



## **Central Billing Office**

### **Questions Related to Payment and Provider Enrollment**

***Q: I am changing from one FEIN to another due to a name change. Should I have all of my authorizations that are made to my current FEIN changed to the new FEIN?***

A: No, existing authorizations do not have to be adjusted. In the event there is a FEIN change there must be an end date for using the old FEIN and an effective date for using the new FEIN. These dates cannot overlap. The request indicating this change must be submitted to Provider Connections and the HFS IMPACT system must be updated as well. Contact Provider Connections at 1-800-701-0995 for more information on the appropriate documents etc. that need to be submitted. Once Provider Connections has finished processing the request, the change is forwarded to the Central Billing Office and updates are made in the claims processing system. The provider will not need to have existing authorizations (or waivers) adjusted however the provider will need to be careful in the billing process. All claims that should be processed under the old tax ID through the end date indicated must be submitted with that tax ID number on the claim. All dates of service as of the effective date for the new FEIN will need to be submitted with the new number.

Note: If you use Qclaims you must contact the Early Intervention Call Center at 1-800-634-8540 for assistance with updating Qclaims. Failure to do so can result in denied claims.

***Q: I moved and have not received payment from Early Intervention?***

A: Early Intervention Providers should update address changes in the HFS IMPACT system and contact Provider Connections regarding address changes or updates. If payment is never received the Early Intervention Provider can request a warrant action to stop pay and reissue (Call the EI Help Desk at 1-800-634-8540 to have a warrant reissued). Note the following guidelines and timeframes to follow before requesting a check be reissued:

- If the check is being mailed to a valid address and the provider has not moved but has not received payment there is a waiting period of 14 days.
- If the provider has moved and did not notify Provider Connections or the Post Office there is a 14 day waiting period.
- If the check is being mailed to a prior valid address from which the payee moved but put in a forwarding order at the Post Office there is a waiting period for 21 days.
- If the check is being sent to a completely wrong address (i.e. typo in address) a request to reissue the check can be done with no waiting period.

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- If the check was received by the provider but lost, stolen, destroyed etc. a request to replace the check can be done with no waiting period.

The waiting period allows time for the check to be received at a valid address, forwarded to a valid address, or be returned. If the check is returned to the state's comptroller's office, a representative from EI will contact the payee to obtain a valid address so the check can be re-mailed to a deliverable address. The payee will still need to update their address with IMPACT and Provider Connection for future payments.

***Q: I received a check but I am unable to cash it due to a misspelling of my payee name?***

A: Report this issue to the Early Intervention Help Desk at 1-800-634-8540. Inform the Help Desk representative that the CBO and/or Comptroller's Office has the payee name misspelled in their system(s). The representative will create a ticket so the correction can be made. The claims for which the check was issued will have to be deleted in the CBO system and re-entered for vouchering. This will produce a new date for the invoice therefore payment for this invoice would not be released until funds are available for that particular invoice week.

## **Questions Related to Billing Insurance**

**Q: I am a provider that tries to diligently adhere to insurance guidelines however I am having a problem obtaining the pre-certification. What should I do?**

A: Early Intervention is payer of last resort and insurance must be utilized when applicable. Waivers can only be issued for specific reasons. However, if you are having an issue the suggestion from the CBO is to thoroughly document your calls to insurance in effort to obtain pre-certification. Documentation should include time, date, the customer service representative you spoke to etc. Inform your Service Coordinator of the issue. The Service Coordinator can forward the information to the CBO for review. There is no guarantee that a waiver will be issued but the CBO will work with DHS to obtain a resolution for the issue. If a waiver is granted, that is not an indication that a similar scenario would result in a waiver. Each issue is reviewed on a case by case basis and DHS makes the final determination.

***Q: I render services for an EI participant that has insurance. I am an out of network provider. What should I do?***

A: Before rendering services to EI participants that have insurance coverage the provider is required to contact the insurance company to verify benefits (including in or out of network benefits). If the insurance company does not have out of network benefits contact the Service Coordinator. The Service Coordinator will attempt to find another provider that is available to see the child and is in network with the child's insurance policy. If the Service Coordinator is unsuccessful he/she will submit a request to the Central Billing Office for a waiver so that the

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out of network provider can render services but not bill insurance. The provider listed on the waiver would bill directly to the Central Billing Office.

***Q: An insurance company requires that a pre-certification be done. What is the billing process to the CBO for this scenario?***

A: Providers are always required to follow insurance guidelines. The provider should send to the insurance all of the required information to obtain pre-certification. Services with the EI participant should not begin until the insurance has responded by approving or denying the services. Upon receipt of the approval/denial letter from the insurance the provider would begin services and begin billing to insurance. Upon receipt of the insurance EOB for the date of services rendered and billed to insurance, the provider would send the claim form, insurance EOB and a copy of the approval/denial letter to the CBO for payment consideration.

***Q: How do I get started billing insurance companies?***

A: Because every insurance policy and insurance carrier is different, this is a very complex question. Many insurance companies will require paperwork to register a provider and this must be done prior to any billing. Other companies will enter a provider in the system with the receipt of the first claim. It is advised that the provider contact any insurance carriers that they are interested in registering with and complete any registration requirements prior to accepting a child with a specific insurance. Please call the Help Desk at 1-800-634-8540 and request to speak with a representative from the Insurance Billing Unit.

## **Questions Related to Billing the EI Central Billing Office**

***Q: I am a new provider and I have a lot of questions. Where can I go to find out more about Early Intervention and billing guidelines?***

A: Contact the Illinois Early Intervention Training Program at 1-866-509-3867 ext. 250 or visit the website at <https://eitp.education.illinois.edu/> for more information on training and an overview of the program.

Contact Provider Connections with questions related to credentialing and enrollment in the EI program at 1-800-701-0995 and visit the website at [www.wiu.edu/providerconnections](http://www.wiu.edu/providerconnections).

Visit the Early Intervention Central Billing Office website at [www.eicbo.info](http://www.eicbo.info) to obtain information on billing rules and guidelines or contact Help Desk services at 1-800-634-8540.

The Early Intervention Program is administered by the Department of Human Services Bureau of Early Intervention. It is suggested for providers to also view the State of Illinois Early

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Intervention program website at [www.dhs.state.il.us/ei](http://www.dhs.state.il.us/ei) for information on the program, provider guidelines and other requirements.

***Q: I would like to learn more about billing using the new billing services, including the free electronic billing option, and how to ensure payment for services.***

A: 1. Be sure to read the Early Intervention Provider Handbook

(<http://www.wiu.edu/ProviderConnections/policy/EIProviderUpdate.php?id=494> ).

2. If you are providing services for a child that has private insurance coverage, be sure to contact the insurance carrier to complete benefit verification.

a. If you are out of network and there are no out of network benefits with the child's insurance you must have a waiver in hand prior to providing services

3. Make sure that you have the paper copies of your authorizations in your hand prior to providing the services.

4. Be sure to provide the exact service that is on the authorization.

5. Be sure to submit your claims to the EI-Central Billing Office within the 90 day filing limit. You will receive a remittance, a Provider Claim Summary or a Mailback letter from the EI-CBO once your claim has been processed. It is the provider's responsibility to follow-up with the EI-CBO if the provider does not receive anything back from the claim that they have submitted to the EI-CBO. Follow-up by calling the Help Desk at 1-800-634-8540

***Q: I provided services for 90 minutes but the CBO only paid me for 60 minutes. The Provider Claim Summary from the CBO indicated an excess billed over the authorized intensity. I performed the services and would like to be paid for my time. How can I recoup the additional time?***

A: Unfortunately, there is no way to recoup additional dollars if the amount of minutes billed per session is over the authorized amount. Providers must bill according to their authorization. It is suggested upon receipt of the authorization the provider reviews the authorization for errors. If errors are found then the provider should contact the Service Coordinator immediately to discuss and to get the authorization corrected. After a correction is made the provider will receive an updated authorization. Providers should never provide service without and authorization in hand or beyond the level of service listed on the authorization.

If the provider has an authorization for 90 minutes then the claim may have been applied to the wrong authorization. Contact the Help Desk at 1-800-634-8540 to have the claim reviewed and possibly reprocessed.

***Q: I have an authorization for two times per week at 60 minutes. Can the session occur in the same day?***

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A: No. Only one session per discipline should be rendered in one day. The correct interpretation of the authorization is 2 separate sessions during a seven day interval for duration of 60 minutes. If the services are performed in the same day that is 120 minutes which is billing in excess of what was authorized.

***Q: How is a “month” determined for authorizations that are issued for monthly (2x/ month) services?***

A: 30 days from the start date of the authorizations is a rolling month. A month is not determined by a traditional calendar month (1<sup>st</sup> to the 30<sup>th</sup>). If the authorization starts on the 8<sup>th</sup> of January, the provider will have until the 8<sup>th</sup> of February to perform the authorized number of sessions.

It is wise to calculate the number of sessions permitted to avoid providing services beyond the authorized number of sessions. The provider runs a risk of not getting paid when extra (unauthorized) services are performed.

***Q: What is the filling limit for claims to the CBO?***

A: If the claim is not required to be billed to an insurance carrier, the claim must be received by the CBO office within 90 days from the date of service. If the claim requires insurance billing and an insurance Explanation of Benefits is required for billing, the claim and EOB must be received by the CBO within 90 days from the insurance processing date indicated on the insurance EOB. For Example, If the date of service or insurance EOB date is 5/15/16, day one of the 90 day clock starts the following day 5/16/16. Timely filing is never determined by when a claim was submitted but when it was received at the CBO. It is suggested that billing to the CBO at least occur monthly in effort to not have claims denied due to timely filing.

***Q: I submitted claims electronically but have had issues lately with claim denying for over timely filling. I submitted by claims on the 89<sup>th</sup> or 90<sup>th</sup> day.***

A: The timely filing rule states that “claims must be received by the CBO Office on or before the 90<sup>th</sup> day....”. All claims submitted to the CBO must follow an electronic path before being “received” by the CBO system. Please allow a minimum of 24 to 48 hours from the time of your submission of your claim for it to be considered received by the CBO.

***Q: What is the policy on makeup sessions?***

A: If a weekly or monthly session is missed it can be rescheduled but it must be done within 7 days of the missed session. If the session cannot be rescheduled in this time frame it must be considered as a missed session. If the provider knows beforehand that there will be scheduling conflict due to vacation for example, the session can be made up within 7 days prior to the regularly scheduled session. Once again if this session cannot be scheduled within 7 days prior to regularly scheduled session it should be considered a missed session.

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Note: The makeup session cannot be done on the same day as the regularly scheduled session. This is considered a duplicate service and the claim is not payable by the CBO. The provider should document the following in their case notes, the reason for the missed visit, and if it was rescheduled, the date of the makeup session should all be documented.

***Q: I like to bill my hourly services on separate lines in fifteen minute increments. The CBO paid the first line (15 minutes) and denied the other lines of service as duplicates. Why is this considered duplicate billing?***

A: Services rendered should be billed as one time per day in one line of service. This line of service will indicate the date of service, place of service, procedure code, duration of the session, and the amount billed. The CBO cannot process the same data on a second line of service or on another claim as this is viewed as a duplicate billing.

***Q: I used to provide services for a participant that has now aged out of the system. My claims are being denied due to an address discrepancy. What should I do since I no longer have any contact with this family?***

A: If the participant has aged out of the program contact the Help Desk to request a review of the claims by CBO. It is possible for the address to be updated but the EI provider(s) is not notified since they no longer render services. If the participant has aged out and the address on the claim was the last known address and claim will be honored by CBO staff.

***Q: Is the procedure code 92507 TL (Aural Rehabilitation and other related services) a billable code to insurance per the EI program.***

A: Local HCPC code 92507 TL is billable code to the insurance company. However, the determining factor of whether the provider is required to bill the insurance company depends upon the category of service that the rendering provider is credentialed under for the Early Intervention Program. Provider types AU, AR, DT, DV and ST currently used this procedure code for Early Intervention billing. Per Early Intervention guidelines Development Therapist/Hearing are not required to bill insurance therefor rendering provider types DT or AR are not required to bill the insurance company but can submit claims directly to the EI-CBO. The remaining rendering provider types ST, AU, or DV are required to submit their claims to insurance first.

***Q: I completed an initial evaluation for an EI participant. The family decided to not have an IFSP meeting and not to continue on with the Early Intervention Program. I am concerned about not being paid for the initial evaluation because it cannot be billed along with the IFSP meeting since one did not occur.***

A: In the event that a family decides to exit the program during the Intake period after initial evals have been completed, the credentialed evaluators can still be paid for the evals as long as the case was closed and an IFSP period was not entered by the Service Coordinator. During the

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billing process the CBO can verify that the case is closed and an IFSP was not entered. As long as all other billing rules were adhered to, the claim would be paid.

Note: The credentialed evaluator can also be paid for the initial eval under the following scenario: After the initial evals are completed, an IFSP (IM) meeting occurred but then the parent decided to exit the program and then the case is closed. Since the provider actually spent time at an IFSP meeting then they are entitled to be paid for this service. The Service Coordinator should issue an IM auth that exists during the Intake period. An IFSP period will not be entered. The provider should bill both dates and procedures to the CBO for payment consideration.

***Q: Can providers' bill for time spent completing the Developmental Justification of Need Worksheet?***

A: Yes, this worksheet along with any required Early Intervention report can be billed using IFSP Development codes. Please refer to the Early Intervention Codes and Rates Manual for more information on billable and non-billable activities for IFSP Development.

***Q: When I bill a claim to insurance sometimes I have to use multiple codes (i.e. 92507 and 92526) for appropriate billing to the insurance company. How should I then bill this to Early Intervention CBO?***

A: Providers are always required to bill insurance in a manner that is acceptable for the insurance company. Providers are also required to bill Early Intervention per specific billing guidelines therefore, when applicable, changes would be made to the claim in order to adhere to billing rules for both entities'. After billing the insurance company, the EOB would indicate both procedure codes and display how each code was processed (applied to deductible, paid denied, etc.). Since Early Intervention only authorizes one procedure code for direct service (i.e. 92507) the claim would need to be adjusted before submitting to the CBO. The only code that would be submitted on the claim form to CBO is the EI authorized procedure code. This code would be billed in one line of service but include the total billed amount for both codes to insurance. If the claim is submitted inappropriately to the CBO, it will be denied as billed amount does not match. The provider would be required to correct the billed amount on the EI claim to match the total billed amount on the insurance EOB.

***Q: My credential expired. Will I be able to be paid for the services that I have rendered?***

A: If the providers plan to continue providing Early Intervention services, then we encourage the provider to get re-credentialed as soon as possible through Provider Connections. If the provider had an authorization in their own individual name or was using an authorization that was entered to another provider at the same tax ID for the same service type, and that provider was the rendering provider 99% of the time for the participant in question, the CBO will continue to pay the provider. If these criteria are met, payment will continue until the end date

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of the existing authorization even though the credential has expired. Note: The provider will not be able to obtain any new authorizations until the credential has been restored.

***Q: I received a denial from the CBO indicating that I needed an insurance EOB. I sent a print out from my system along with the claim.***

A: The CBO cannot accept the printout from the provider's system or screen shots of any kind. The insurance EOB must be produced by the insurance company. The CBO only accepts a copy of the original EOB sent from the insurance company or a Remittance Advice that was sent from the insurance in response to the electronic claim. If the EOB is available online, a printable PDF version is acceptable; however, a screen shot is not. The remark code page must be submitted as well.

***Q: My claim was denied because the Associate Level Provider was not enrolled but they were supervised by and Early Intervention enrolled provider.***

A: All Early Intervention services must be performed by enrolled Associate Level providers and/or fully credentialed enrolled providers. All providers must go through Provider Connections and have received approval for either level. If the service was provided by a provider that is not known to the Early Intervention system, but was supervised by an Early Intervention provider, this claim will still not be paid by the Central Billing Office. If the CBO has mistakenly paid a claim for a provider that was not appropriately enrolled, a refund would be due to Early Intervention.

***Q: How do I know if a waiver has been issued?***

A: There are two categories of waiver, Pre Billing Waiver and Post Billing Waivers.

Pre Billing: A Pre Billing Waiver request is received by the Central Billing Office from the Service Coordinator. The Central Billing Office will review the supporting documentation submitted and approve or deny the waiver request. A copy of the approved or denied waiver is emailed to the Service Coordinator. The Service Coordinator is responsible for forwarding the waiver to the provider. It is important to verify and note the information listed on the waiver form. Check to make sure that the correct provider name, tax ID and category of service is listed. Also note coverage dates of the waiver. Services performed outside of the coverage dates may not be payable by the CBO. Providers can call the Help Desk (1-800-634-8540) and request waiver detail from a representative prior to starting services if you have not received a hard copy from the Service Coordinator.

Post Billing: Post Billing Waivers will appear on Provider Claim Summaries. Post Billing Waivers are issued after the CBO receives a qualifying insurance EOB along with a claim. The waiver is entered into the CBO system when the claim is processed. The approval of the waiver along

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with the start and term date appear in a shaded box underneath the claim data on the Provider Claim Summary. The Service Coordinator is not notified when post billing waivers are issued.

***Q: My claim was denied for needing an insurance EOB but there should be a waiver in the system.***

A: To ensure that a waiver is on file with the CBO and that it is accurate, the provider should always obtain a copy of the waiver from the Service Coordinator.

Note: Waivers cannot be backdated therefore; waivers must be in place before services begin. Waivers are service specific. For example, if a waiver was issued for group speech therapy services, individual speech therapy services are not covered by the group speech therapy waiver.

***Q: My claim to insurance was denied indicating the medical group did not approve. I sent this to the CBO and was informed that this denial reason was insufficient. I would like to know why the denial is considered insufficient?***

A: When the CBO receives this type of denial reason attached to a claim form the CBO makes a call to the insurance company to verify why the medical group did not approve the service. If the insurance indicates that it is not covered then the CBO will consider the claim for payment. If the insurance indicates that documentation was requested from the provider and not received, then the CBO will not consider the claim for payment. CBO will also not consider the claim for payment if the call to insurance indicates that a pre-certification, pre-authorization or referral was required but was not obtained. It is suggested when the insurance EOB does not clearly state that the service is not covered then the provider should also call to get clarification of the insurance denial.

***Q: I haven't received a Provider Claim Summary for months. Can I have a reprint of all of my summaries?***

A: The CBO mails the summaries weekly to those providers that had claims completed. If the CBO has previously received mail back from the post office then the provider is placed on mail hold status. When numerous requests for claim summaries are made, the CBO will first investigate why the summary was not received. We will verify address data and request that any address discrepancies be updated with the CBO through Provider Connections (IMPACT must be updated as well). Once the address is corrected, the CBO will then print a summary report of claims processed during the time frame stated of not receiving the Provider Claim Summary.

***Q: I owe the EI program money and cannot pay it all at once I would like to setup a payment plan. What do I need to do?***

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A: In order to set up a payment plan this request must be submitted to the CBO in writing. The letter to CBO requesting a payment plan must include the total dollar amount owed, reason for the refund (i.e. initiated by EI monitor, initiated by Early Intervention Central Billing Office, initiated by the provider) and the amount of the monthly payment. The letter should be submitted to: Early Intervention Central Billing Office, Attention Family Fee Accountant, P.O. Box 19485, Springfield, IL 62794.

***Q: I have noticed lately the CBO has indicated on the weekly PCS a discrepancy with participants' name. Although my claim was paid could this discrepancy result in denied claims in the future?***

A: Yes, it is possible for claims to be denied in the future due to discrepancies with the participants demographic data. The CBO uses the current data only to process claims. The CBO does not use nicknames or A.K.As for claim processing. The CBO staff will try and determine if in fact it is the correct participant for the EI number given but will note to the provider the discrepancy in the name. Upon receiving the notification the provider should verify with the family and the Service Coordinator which data is actually correct. The CBO uses the data that has been received electronically from the CFC sites. If the participant's demographic data needs to be updated, the SC must be notified in order to make the necessary changes.

***Q: I received a Provider Claim Summary but did not receive a check.***

A: Provider Claim Summaries are mailed weekly from the CBO. The Provider Claim Summary will have a date and an invoice number if any of the claims on the Provider Claim Summary will be paid. Checks are issued from the Illinois Comptroller's Office. Currently Early Intervention payments are delayed. To inquire on the status of payments visit the Early Intervention website at [www.eicbo.info](http://www.eicbo.info) or call 1-800-634-8540. If payments have been released then go to the IOC website at <https://illinoiscomptroller.gov/vendors/> to inquire on the date payment was actually issued.