dhs.ri.gov
- Select “MMIS Web Transactions”
- Enter their Trading Partner ID and password
- Choose from the list of options that appear (these will vary and
- depend on those selected on the TPA)
- Select “Eligibility”

Other enhancements available to providers on the DHS web site include:

- Claim Status (the information contained on the Remittance Advice, which is processed two times a month)
- Prior Authorization Status
- Remittance Advice Amount
- Message Board
- National Drug Code (NDC) list (pharmacy providers)

V. ADDENDUM E: EDS

How to confirm eligibility

- Use REVS (Recipient Eligibility Verification System); 401-784-8100 or DHS website to verify Medicaid Eligibility, Managed Care Eligibility, and Third Party Insurance

How to confirm if patient has EI benefits

- See above, Recipients with Medicaid Coverage or Early Intervention Benefits Only have EI benefits

What is a self funded account?

- N/A

How to identify self funded accounts (where EI benefits may not apply)

- N/A

What about State of RI employees?

- N/A

If self funded and denial is received - what to do- send to EDS for payment?

- Yes either on paper with the EOB from the primary insurance or electrically indicating that it is a self funded plan (see attached letter that went to providers explaining)

How to file a claim-

Special instructions codes/modifiers/fields that much appear on claim forms etc.?

- Instructions for the CMS 1500 paper claim form can be found at: http://www.dhs.ri.gov/dhs/heacre/provsvcs/manuals/cms1500_directions.pdf
- See additional attachment for a list of codes/modifiers for Medicaid

Any special instructions for RItecare claims for EI services?

- N/A

How to determine if patient has met the $5000 maximum?

- Typically the EOB from the primary insurance will deny claims with an EOB that states recipient has reached their maximum benefit allowed.

What to do when you think a claim has been processed in error?

- If you can correct the error, then the claim can be resubmitted
- If you need assistance understanding a denial reason then contact our Customer Service Help Desk at 784-8100

When can claims be sent to EDS for payment?

- After the primary insurance has denied a claim, has made a partial payment, or the maximum benefit has been reached.

What does EDS require from the EI providers to "prove" that the commercial carrier does not cover these benefits? (either as not included in benefit package or as patient has already met their maximum)

- If submitting claims on paper to EDS then the EOB from the primary carrier must be included or the TPL Form indicating the maximum benefit has been reached or that the primary insurance does not cover EI benefits.

- If submitting electronically then the provider must code the claim to indicate what the primary insurance has done: denied the claim, made a payment, maximum benefit, non-covered, self-funded, etc.

EDS DENIALS PAYMENT PROCESS

In order to reduce the turn around time for claims you send to EDS, please bill the following scenarios electronically:

- Self Insured (No EI benefit)

- Benefits Exhausted

When creating the claim in the EDS Provider Electronic Solutions software, check Yes on Header 3 to indicate the client has other insurance. Complete the Policy Holder Information on the Other Insurance (OI) Tab. On the Other Insurance Adjustment (OI ADJ) Tab, see the table below for the appropriate codes to use for the Adjustment Group and Reason codes. If using software other than PES, please forward this information to your software vendor.

	Adjustment Group Code	**Adjustment Reason Code**
Self Insured	CO – Contractual Obligation	96 – Non Covered Charges
Benefits Exhausted	CO – Contractual Obligation	119 – Benefits Maximum for this time period or occurrence has been reached

If you have any questions please feel free to call me at (401) 784-3888 or email me at karen.murphy@eds.com

THIRD PARTY INSURANCE COORDINATION OF BENEFITS

EARLY INTERVENTION Date: _____

Provider ID _____ Provider Name _____

Patient Name:	Patient MID	Dates of Service	Procedure Code(s)
_____	_____	_____	_____
			_____

Name of Primary Commercial Health Insurer:_____ Policy Holder name:_____ Policy Number:___

Name of Secondary Health Insurer (if any):_____ Policy Holder name:_____ Policy Number:___

_____ EI Benefits Exhausted for this calendar year. Total amount of benefits Paid $_____ for year ended _____

_____Primary Commercial Insurer Does Not Cover EI Benefits:
Employer (through whom insurance is provided): _____ Explain: _____

_____Secondary Commercial Insurer Does Not cover EI Benefits:
Employer (through whom insurance is provided): _____ Explain:_____

_____Other (Please Explain) _____

Provider/Agency Confirmation Of Denied Services

I certify that to the best of my knowledge, I have determined that the EI services are not covered under the benefits of this commercial insurance policy as documented above.

Name:_____ **Signature**: _____**Date:**_____

EITPL 1.00 (January 2005)

VI. ADDEMUM F: NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND

Eligibility and Benefits

How to confirm eligibility- Phone and on line resources

Eligibility can be confirmed via the telephone through Customer Service at
(401) 459-6020 or (800) 459-6019

or by calling the automated Interactive Voice Response (IVR) System at (401) 459.6610

To be set up to use this IVR system, please contact Customer Service at (401) 459-6020 or (800) 459-6019.

How to confirm if patient has EI benefits- phone and on line resources

Please see above information.

How to determine if patient has met the $5000 maximum?

The $5000 maximum is not a benefit limitation and therefore does not impact the provider. This only affects Health Plan arrangements with DHS.

Self Funded Accounts

NHPRI does not have any self- funded accounts, they are a RItecare plan only.

Claim filing

Address(es) to send claims:

All claims and claims inquires should be sent to:

Neighborhood Health Plan of RI
Claims Department
299 Promenade Street,
Providence, RI 02908
or Fax (401) 459-6146.

Neighborhood Health Plan of RI also accepts electronic claims submission of CMS-1500 and UB04 forms using federally required ANSI 837 Version 004010 format through Emdeon Business Services. NHPRI also accepts electronic claims information on diskette, CD or sent over the Internet to FTP site. If you choose to send the file over the Internet, then you will be

required to purchase encryption software compatible with the one that NHPRI is currently using. This will ensure the proper level of security and confidentiality of the data being submitted.

Special instructions codes/modifiers/fields that much appear on claim forms or on electronic submissions?

NHPRI Required CMS 1500 Claims Information

The following is a listing of the claims information that is required by NHPRI in order for claims to be reviewed for potential payment. If any of the required information is omitted or invalid, claim (s) may be returned for correction and resubmission. The "Instruction" column indicates whether a particular field is Required (mandatory) or Optional:

Box	Box Heading	Instruction
1	*Carrier Type*	*Optional*
1a	*Insured's ID Number*	*Required*
2	*Patient's Name*	*Required*
3	*Patient's Date of Birth*	*Required*
4	*Insured's Name*	*Required*
5	*Patient's Address*	*Required*
6	*Patient's Relationship to Insured*	*Optional*
7	*Insured Address*	*Optional*
8	*Patient Status*	*Required*
9	*Other Insured's Name*	*If Applicable*
9a	*Other Insured's Policy or Group Number*	*If Applicable*
9b	*Other Insured's Date of Birth*	*If Applicable*
9c	*Employer's Name or School Name*	*If Applicable*
9d	*Insurance Plan Name or Program Name*	*If Applicable*
10	*Is Patient's Condition Related to:*	
10a	*Employment*	*Required*
10b	*Auto Accident*	*Required*
10c	*Other Accident*	
10d	*Reserve for Local Use*	*Optional*
11	*Insured's Policy Group or FECA Number*	*Optional*
11a	*Insured's Date of Birth*	*Optional*
11b	*Employer's Name or School Name*	*Optional*
11c	*Insurance Plan Name or Program Name*	*Optional*
11d	*Is There Another Health Benefit Plan?*	*Optional*
12	*Patient's or Authorized Person's Signature (Medical Records/Information Release)*	*Required*
13	*Insured's or Authorized Person's Signature (Assignment of Benefits)*	*Required*
14	*Date of Current Illness, Injury, Pregnancy*	*Optional*
15	*First Date of Onset of Same/Similar Illness*	*Optional*
16	*Dates Unable to Work in Current Occupation*	*Optional*
17	*Name of Referring Physician*	*If Applicable*

17a	*Legacy Referring*	*Optional*
17b	*Referring Physician NPI#*	*Optional*
18	*Hospitalization Dates Related to Current Services*	*If Applicable*
19	*Reserved for local use*	*Optional*
20	*Outside Laboratory?*	*Optional*
21	*Diagnosis or Nature of Illness or Injury*	*Required*
22	*Medicaid Resubmission Code*	*Optional*
23	*Prior Authorization Number*	*If Applicable*
24a	*Date of Service*	*Required*
24b	*Place of Service (Valid codes only, outdated codes are not accepted).*	*Required*
24c	*Emergency Service*	*Optional*
24d	*Procedures, Services or Supply Code (modifiers)*	*Required*
24e	*Diagnosis Pointer*	*Required*
24f	*Charges*	*Required*
24g	*Days or Units*	*Required*
24h	*EPSDT Family Plan*	*Optional*
24i	*ID Qualifier (XX) Electronic submission*	*Required, for*
24j	*Legacy Rendering Provider ID Number*	*Required*
24j	*Rendering Provider NPI Number shaded area)*	*Required (in non-*
25	*Federal Tax ID Number*	*Required*
26	*Patient's Account Number*	*Required*
27	*Accept Assignment*	*Required*
28	*Total Charge*	*Required*
29	*Amount Paid*	*If Applicable*
30	*Balance Due*	*If Applicable*
31	*Signature of Practitioner or Supplier*	*Required*
	Name/Address of Facility Where Services Rendered	*Required*
32	*Practitioner/Supplier's Billing Name/Address/ Telephone Number. For Participating Providers the NHPRI Provider and Vendor Number which is assigned by NHPRI. For Non-Participating Providers submit your PIN#.*	*Required*

Any special instructions for RItecare claims for EI services/other?

In NHPRI's continuing effort to ensure accurate and appropriate payment of claims for health care services, the Claim Department implemented the use of claims auditing software. The software evaluates all of our practitioner's claims and identifies billing errors, including potential utilization issues. Claims auditing software assist NHPRI in the ability to process and manage claims efficiently and comprehensively. When submitting claims for EI services, when possible, providers are asked to file with the greatest level of specificity.

What to do when you think a claim has been processed in error?

Providers may call Customer Service if they believe a claim has been paid in error. The claim will be researched and a determination made on the disposition. Providers have the right to reconsideration, according to timely filing guidelines.

Formal appeals should be sent to:

Appeals Coordinator
Neighborhood Health Plan of RI
299 Promenade Street
Providence, RI 02908

Providers are entitled to 2 levels of appeal. If the practitioner is not satisfied with the decision of the first level appeal, the practitioner may appeal again. Decisions are made according to the following timelines:

*Written acknowledgement of your appeal will be sent within 5 days
* The outcome of the appeal will be determined with in 30 days of receipt of the initial request
*Practitioners will be notified in advance if a determination will require more than 30 days, requiring an extension. The extension for a determination will not exceed 15 days.
*A notification letter which includes the appeal determination and the rights of t he provider for further appeal will be sent within one day of the determination.

An appeal may require additional time for processing in the event additional documentation is needed.

Contact names and numbers:

Customer Service	(800) 459-6019
	(410) 459-6020
Provider Services	(401) 459-6000

<u>Filing limits</u>

Contracted providers- initial claims timely filing limit?

Claims must be submitted with in 90 days of the date of service.

As a secondary payer- what is the timely filing limit if claim is initially denied by first carrier?

If a claim is inadvertently submitted to another carrier for payment, it must be submitted to NHPRI within 90 days from the date of rejection from the other carrier to be considered for payment. An EOB documenting the rejection from the other carrier must accompany the claim.

VII. ADDENDUM G: BLUE CROSS AND BLUE SHEILD OF RHODE ISLAND

The information below is to be used as a quick reference guide and is not intended to replace Blue Cross & Blue Shield of Rhode Island's (BCBSRI's) existing provider communication materials. BCBSRI participating providers should read and refer to the Participating Provider Administrative Manual and *Provider Update* for any changes or updates to this information. Both of these publications can be found in the Provider section of BCBSRI.com.

Early Intervention Services
Funded with federal and state money, the state of Rhode Island has offered the Early Intervention Program since 1986. The Department of Health is the primary agency responsible for monitoring the program. BCBSRI began covering certain services and modalities for the early intervention population in 2003.

Based on a collaborative approach between families and professionals, early intervention services promote the development of infants and toddlers with developmental delays and challenges. Services are delivered to children three years of age or younger who have (or are at risk of developing) a disabling condition or other special need that may affect their development. These services may be either remedial or preventive in nature.

Early intervention may focus on the child individually or on the child and the family together. Early intervention programs may be center-based, home-based, hospital-based, or any other combination. Services range from identification of development delays and challenges (hospital or school screening and referral services) to diagnostics and direct intervention programs and may begin at any time up to the age of three. While the child's development is enhanced, the family is able to receive support and assistance.

The following will typically be covered for members (from birth to three years old) who are Rhode Island residents:

- Speech and language therapy
- Physical therapy
- Occupational therapy
- Evaluation
- Case management
- Nutrition
- Service plan development and review
- Nursing services
- Assistive technology services and devices up to an annual limit of $5,000.

Services must be performed by early intervention staff who are certified by the RI Department of Human Services and BCBSRI-credentialed providers. Typically, coinsurance, copayments, and deductibles will ***not*** apply, however there may be exceptions to this. Please be sure to verify benefits and eligibility. Services in excess of $5,000 annually will be the responsibility of the state of Rhode Island.

Eligibility and Claims Submission Information

Health Plan	**Eligibility Contact Information**	**Copayments, coinsurance, deductible**	**Claims Submission Address**	**Claims Submission Following $5,000 Limit**
HealthMate Coast-to-Coast	Physician and Provider Service Center: (401) 274-4848 or 1-800-230-9050 Hours of operation: 8:00 a.m. to 4:30 p.m.	Not subject to copayments, coinsurance, or deductibles	Claims Department, Blue Cross & Blue Shield of Rhode Island, 444 Westminster Street Providence, RI 02903-3279	RI Department of Human Services
BlueCHiP	Physician and Provider Service Center: (401) 274-4848 or 1-800-230-9050 Hours of operation: 8:00 a.m. to 4:30 p.m.	Not subject to copayments, coinsurance, or deductibles	Claims Department, Blue Cross & Blue Shield of Rhode Island, 444 Westminster Street Providence, RI 02903-3279	RI Department of Human Services
BlueCHiP for RIte Care	Physician and Provider Service Center: (401) 274-4848 or 1-800-230-9050 Hours of operation: 8:00 a.m. to 4:30 p.m.	Not subject to copayments, coinsurance, or deductibles	Claims Department, Blue Cross & Blue Shield of Rhode Island, 444 Westminster Street Providence, RI 02903-3279	Claims Department, Blue Cross & Blue Shield of Rhode Island, 444 Westminster Street Providence, RI 02903-3279
Federal Employee Plan (FEP)	(401) 831-0153 or 1-800-377-4418	Contact FEP at (401) 831-0153 or 1-800-377-4418		RI Department of Human Services
Federal Employee Health Benefit Plan (FEHBP)	(401) 831-0153 or 1-800-377-4418	Contact FEP at (401) 831-0153 or 1-800-377-4418		RI Department of Human Services
Self-funded Accounts	Physician and Provider Service Center: (401) 274-4848 or 1-800-230-9050 Hours of operation: 8:00 a.m. to 4:30 p.m.	Contact the Physician and Provider Service Center		

BlueSolutions for HSA	Physician and Provider Service Center: (401) 274-4848 or 1-800-230-9050 Hours of operation: 8:00 a.m. to 4:30 p.m.	Applies the deductible	Claims Department, Blue Cross & Blue Shield of Rhode Island, 444 Westminster Street Providence, RI 02903-3279	RI Department of Human Services
HealthMate Coast-to-Coast HDHP	Physician and Provider Service Center: (401) 274-4848 or 1-800-230-9050 Hours of operation: 8:00 a.m. to 4:30 p.m.	Applies the deductible	Claims Department, Blue Cross & Blue Shield of Rhode Island, 444 Westminster Street Providence, RI 02903-3279	RI Department of Human Services
HealthMate for HSA Direct	Physician and Provider Service Center: (401) 274-4848 or 1-800-230-9050 Hours of operation: 8:00 a.m. to 4:30 p.m.	Applies the deductible	Claims Department, Blue Cross & Blue Shield of Rhode Island, 444 Westminster Street Providence, RI 02903-3279	RI Department of Human Services
Out-of-state Blue Cross and Blue Shield Plans	1-800-676-BLUE (2583) Hours of operation: 7:00 a.m. to 10:00 p.m.	Verify with the home plan.	Claims Department, Blue Cross & Blue Shield of Rhode Island, 444 Westminster Street Providence, RI 02903-3279	Verify with the home plan

Eligibility and Benefits

Contact Information

Plan	Contact Information
BCBSRI plans including self-funded accounts	**Physician and Provider Service Center: (401) 274-4848 or 1-800-230-9050 Hours of operation: 8:00 a.m. to 4:30 p.m.**
Out-of-state Blue Cross and Blue Shield Plans (Including New England Health Plans)	**1-800-676-BLUE (2583) Hours of operation: 7:00 a.m. to 10:00 p.m.**

Providers should verify benefits and eligibility for early intervention services for BCBSRI members by contacting the Physician and Provider Service Center. The Physician and Provider Service Center will be able to provide information related to eligibility for early intervention services and confirm if the member has met the $5,000 annual maximum allowed for this benefit (or how much the member has met to-date). When contacting the Physician and Provider Service Center, the provider should have the following information readily available:

- Provider name and National Provider Identifier (NPI)
- BCBSRI member name
- Member insurance identification number
- Member date of birth

All callers will be asked to provide their first and last name.

Please be aware that the Rhode Island Early Intervention Services mandate does not apply to out-of-state Blue Cross and Blue Shield plans. You must contact the out-of-state number listed above to determine eligibility and benefit information related to early intervention services.

Self-Funded Accounts

Contact Information: **BCBSRI Physician and Provider Service Center
(401) 274-4848 or 1-800-230-9050
Hours of operation: 8:00 a.m. to 4:30 p.m.**

Self-funded accounts assume the claims risk themselves and pay an administrative fee to BCBSRI to administer the program. Because of a federal law called the Employee Retirement Income Security Act (ERISA), most self-funded accounts are not subject to the Early Intervention Services state mandate. In order to determine if a member is eligible for early intervention services, please contact the Physician and Provider Service Center at one of the numbers listed above.

Federal Employee Plans

Federal Employee Plans (FEPs) and the Federal Employee Health Benefits Plan (FEHBP) benefits supersede state mandates. Please contact FEP at (401) 831-0153 or 1-800-377-4418 to verify benefits and eligibility.

Claims Filing

Electronic Claims Submission

Providers who have the capability to submit claims electronically should contact the Electronic Data Interchange (EDI) Outreach and Support Team at (401) 459-1970 or by e-mail at ***hipaa.edi.support@bcbsri.org***.

Paper Claims Submission

Early intervention providers should adhere to the following claims submission guidelines when submitting paper claims for early intervention services.

CMS-1500 (08-05) Form Completion Guide Effective May 1, 2008

All services filed to BCBSRI must be filed on a CMS-1500 (08-05) paper claim form or electronic format. Instructions for completing each field of the CMS-1500 (08-05) claim form are listed below. **To ensure prompt payment from BCBSRI, complete the BCBSRI mandatory fields identified with the grey background and bold type below on the CMS-1500 (08-05) claim form**.

Field	Name of Field	Information to Enter
1	Type of Insurance	Mark an "X" in the subscriber's corresponding health insurance type
1A	**Insured's ID Number**	**Insured subscriber's health plan identification number**
2	**Patient's Name**	**Last name, first name, and middle initial of patient**
3	**Patient's Birth Date/Sex**	**Date of birth (MM/DD/YY) and an "X" in appropriate box (M or F)**
4	Insured's Name	Last name, first name, and middle initial of insured subscriber
5	Patient's Address	Number, street, city, state, ZIP code, and telephone number (including area code) of patient
6	Patient Relationship to Insured	Mark an "X" in appropriate box (self, spouse, child, or other)
7	Insured's Address	Number, street, city, state, ZIP code, and telephone number (including area code) of insured subscriber
8	Patient Status	Mark an "X" in the appropriate box for the patient's marital status, and whether employed or a student
9	Other Insured's Name	Last name, first name, and middle initial of the enrollee of another health plan, if it is different from that shown in Field 2
9A	Other Insured's Policy or Group Number	The other insured's policy/and or group number identified in Field 9
9B	Other Insured's Date of	The date of birth (MM/DD/YY) of the other insured identified in

	Birth and Sex	Field 9 and an "X" in appropriate box (M or F)
9C	Employer's Name or School Name	The employer's name or school name of the other insured identified in Field 9
9D	Insurance Plan Name or Program Name	The insurance plan name or program name of the other insured identified in Field 9
10A-C	Is Patient's Condition Related to:	Check "YES" or "NO" to indicate whether employment (A), auto accident (B), or other accident (C) involvement applies to any of the services described in Field 24.
10D	Reserved for Local Use	Exclusive to Medicaid information. If patient is entitled to Medicaid, this item must show the patient's Medicaid number preceded by "MCD."
11	Insured's Policy Group or FECA Number	The insured's policy, group, or FECA (Federal Employees Compensation Act) number. Also for worker's compensation carrier identifier.
11A	Insured's Date of Birth and Sex	The insured's date of birth (MM/DD/YY) and an "X" in appropriate box (M or F) if different from Field 3
11B	Employer's Name or School Name	The employer's name, if applicable
11C	Insurance Plan Name or Program Name	The insurance plan name or program name referring to Field 1A
11D	Is There Another Health Benefit Plan?	Indicate by an "X" that the patient does or does not have insurance coverage other than the plan indicated in Field 1
12	Patient's or Authorized Person's Signature and Date	The patient or authorized representative must sign and enter a date unless the signature is on file, or a designated representative must sign on the patient's behalf.
13	Insured's or Authorized Person's Signature	The signature in this item authorizes that there is a signature on file authorizing payment of medical benefits.
14	Date of Current: Illness, Injury or Pregnancy	Date (MM/DD/YY) of current illness, injury, or pregnancy
15	If Patient Has Had Same or Similar Illness, Give First Date	Date (MM/DD/YY) that patient has had same or similar illness as indicated in Field 14. Indicates that patient had a previously related condition.
16	Dates Patient Unable to Work in Current Occupation	If the patient is employed and is unable to work in current occupation, enter date (MM/DD/YY) from and to the date when the patient is unable to work.
17	Name of Referring Provider or Other Source	The name of the referring/ordering physician if the service or item was ordered or referred by a physician. *If there is no referring provider or if a self-referral, please leave all of Field 17 (including 17a and 17b) blank.*
17A	ID Number of Referring Physician	Leave blank.
17B	NPI of Referring Physician	NPI of the referring/ordering physician listed in Field 17
18	Hospitalization Dates Related to Current Services	Dates (MM/DD/YY) when a medical service is furnished as a result of, or subsequent to, a related hospitalization
19	Reserved for Local Use	Enter a concise description of an "unlisted procedure code"
20	Outside Lab	Complete this item when billing for diagnostic tests subject to

	$ Charges	purchase price limitations. Enter purchase price under charges if the "yes" block is checked. "Yes" indicates that an entity other than the entity billing for the service performed the diagnostic test. When "yes" is annotated, Field 32 shall be completed.
21	**Diagnosis or Nature of Illness or Injury**	**Primary, secondary, tertiary, and quaternary diagnosis codes (ICD-9-CM©) in order of priority**
22	Medicaid Resubmission Code	The code and original reference number of a previously submitted claim or encounter
23	Prior Authorization Number	The prior authorization number for those procedures requiring prior approval. Enter the Investigational Device Exemption (IDE) number when an investigation device is used in an FDA-approved clinical trial. Post Market Approval (PMA) number should also be placed here when applicable.
24A	**Date(s) of Service**	**Date (MM/DD/YY) for each procedure, service, or supply**
24B	**Place of Service**	**The code(s) for the place the service was rendered**
24C	EMG	Emergency indicator code. Leave blank.
24D	**Procedures, Services, or Supplies**	**The procedures, services, or supplies using CPT®/HCPCS© codes and any applicable modifiers**
24E	**Diagnosis Pointer**	**The diagnosis code reference number (1, 2, 3, or 4) listed in Field 21**
24F	**$ Charges**	**The charge for each service listed on the corresponding lines**
24G	**Days or Units**	**Number of services provided (in days or units). This field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or oxygen volume.**
24H	EPSDT Family Plan	Enter "Yes" or "No" if the claim is related to "Early & Periodic Screening, Diagnosis, and Treatment"
24I	ID Qual.	Leave blank or enter "XX"
24J	**Rendering Provider I.D. #**	**Leave the shaded area blank for claims submitted to BCBSRI. Enter the NPI of the rendering provider in the *unshaded* area.**
25	**Federal Tax I.D. Number**	**The provider of service or supplier Federal Tax ID or Social Security Number. Mark an "X" in appropriate box (SSN or EIN).**
26	Patient's Account Number	The patient's account number assigned by the provider of service or supplier's accounting system
27	Accept Assignment?	Mark an "X" in the appropriate box (Yes or No) to indicate whether the provider of service or supplier accepts assignment of Medicare benefits.
28	**Total Charge**	**Total charges for the services (i.e., total of all charges in Field 24f)**
29	Amount Paid	Total amount the patient paid on the covered services only
30	Balance Due	Total amount due
31	**Signature of Physician or Supplier Including Degrees or Credentials**	**Signature, date, and degree/credentials of the physician/provider/supplier of the services or authorized representative**
32	**Service Facility Location**	**The name, address, and ZIP code of the facility if the**

	Information	services were rendered in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office
32A		NPI of the service facility
32B		Leave blank.
33	**Billing Provider Info & PH #**	**Provider of service/supplier's billing name, address, ZIP code, and telephone number**
33A		**NPI of the billing provider or group**
33B		Leave blank.

Additional Information:

Field 24J: When early intervention services are provided by a BCBSRI-credentialed provider, this provider's NPI should be indicated in this field. When the services are performed by certified early intervention staff who are not BCBSRI-credentialed providers, the Type 2 NPI of the Early Intervention Program must be indicated.

Procedure Codes

The following services will be covered for members from birth to three years of age who are living in Rhode Island (Rhode Island resident) and who are certified by the Department of Human Services as eligible for early intervention services. Claims for early intervention services must be filed using one of the following procedure codes:

90801EP	Psychiatric diagnostic interview examination
90802EP	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication
90806EP	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient
90814EP	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient
90847EP	Family psychotherapy (conjoint psychotherapy) (with patient present)
92002EP	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004EP	Comprehensive, new patient, one or more visits
92506EP	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status
92507EP	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual

92507HN	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual (SLPA)
92508EP	Group, two or more individuals
92508HN	Group, two or more individuals (SLPA)
92557EP	Comprehensive audiometry threshold evaluation and speech recognition
96111EP	Extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments (e.g., Bayley Scales of Infant Development) with interpretation and report, per hour
96150EP	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment
96151EP	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment
96152EP	Health and behavior intervention, each 15 minutes, face-to-face; individual
96154EP	Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)
96155EP	Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)
97001EP	Physical therapy evaluation
97003EP	Occupational therapy evaluation
97110EP	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97110HM	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility (Certified PTA)
97150EP	Therapeutic procedure(s), group (2 or more individuals)
97150GO	Therapeutic procedure(s), group (2 or more individuals) (Licensed OT)
97150GOHM	Therapeutic procedure(s), group (2 or more individuals) (Certified COTA)
97150GP	Therapeutic procedure(s), group (2 or more individuals) (Licensed PT)
97150GPHM	Therapeutic procedure(s), group (2 or more individuals) (Certified PTA)
97530EP	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97530HM	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes (Certified COTA)
97535EP	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
99361EP	Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes

99371EP	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other healthcare professionals (e.g., nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (e.g., to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy)
H0046HN	Mental health services, not otherwise specified (Bachelor's Level)
H0046HO	Mental health services, not otherwise specified (Master's Level)
H0046HP	Mental health services, not otherwise specified (Doctoral Level)
H2000EP	Comprehensive multidisciplinary evaluation (Level II)
H2011EP	Crisis intervention service, per 15 minutes (Level II)
H2015EP	Comprehensive community support services, per 15 minutes (Level II)
H2015HM	Comprehensive community support services, per 15 minutes
H2015HQ	Comprehensive community support services, per 15 minutes
H2016EP	Comprehensive community support services, per diem
S0316EP	Disease management program; follow-up/reassessment (Level II)
S0316HM	Disease management program; follow-up/reassessment (Level I)
S9446EP	Patient education, not otherwise classified, non-physician provider, group, per session (Level I)
S9470EP	Nutritional counseling, dietitian visit
T1002EP	RN services, up to 15 minutes
T1013EP	Sign language or oral interpretive services, per 15 minutes
T1016EP	Case management, each 15 minutes
T1016TG	Case management, each 15 minutes
T1023EP	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter [Intake/Family Assessment (INITIAL, brief, comprehensive meeting to gather information about child's history. Includes signing of forms, explanation of services, etc.) Outcome of this meeting is a written service plan.]
T1023TS	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project, or treatment protocol, per encounter (Meetings conducted within 45 days after initial referral, and annually thereafter. Meetings are to discuss service plan. If it has not been signed at the initial meeting, disagreements are ironed out. If plan has been signed, then this is a chance to review and revise if necessary.)
T1026EP	Intensive, extended multidisciplinary services provided in a clinical setting to children with complex medical, physical, medical, and psychosocial impairments, per hour
T1027EP	Family training and counseling for child development, per 15 minutes
T2004EP	Non-emergency transport; commercial carrier, multi-pass
T5999EP	Supply, not otherwise specified
V2799EP	Vision service, miscellaneous
V5008EP	Hearing screening
V5010EP	Assessment for hearing aid

Note:

- For a more complex assessment, use H2000EP with a -22 modifier.
- Use 92499 for the MRI photo screening done by ORS/Services for the blind and visually impaired.
- 96150, 96151, 96152, 96154, 96155, 97535, T1013, and T1027 must be filed with two units for 30 minutes.

Services must be performed by Department of Human Services-certified early intervention staff and BCBSRI-credentialed providers up to an annual limit of $5,000. Typically, coinsurance, copayments, and deductibles will ***not*** apply. A current exception to this are high-deductible health plans (HDHPs), which are compatible with health savings accounts (HSAs). These products are: **BlueSolutions for HSA; HealthMate Coast-to-Coast HDHP, and HealthMate for HSA Direct.** These products will apply the deductible.

Claims Mailing Address Information

Plan	**Claims Mailing Address**
BCBSRI plans and out-of-state Blue Cross and Blue Shield Plans	Claims Department Blue Cross & Blue Shield of Rhode Island 444 Westminster Street Providence, RI 02903-3279
Federal Employees Health Benefits Plan	Claims Department Attention: FEP Blue Cross & Blue Shield of Rhode Island 444 Westminster Street Providence, RI 02903-3279

Claims Filing Instructions Following the Annual Limit

In accordance with the Rhode Island mandate, early intervention services are covered up to an annual limit of $5,000. Once the member's annual limit has been met (for all products except Blue CHiP for RIte Care), claims should be submitted to the RI Department of Human Services. For BlueCHiP for RIte Care members, claims should continue to be submitted to BCBSRI. BCBSRI will continue to process early intervention claims for BlueCHiP for RIte Care members, therefore providers should continue to send claims for Early intervention Services to BCBSRI when the annual maximum has been met.

VIII. ADDENDUM H: UNITED HEALTHCARE

Eligibility and Benefits

How to confirm eligibility-Phone and on line resources

(1) United Voice Portal (UVP) 877-842-3210
(2) Unitedhealthcareonline.com
(3) Customer Service phone number located on the back of the Member's identification card.

How to confirm if patient has EI benefits- phone and on line resources

Same resources as above

How to determine if patient has met the $5000 maximum?

Same resources as above

Self Funded Accounts

What is a self funded account?

A self-funded account is a policy that is administered through United Healthcare or its affiliates, but funded by the employer. Claims are processed identical to any other plan; however the group receives a statement of claims received and funds the pay amount to United Healthcare. Payments are issued by the health plan.

How to identify self funded accounts (where EI benefits may not apply)

Please be sure to check the funding status of the employer group when calling to verify eligibility.

What about State of RI employees?

A plan shall provide a benefit of $5,000 each calendar year for early intervention services provided to dependents from birth to age 3. The Rhode Island Department of Human Services must be certified the dependent as eligible for early intervention services. The benefits shall NOT be subject to any deductible or coinsurance factor. This benefit shall NOT be applied to any annual or lifetime maximum.

State of Rhode Island employees continued-

Early Intervention Services

The following services, not limited to these services:

- Speech and language therapy.
- Occupational therapy.
- Physical therapy.
- Evaluation.
- Case management.
- Nutrition.
- Service plan development and review.
- Nursing services.
- Assistive technology services and devices consistent with early intervention programs approved by the Department of Health.
- Psychological Counseling

The plan shall reimburse certified early intervention provided, who are designated as such by the Rhode Island Department of Human Services. Such reimbursement shall be at rates equal to or greater than the prevailing integrated state/Medicaid rate.

Claim filing

Address(es) to send claims

(1) Submit electronically through your current clearinghouse
(2) Submit on-line through unitedhealthcareonline.com
(3) Paper claims should be submitted to the address on the back of the members ID card or where indicated on line during eligibility verification.

Special instructions codes/modifiers/fields that much appear on claim forms or on electronic submissions?

There aren't any special instructions except for RItecare (see below).

Any special instructions for RItecare claims for EI services/other?

(1) -59 modifier needs to be submitted on every procedure code for RItecare.
(2) Claims should be submitted to the address on the back of the members ID card.
(3) Medicaid site www.uhcmedicaid.com/rhodeisland has the billing address for hard copy claims.

Medicaid/AmeriChoice
P.O. Box 31361
Salt Lake City, Utah 84131

What to do when you think a claim has been processed in error?

(1) Submit a claim reconsideration request through unitedhealthcareonline.com

(2) Contact Customer Care at the phone number located on the back of the members ID card to request a review.
(3) United Voice Portal (UVP) 877-842-3210

Contact names and numbers:

Rhode Island Provider Advocate:

Shannan Medieros
(401) 732-7115 p
(866) 647-4358 f
United Healthcare
Rhode Island
shannan_m_medeiros@uhc.com

Filing limits

Contracted providers- initial claims timely filing limit?

We must receive a claim within 90 days of the date services were rendered.

As a secondary payer- what is the timely filing limit if claim is initially denied by first carrier?

We must receive a claim within 90 days of the date on the primary carrier's Explanation of Benefits.

IX. ADDENDUM I - HEALTH PLAN CONTACTS FOR EI PROVIDERS

Blue Cross and Blue Shield of Rhode Island

Family Resources Community Action -EI	Rena Sheehan	401/459-5009	Rena.Sheehan@bcbsri.org
Hasbro- EI	Rena Sheehan	401/459-5009	Rena.Sheehan@bcbsri.org
Trudeau Memorial Center-EI	Rena Sheehan	401/459-5009	Rena.Sheehan@bcbsri.org
Groden Center- EI	Rena Sheehan	401/459-5009	Rena.Sheehan@bcbsri.org
Meeting Street - EI	Rena Sheehan	401/459-5009	Rena.Sheehan@bcbsri.org
Children's Friend and Service -EI	Phyllis Bailey	401/459-5411	Phyllis.bailey@bcbsri.org
Family Service -EI	Rena Sheehan	401/459-5009	Rena.Sheehan@bcbsri.org
James L. Maher Center -EI	Phyllis Bailey	401/459-5411	Phyllis.bailey@bcbsri.org
Easter Seals, RI - EI	Phyllis Bailey	401/459-5411	Phyllis.bailey@bcbsri.org
Homestead Group -EI	Rena Sheehan	401/459-5009	Rena.Sheehan@bcbsri.org
Looking Upwards -EI	Phyllis Bailey	401/459-5411	Phyllis.bailey@bcbsri.org

UnitedHealthcare of New England

RItecare	Susan Ephraimson	401/732-7568	susan_j_ephraimson@uhc.com
	Joan Pillsbury	401/732-75449	Joan_Pillsbury@uhc.com
Commercial	Carol Hathaway	401/732-7130	Carol_Hathaway@uhc.com

Neighborhood Health Plan of New England

Primary Contact Secondary Contact	Kevin Kruth Ken Vinhateiro	401/459-6024 401/459-6196	kkruth@nhpri.org kvinhateiro@nhpri.org

Medicaid Fee for Service/ EDS

Primary Contact	Karen Murphy	401/784-3888	Karen.Murphy@eds.com

X. ADDENDUM J: MECHANISMS FOR RESOLVING HEALTH PLAN/PROVIDER DISPUTES

Provider Complaints (A complaint is any expression of dissatisfaction with the health plan)

	Vehicle to Submit	Time-frame to Submit	Timeframe for Response	Levels of Review	Company Contact if Dissatisfaction with Complaint/Appeal Response
BLUE CROSS & BLUE SHIELD OF RI (Commercial and Medicaid)	**Call**: Physician and Provider Service Center - 401-274-4848 **Write**: Grievance and Appeals Unit BCBSRI 444 Westminster Street Providence, RI 02903	No timeframe	**Commercial** 30 Business Days **Medicaid** 30 Calendar days	Up to two (2) levels of complaint, depending on issue. Response to level 1 will notify complainant if a second level is available.	Tracy McCaughey Manager, Grievance & Appeals 444 Westminster Street Providence, RI 02903 (401) 459-5580
UNITED HEALTHCARE OF NEW ENGLAND (Commercial and Medicaid)	**Contract issues:** **Write** : Network Management UnitedHealthcare 475 Kilvert Street Warwick, RI 02886 **Non- contract issues:** **Call** : Physician and Provider Service Center at 877-842-3210	No timeframe	**Commercial** 60 Business Days Medicaid 30 Calendar days	Up to two (2) levels of complaint, depending on issue. Initial response from Network Management. Response to level 1 will notify complainant if a second level is available. Non-contract related complaints have only one level of appeal.	***Phil Anderson*** UHC- Legal and Compliance 48 Monroe Turnpike Trumbull, CT 06611 (203) 459-6121
NEIGHBORHOOD HEALTH PLAN OF RI	**Call**: NHPRI Customer Service Department - (401) 459-6020	No timeframe	15 Business Days	If dissatisfied, provider may appeal the complaint resolution/outcome	**Primary Care**: Charles Scaletta, Manager of Primary Care: (401) 459-6098; **Specialty/Ancillary**: Ken Vinhateiro, Manager of Specialty Care: (401) 459-6196; **Facilities**: William Mancini, Manager of Hospitals/Facilities: (401) 459-6142

PROVIDER ADMINISTRATIVE APPEALS

An ADMINISTRATIVE APPEAL is a request for a reconsideration of a full or partial denial of a claim that is NOT related to a utilization review determination.

	VEHICLE TO SUBMIT	TIME-FRAME TO SUBMIT	TIME-FRAME FOR RESPONSE	LEVELS OF REVIEW	COMPANY CONTACT IF DISSATISFIED WITH COMPLAINT/ APPEAL RESPONSE
BLUE CROSS & BLUE SHIELD OF RI (Commercial and Medicaid)	**Call**: Physician and Provider Service Center -401-274-4848 **Write**: Grievance and Appeals Unit BCBSRI 444 Westminster Street Providence, RI 02903	60 Calendar days from denial notification	Commercial 60 Calendar Days Medicaid 30 Calendar days	One level of Appeal only	Tracy McCaughey Manager, Grievance & Appeals 444 Westminster Street Providence, RI 02903 (401) 459-5580
UNITED HEALTHCARE OF NEW ENGLAND (Commercial and Medicaid)	**Level 1-three options:** **1**) Physician and Provider Service Line at 877-842-3210 **2**)UnitedHealthcareonline-Claim Adjustment Request **3**) Written Request for Reconsideration Form submitted to the address on the back of the patient's card **Level 2:** Call Provider Central Service Unit (PCSU)- 800-521-2603 (**Commercial**) 800-718-5360 (**Medicaid**)	up to 1 year from claim payment date	Commercial 30 Business days Medicaid 15 calendar days	Two levels of Appeals available	**Commercial** Beverly Jane Perry Director, Network Management 475 Kilvert Street Warwick, RI 02886 (401) 732-7545 **Medicaid** Joan Pillsbury Director Marketing & Operations 475 Kilvert Street Warwick, RI 02886 (401) 732-7544
NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND	**Write**: Appeals Coordinator Neighborhood Health Plan of Rhode Island 299 Promenade Street Providence, RI 02908	Within 365 days from date of initial denial	Written acknowledgement within 5 business days; outcome within 30 business days. If extension is necessary to complete determination, provider is notified.	Two levels of Appeals available	Debbie Ricci Appeals Coordinator 299 Promenade Street Providence, RI 02908 (401) 459-6167

UTILIZATION REVIEW APPEALS

A UTILIZATION REVIEW APPEAL is a request for reconsideration of a full or partial denial of the plan's prospective, concurrent or retrospective assessment of the necessity and/or appropriateness of the allocation of health care services of a provider, given or proposed to be given to a patient.

	VEHICLE TO SUBMIT	TIMEFRAME TO SUBMIT INITIAL APPEAL	TIMEFRAME FOR RESPONSE	LEVELS OF REVIEW	COMPANY CONTACT IF DISSATISFIED WITH COMPLAINT/ APPEAL RESPONSE
BLUE CROSS & BLUE SHIELD OF RI (Commercial and Medicaid)	**Call** :Physician and Provider Service Center - 401-274-4848 **Write:** Grievance and Appeals Unit BCBSRI 444 Westminster Street Providence, RI 02903	**Commercial** 180 days from notice of adverse determination **Medicaid** 90 days from notice of adverse determination	Written response for precert and concurrent appeals within 15 calendar days and retro appeals within 15 business days after receiving necessary documents. Expedited appeals are available with a maximum 2 business day turnaround.	Two levels of internal appeals and one level of external appeals available	Tracy McCaughey Manager, Grievance & Appeals 444 Westminster Street Providence, RI 02903 (401) 459-5580
UNITED HEALTHCARE OF NEW ENGLAND (Commercial and Medicaid)	**Call:** Medical Professional Line- 1-877-842-3210 **Commercial**: Submit a Request for Reconsideration Form and all supporting documentation to address on the back of the members card. **Medicaid**: Submit written request and all documentation to: UHC/AC Grievance & Appeals PO Box 659780 San Antonio, TX 78265	180 days from date of the adverse determination.	Written response for precert/concurrent/retro appeals within 15 business days after receiving necessary documents. Expedited appeals are available with a maximum 2 business day turnaround.	Two levels of internal appeals and one level of external appeals available.	Phil Anderson UHC- Legal and Compliance 48 Monroe Turnpike Trumbull, CT 06611 (203) 459-6121
NEIGHBORHOOD HEALTH PLAN OF RHODE ISLAND	**Call:** Appeals Coordinator 401/459-6167 **Write:** Appeals Coordinator NHPRI 299 Promenade Street Providence, RI 02908	Within 90 days from notice of adverse determination	Written response for precert/concurrent/retro appeals within 15 business days after receiving necessary documents. Expedited appeals are available with a maximum 2 business day turnaround.	Two levels of internal appeals and one level of external appeals available.	Debbie Ricci Appeals Coordinator 299 Promenade Street Providence, RI 02908 (401) 459-6167

NOTE: Health Plans may delegate utilization review activities for certain health care services (e.g. mental health, pharmacy) to another entity