Questions Related to Waivers and Exemptions

Q: When should a BV request be submitted to the CBO?

A: BV should be submitted:

1. During Intake
2. Within 30 days of the annual
3. Upon notification of new insurance
4. Upon notification of possible insurance termination
5. To requests waivers or exemptions
6. To respond to CBO requests for information
7. To inform CBO of unique circumstances

Q: I have a waiver for Social Work but the child will be receiving (provider will be billing for) Psych services. Are these services the same and if not, what do I need to do next?

A: Psych and Social Work services are not the same. Waivers issued for SW cannot be used to cover Psych services and Psych waivers cannot be used to cover SW services. If the SW waiver needs to be changed and Psych services was not selected on the Benefit Verification request, then a new BV must be completed for Psych services. After the BV has been completed it can be determined if a waiver is needed for the Psych services. If a waiver is needed then a waiver will be issued.

Q: When is it appropriate to request a 45 day exception?

A: A 45 day exception is applicable when a family has a change in insurance coverage. A change in insurance coverage includes the following:

1. A family that changes from no insurance coverage to insurance coverage during an IFSP period.
2. A change in the insurance policy number
3. A change in the insurance group number
4. A change in insurance carriers (i.e. Changed from Aetna to Blue Cross Blue Shield)
5. A change in the insurance policy type (i.e. policy changed from a PPO to an HMO)

When the CBO receives the appropriate forms and the Fax Cover Sheet indicates the request for a 45 day transition waiver, the exception will be entered into the CBO system and a hardcopy of the exception will be emailed to the Service Coordinator through the CFC EI-CBO email account.

The purpose of the 45 day exception is to allow time for providers to obtain benefit coverage details for the new insurance or policy change. During the temporary 45 day exception, providers are expected to complete any pre-authorizations, pre-certifications and registrations that may be required by the insurance

policy. It also allows time for the Service Coordinator to apply, when applicable, for pre-billing waivers that will cover the provider(s) until the end of the child's current IFSP.

Although a 45 day exception may be listed in the CBO billing system, it is expected for the provider to begin billing the insurance company once they have obtained information that their service is covered and all insurance requirements have been met. Once the insurance has responded to the provider with an acceptable EOB, the claim and insurance EOB should be submitted within timely filing to the CBO.

To verify if a 45 day exception exists in the system, please contact the Help Desk at 1-800-634-8540.

Q: There is a waiver in the system for a provider but this provider has given notification that they will no long be able to render services. I have to find another provider agency that can continue services. Can the same waiver be used for the new provider?

A: No. Waivers can only be used by the provider agency they were issued to initially. In the event of a provider change, the provider is required to give a 30 day notice to the Service Coordinator. This allows time for the Service Coordinator to find another provider as well as submit a waiver request if applicable for the new provider to the CBO. A provider change should be indicated on the Fax Cover Sheet. Case Notes should indicate the day the new provider will begin to see the child or the last day the current provider will provide service to the child. This will insure that the CBO terminates the current waivers and issues new waivers appropriately.

Q: There is a waiver in the system for a provider but the provider is changing companies (payees). The provider will be the same; just the company (payee) they work for is changing. Can the same waiver be used for the provider under their new company?

A: No. Waivers can only be used by the provider agency they were issued to initially. In the event of a provider payee change, the Service Coordinator will submit a change of payee waiver request to the CBO. The change should be indicated in section 4 of the fax coversheet. Case Notes should indicate the date the change will occur. This will insure that the CBO terminates the current waivers and issues new waivers appropriately.

Q: Whose responsibility is it to obtain waivers before the annual IFSP meeting occurs.

A: In effort to not have interruptions in services/ payment and so that there is no gap in waiver coverage, it is the responsibility of the Service Coordinator to submit waiver request for an upcoming annual during the month before the annual IFSP meeting will convene. The Service Coordinator can submit the request 30 days prior to the end of the existing IFSP. This allows ample time for the Benefit Verification process to be completed at the CBO and the Service Coordinator to then re-apply for any applicable waivers. It is the responsibility of the provider to verify that a new waiver has been issued. It is the responsibility of the provider to obtain the waiver before continuing services into the new IFSP period.

Q: I work with an EI participant that has insurance coverage however, there are no out of network rates. There are no other providers in the area available so I was given a waiver. I have three authorizations for A.T. equipment, should I have a waiver for each piece of equipment.

A: Yes, waivers are specific and not to be considered a blanket waiver. Each authorization represents a different piece of equipment therefore a separate waiver is needed for each procedure code authorized.

Q: What are the guidelines for receiving a post billing waiver.

A: The CBO will enter a post billing waiver upon processing a claim that has no errors and if the insurance EOB clearly indicated that the service is not covered or that the maximum benefits allowed has been met. The notification and details of the post billing waiver are printed on the Provider Claim Summary. A gray box with the waiver detail will appear underneath the claim that prompted the waiver to be entered.

Q: When waivers are issued do they cover individual direct services as well as group services?

A: Individual direct services and group services are separate types of services with different procedure codes and rates of pay therefore they must be treated desperately. Insurance companies sometimes will pay one type of service and not the other. In the event, the insurance is covering for one service type there is no need for a waiver to be issued for the service type being covered by the insurance company.

In the instance of pre-billing waivers, the Service Coordinator must indicate on the Benefit Verification request if it is for individual only, group only or both. If nothing is indicated and the waiver is applicable, the CBO will issue the waiver for individual services only. The waiver form will list the service type approved. In instances of post billing waivers, depending upon the procedure code billed to the insurance company a waiver is issued for individual or group services.