

Louisiana EarlySteps CFO Billing Manual

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Louisiana Department of Health
EarlySteps
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Section 1: INTRODUCTION

Louisiana Department of Health

The Louisiana Department of Health (LDH) is the lead agency for the Louisiana EarlySteps Program and responsible for ensuring the provision of early intervention services to eligible infants and toddlers, birth to three years of age, and their families consistent with the requirements of Part C of the Individuals with Disabilities Education Act (IDEA). The Central Finance Office (CFO) is responsible for issuing service authorizations and for some payments made to providers for early intervention services.

Louisiana contracts with CSC Covansys to implement a web-based data system to capture the data for EarlySteps. The LDH also facilitates the coordination of payment for services from federal, state, local and private resources. The data system captures information related to EarlySteps referrals, intake, eligibility determination, IFSP services, and service authorizations for children served by the program. The CFO facilitates functions that determine appropriate payment and creates reimbursement to providers when the payor is not Medicaid. The CFO is housed at CSC Covansys' Operations Center located in Lenexa, KS.

The EarlySteps Online child data system is used by the System Point of Entry Offices (SPOE) across the state to enter child data as designated by the LDH. This data generates service authorizations from the CFO required for billing early intervention services.

Enrollment with the Central Finance Office:

As an EarlySteps approved agency or provider, you will need to be enrolled with the CFO. Instructions for the enrollment process can be found at <https://www.laeikids.com> under the heading *Provider Enrollment Forms*. After all enrollment forms are completed, reviewed and signed by your regional coordinator, mail them to CSC Covansys' Enrollment unit at:

CENTRAL FINANCE OFFICE
C/O CSC Covansys
PO Box 29134
Shawnee Mission, KS 66201-9134

CSC Covansys can be contacted at 1-866-296-4094 (select Option 2) or by e-mail at laeienroll@csc.com if you have questions.

Web Access Enrollment, Certification for Online Claims and E-Signature

These forms can be found on the website, <https://laeikids.com>, and must be completed to obtain access to the documents and forms the CFO office utilizes. The forms are in a .pdf format to download and print. The website provides additional links to policy information and contact information for the CFO/Enrollment Office. An individual's enrollment does not begin until all required paperwork is completed and received at the CFO, following which, the enrollee will receive an email with the system access information.

Services cannot be provided nor authorizations issued until the provider has completed enrollment with the CFO.

Section 2: SERVICE AUTHORIZATION

Service Authorizations are created by the regional SPOE office based on their receipt of all necessary information from the intake service coordinator or family support coordinator after an IFSP team meeting and/or other actions that arrange services for the child and family. These sources include:

- An Individualized Family Service Plan or IFSP.
- A Request for an Authorization/Provider Status Change Form for Eligibility/IFSP/Team Meetings and evaluations; or,
- Any change other action that requires the assignment of a provider to perform a service

Upon receipt of the information, the regional EarlySteps SPOE office enters the information into the data system, generates authorizations for services. This information is transmitted to the CFO immediately and stored for processing claims and payments to providers.

The authorizations are available to view online at the Provider Account Management tab on laeikids.com

1. Login into www.laeikids.com
2. Click on Provider Account Management > Provider Billing > Search > Authorizations.
3. Enter the Provider first and last name and select search. All authorizations assigned to that provider will display.
4. Details for each authorization can be viewed by clicking on the *Detail* icon next to the authorization line.
5. To view canceled, discontinued or inactive authorizations remove the check mark in the Search Filter that defaults the list to *Show Active Only*.

Search Filter										
<input checked="" type="checkbox"/> Show Active Only										

Search Results										
Detail	Claim	Auth Number	Start Date	End Date	Child Last Name	Child First Name	Child ID	DOB	Status	Provider
		A987627535-7	08/10/2005	01/30/2006	DELSEY	Child	987627535	01/31/2003	Active	Speech Pathologist, Provider
		A987627416-12	09/07/2005	11/25/2005	LANDON	Child	987627416	11/26/2002	Active	Speech Pathologist, Provider
		A987632578-9	08/14/2005	01/12/2006	ZAEVIAN	Child	987632578	04/13/2004	Active	Speech Pathologist, Provider

1 3 records

Print Back

Note: This authorization list can be printed by selecting the print block on the lower left of the screen. A print friendly document will open and can be printed directly from your computer.

The authorizations may also be viewed in EarlySteps Online by:

1. selecting the child for which you are authorized and
2. clicking on the Authorizations tab on the left side of the Child Summary page.

Prior to service delivery and submitting claims, the provider must review all details of the authorization for

1. Consistency with the IFSP service page
2. Start and end dates of services
3. Frequency and length of sessions
4. Total number of units/events authorized.

Authorization start dates will be consistent with the start date identified on the IFSP and are not reimbursed if provided *before* the authorization start date

Providers should pay close attention to the end dates of the IFSP and the authorization and are not reimbursed for services provided beyond the end dates if no new IFSP or authorization has been received.

Only services for which a provider has been authorized are reimbursable services. Inconsistencies in authorizations compared to the IFSP/team meeting notes should be discussed with the support coordinator before services are provided. Once the details of the authorization are verified, the provider must provide services as specified and complete and maintain all required documentation as evidence that the service was provided. Please review the EarlySteps Practice Manual and the Documentation Webinar on the EarlySteps website for these requirements.

Services billed by time/units must be billed for the period or time that actual services were provided to the eligible child and/or family/caregiver. Time spent in travel to or from the setting or in service documentation are not reimbursable separately, but are included in the rate paid.

Always verify that the authorization used for billing has not been cancelled or discontinued and that there are sufficient units remaining and services were provided as described in the IFSP.

Missing Authorization

If you are expecting an authorization that is not showing on-line, the missing authorization(s) could occur for one of the following reasons:

1. You may not be enrolled with access to the PAM site.
2. Problems or delays at the Family Support Coordination or EarlySteps SPOE regional office getting the authorized data into the system.
3. The authorization may have been cancelled or discontinued and is not showing on your active authorization list.

If you suspect that an authorization is missing from the system, contact the FSC or SPOE Regional Office to report your concerns.

Section 3: BILLING INSTRUCTIONS

Claims for provider services are paid based on the provider being in active enrollment status on the date of the service. For example, if a provider's account is inactivated on October 1, all service dates for that individual prior to October 1 will be eligible for payment. Services on October 1 and after will not be paid.

If agencies choose to bill the CFO using Electronic Data Interchange (EDI), they must fill out the Certification Statement for Electronic Data Submission form and the Trading Partner Profile. The Trading Partner Agreement (TPA) outlines the selection on how they will communicate with the CFO. The HIPAA legislation standardizes file formats, which must be followed when sending or receiving Protected Health Information electronically. More information on EDI is available in Section 5 of this document. These documents are also located on the website.

Provider claims can be entered on the program's secure website at <https://www.laeikids.com>. Individuals interested in Electronic Data Interchange (EDI) claims submission should go to Section 5 in this manual for specific information regarding this process.

Claims for services must be received within 60 days of service delivery (date of service). Your timely billing to the Central Finance Office is essential to your reimbursement.

The Central Finance Office (CFO) will reimburse claims for all early intervention services authorized and provided according to the child's record that are not otherwise Medicaid payable.. Agencies and providers must bill Medicaid directly for Medicaid payable services delivered to Medicaid eligible children. Providers are not to bill private insurance for early intervention services provided under the direction of an IFSP. Claims are submitted to the CFO through laeikids and providers do not bill LDH, the parents, or any other source for Early Intervention services authorized through the CFO. A child's Medicaid status can be viewed on EarlySteps Online, but is subject to change based on the child's Medicaid eligibility changes. Providers are therefore responsible for verifying Medicaid eligibility monthly for their authorized children and services billed accordingly. For Medicaid-eligible children, Medicaid typically pays for physical, occupational, speech/language therapy services, audiology, psychology and family service coordination. Medicaid billing is not covered in this manual.

CFO Standard Timelines/Deadlines for Claims Process and Payments

Claims Processing Turnaround:

Please see the Reimbursement Schedule located at <https://www.eikids.com/la/matrix/help/>

Stale Checks:

If a manual check is produced for a provider based on special circumstances, the check must be cashed within 6 months or the check is considered void.

Claim Filing Deadline:

Claims must be submitted within 60 calendar days of the date of service.

Provider Account Management (PAM) Claims Submission

Claims are submitted through the PAM web site (<https://laeikids.com>). PAM claims are processed weekly so adjustment can be made during that week. Below is the process for submitting a claim. Details for submitting claims through the website are also available online.

Electronic Billing & Claims Certification Statement

The *Certification Statement for Submitting Online Claims* must be completed by an authorized official of the early intervention provider agency or the provider, if enrolled as an independent provider. It documents that the provider/payee organization certifies the accuracy of claims information submitted electronically. This document is required for claims submitted on PAM .

Instructions:


- 1) Download the *Certification Statement for Submitting Online Claims* from laeikids.com under *the Provider Enrollment Forms* section.
- 2) Review the agreement.
- 3) Fill in the Provider Agency Organization Name.
- 4) Complete the Tax ID number of the provider/payee organization.
- 5) Fill in the name of the official within the organization who has the authority to sign on behalf of the individual provider. If the provider is an independent provider, that individual will sign.
- 6) Fill in the title of the above individual.
- 7) Sign and date the signature.
- 8) Fill in the name of contact person that is responsible for electronic claims at the provider agency organization.

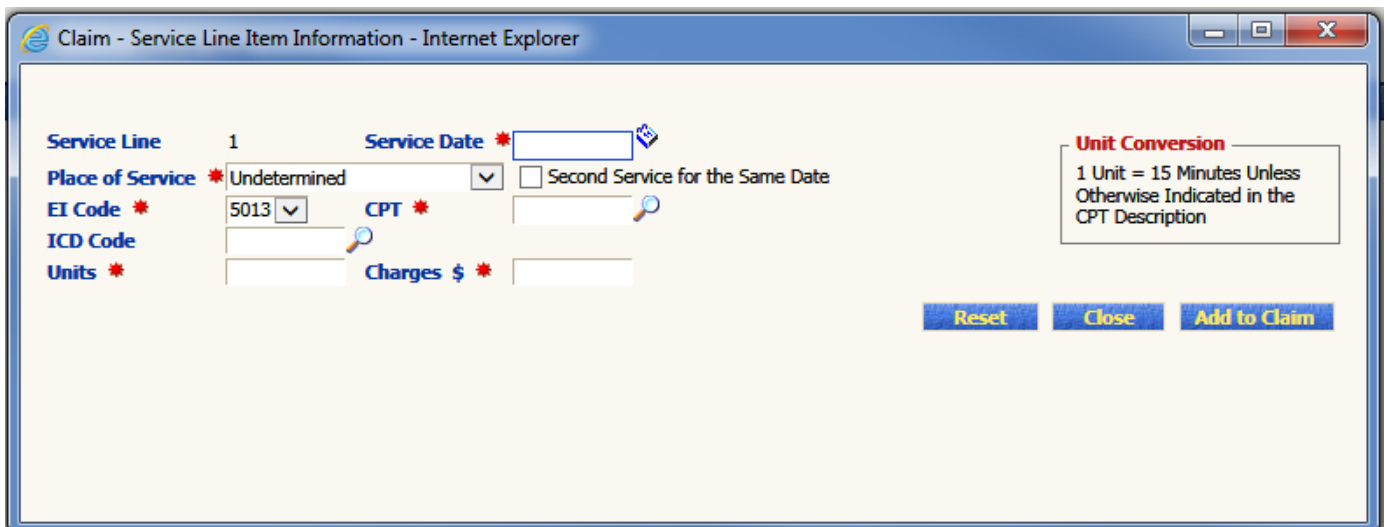
Submit this signed and completed certification form to:
CENTRAL FINANCE OFFICE
C/O CSC Covansys
PO Box 29134
Shawnee Mission, KS 66201-9134
866-296-4094

Provider Account Management (PAM) Claim Submission Process

1. To access the PAM you need to login from the home page at <https://laeikids.com>
2. Use one of the following methods to access the claim entry page:
 - Selecting the **Provider Account Management\Provider Billing\Claim Entry** menu option, or
 - Clicking the **Claim Entry** button on the [Authorization Detail](#) page.
 - Clicking either the **Correct Claim** or **Resubmit Claim** button on the [Claim Detail](#) page will also access the claim entry page.

The Claim Detail page will default to the Service Tab.

2. If necessary, enter the full **Auth #** or click  to search for an authorization. For more information, see [Search for an Authorization in Section 2 above](#).
3. Click the **Enter Service Line** button to add the detail line items for this claim. The [Claim - Service Line Item Information](#) page will appear.



Claim - Service Line Item Information - Internet Explorer

Service Line 1 Service Date *

Place of Service * Undetermined ☐ Second Service for the Same Date

EI Code * 5013 CPT *

ICD Code

Units * Charges \$ *

Unit Conversion
1 Unit = 15 Minutes Unless
Otherwise Indicated in the
CPT Description

4. Complete all of the required information on this page to enter a line for the claim. Fields marked with an asterisk (*) are required.
5. Click **Add to Claim** to save the claim line.

Additional information on authorizations, claims, billing entities, and provider accounts is available through online help located on the menu bar across the top of the page at www.laeikids.com

Explanation of Payment Statement

The CFO generates an Explanation of Payment (EOP) detailing the information on the claims submitted and processed. The EOP includes the claim number assigned to the claim processed, as well as amounts paid or not covered. When claims are rejected in part or in full the EOP will include a rejection reason. The EOP is available to the provider/billing entity on the secure website <https://www.laeikids.com> within "Provider Account Management" tab. To access the EOP, an authorized user must select "Billing Entity" from the dropdown menu then "Billing Detail". Enter the name or tax ID number for the provider agency and open the "Payments" tab on the billing entity detail page. The HIPAA standard 835, remittance advice, is also available for agencies using EDI electronic communication See EDI section which follows.

Explanation of Payment (EOP) Example

The online EOP report is titled "Claim List" and includes the following information:

- Claim Number
- Child Name
- Child ID Number
- Date of Birth
- Date of Service
- Amount Billed – this is the amount submitted by the provider
- Amount Disallowed – this is an amount billed over the allowable rate for the service provided
- Amount Denied – this is an amount not paid from the original claim and will be explained under the column titled "denial reason"
- Denial Reason
- Amount Paid Previously – this may happen with a portion of the claim was paid prior to the current claim
- Net Amount – this is the amount paid on the claim
- Submitted Date
- Provider

Resubmission of Rejected Claim

Resubmission of a previously denied claim must be marked as a 'Resubmission' and presented to the CFO as a paper claim. If the claim was denied and a correction is required on the authorization, please contact the family support coordinator. Corrections to authorizations require verification with the Individualized Family Service Plan. Required billing corrections may be completed and marked as such on the resubmitted form.

Claims Corrections

Corrections to previously submitted and paid claims should be marked as 'Correction' when submitted to the Central Finance Office.

Example # 1- Not enough service billed:

Agency bills and receives payment for services that represent 60 minutes when actual services for that day were 60 minutes. An additional claim is submitted, marked as "correction" on the face of the claim form, for the incremental 30 minutes of service. In addition, please place an X in the yes block indicating this is a resubmission of a claim, and make a note on the face of the claim form indicating this is for additional minutes.

Example # 2- Too much service billed:

Agency bills and receives payment for services that represent 60 minutes when actual services for that day were 30 minutes. Agency submits an additional claim, marked as 'correction' on the face of the paper claim, for the reduction of 30 minutes of service. The reduction should be noted with a minus sign or in brackets for both the time and the charges.

In addition, please place an X in the yes block indicating this is a resubmission of a claim. Make a note on the face of the claim form indicating too many minutes were billed and this would to be set up as an overpayment.

Automated Payment Adjustments:

CFO has implemented a system of automated claim adjustments or offsets to address agency overpayments or underpayments caused by an incorrect billing procedure. When errors are discovered, adjustments will be entered on the system after receipt of a written explanation from the agency. In cases of overpayment agencies will not refund payments manually through submission of checks. **The adjustments will be entered on the system against the individual claim and the system will deduct the amount** of overpayment on subsequent claim(s) payments processed for the provider. In cases of underpayments adjustments will be entered on the system against individual claims and the system will augment the amount of the underpayment on the next claim payments processed.

Manual Overpayment Refund:

Only when automated claims adjustment/offset is not a viable alternative the agency will be mailed two written notices (at 30 and 90 days from original overpayment date) instructing them to refund the overpayment identified by CFO. All manual refunds must be made to CFO no later than 180 days from original overpayment date. When submitting manual claims corrections for overpayment please make the refund check out to:

Central Finance Office
c/o CSC Covansys
and mail to:
Central Finance Office
C/O CSC Covansys
PO Box 29134
Shawnee Mission, KS 66201-9134

Section 4: CALCULATION OF UNITS ENCUMBERED

It is the responsibility of providers/agencies to monitor the utilization of service units they have been authorized to deliver, providers should familiarize themselves with the information below which describes the process by which the total units on an authorization are calculated. Most authorization types are addressed by the information below. However, in the case of Assistive Technology, authorizations are based on fixed dollar amounts for specific items.

Background

The CFO Claims system) determines the maximum usage of many types of authorization based on a calculated number of units authorized. For example, an authorization for a service with a frequency of 3 times a week for a length of 1 hour would have a total "units authorized" of 12 units (4 15-minute units x 3 sessions) per week.

Once all units authorized have been paid, claims are denied with reason code 12, "authorized limit exceeded." For individual authorizations, the total number of units authorized, number of units claimed and paid to date and number of units still available can be checked on-line. Log into laeikids.com and select the "Provider Account Management" tab. From there choose provider billing, then search, and finally authorizations. The following screen will become available:

Search options are varied and will all lead to the needed information; however, the easiest option is to enter the authorization number. Once your authorization is displayed on the screen, select “Detail” to view more specific information about the individual authorization. At the bottom of the page there are four options – *Print*; *Unit Summary*; *List Claim*; and *Claim Entry*. When you select *Unit Summary*, a screen with the following information will appear. You will see changes in these numbers as you submit claims for dates of service. A new authorization with no services billed and paid will show the total of units authorized in the first box and zeros in the other two.

Units Authorized	20
Units Used	7
Units Remaining	13

The system provides flexibility in how authorizations are determined resulting in the number of units. For example, an authorization can be written for x number of 15 minute units (length), y times (sessions) per z time period (frequency), from a start date to an end date (duration). This flexibility adds complexity to the calculation of the maximum number of units authorized. Most of the calculation is fairly simple. Usually, the difference in total units authorized that results from a variance of plus or minus a week or month is relatively minor. In some cases, the difference can be quite large, particularly when the authorization is written on a per-month, per-quarter or per-year basis.

Example of the challenge of calculating units:

A. 4 15-minute units (1 hour), 2 times per week from 1/1/2013 to 2/12/2013. This is about 6.14 weeks or 12.28 sessions.

Possible Totals: 48 units, if the date range is rounded to 6 weeks,

56 units, if the date range is rounded to 7 weeks,

B. 4 15-minute units, 8 times per month from 3/10/13 to 5/25/13

Possible Totals: 96 units, if the date range is rounded to 3 months,

64 units, if the date range is rounded to 2 months.

48 units, if the date range is prorated to 1.5 months.

A provider should carefully review the length of the authorization period and match to the number of units authorized.

Solution

An algorithm for converting a specified date range into a number of weeks, months or years is used to calculate the number of units each time a claim is submitted to determine whether it can be paid as follows:

U = the number of units authorized per session with one unit equaling 15 minutes. In other words the length of the service on the IFSP.

D = Duration of the authorization based on the number of days between the start and end date inclusive.

F = Frequency can be once, week, bi-weekly, month, bi-monthly or 7, 14, 30, or 56 respectively.

S = Number of sessions during the time period specified by frequency.

T = the number of sessions during the authorization, based on the number of days from start date to end date, divided by 7, 14, 30, 56 multiplied by the sessions during the time period specified by frequency.

If start date = end date or the time period is "Once," then T = 1, otherwise

T = the number of days between start date and end date (D), inclusive, divided by the frequency of the sessions (F) multiplied by the number of sessions (S) rounded up to the next visit.

Total Units Authorized = U x T. Summary:

The last section above describes the calculation, which simply put is this:

U = the number of units per visit

D = Duration measured in days from start to end date

F = Frequency that is weekly, bi-weekly, monthly, bi-monthly

S = Number of visit

T = the number of sessions falling between the authorization start date and end date. It is rounded up to the next session in the case of partial sessions, and it is determined as follows:

$T = \text{Round Up } (D / F \times S)$

Units Authorized = U x T where

Examples of Authorized Units

The following are some examples:

A. 60 minutes 2 times per week, from January 1, 2013 to February 12, 2013

U = 4 units

T = Rounded Up (43 days / 7 days per week x 2 times per week)

T = Rounded Up (12.286 sessions)

T = 13

U x T = (4 x 13) = 52

Units Authorized = 52

B. 60 minutes 8 times per month, from March 1, 2013 to May 25, 2013

U = 4 units

T = Rounded Up (77 days / 30 days per week x 8 times per month)

T = Rounded Up (20.533 sessions)

T = 21

U x T = (4 x 21) = 84

Units Authorized = 84

C. 45 minutes 2 times per week, from April 1 to May 31

U = 3 units T = Rounded Up (61 days / 7 days per week x 2 times per week)

T = Rounded Up (17.429 sessions)

T = 18

U x T = (3 x 18) = 54 Units Authorized = 54

D. 60 minutes 2 times per month, from February 1 to May 31

U = 4 units

T = Roundup (120 days / 30 days per month x 2 timer per month)

T = Roundup (8.0)

U x T = 4 x 8 = 32

Units Authorized = 32

The best way to avoid billing errors due to over-utilization is to monitor the unit summary for the balance of the units left available each time claims are submitted. Remember, you can only be reimbursed for the authorized number of units regardless of the actual schedule and for the date ranges in the authorization.

Section 5: Electronic Data Interchange (EDI) Claims Processing

The following information applies to only those individuals or agencies who are interested in receiving authorizations and submitting claims via Electronic Data Interchange (EDI) Authorization Files. The Provider Service Matrix has information on HIPAA Electronic Authorizations that are available as EDI files. This information is located at <http://laeikids.com/> under Louisiana Service Matrix >Help>Other Documents>EDI Claims Processing.

EDI Claims submission

CSC Covansys will accept up to 5000 claims per 837P batch file. The Implementation Guide recommends the creation of this limitation to avert circumstances where file size management may become an issue. The Implementation Guide can be purchased from the Washington Publishing Company (WPC) and may be available from other sources. Web site for WPC is <http://www.wpc-edi.com>.

CSC Covansys has determined the Electronic Transmitter Identification Number (ETIN), as used in the Implementation Guide, to be the Agency's nine-digit tax ID + a four-digit number as assigned by the CFO during enrollment.

The File Distribution System or FDS is part of the Service Matrix where HIPAA-compliant files are posted for the CFO and retrieved by providers and payees who are interested in submitting claims electronically. The first step in the process is to submit a completed Trading Partner Agreement to the CFO. The Trading Partner Agreement or TPA can be obtained from the Service Matrix website. Once a properly completed Trading Partner Agreement has been entered into the system by the CFO, the FDS system will be made available when logging into the Service Matrix with the provider's/payee's ADMIN username and password. If you need help finding this information, please contact the helpdesk.

Electronic billing is available through EDI transaction using files that follow HIPAA standard formats. Details regarding submitting claims electronically using EDI transaction are in the Companion Guides that are available at <http://laeikids.com/> under Louisiana Service Matrix >Help>Other Documents>EDI Claims Processing. To activate the electronic billing option please read the Companion Guides, complete and mail the Trading Partner Agreement and the certification statement. When we receive all of this information, we will email you about the next steps required for testing your HIPAA transmissions. **NOTE: For information on EDI testing, see Appendix A at the end of this document.**

CSC Covansys will accept the following files/transactions:

Number	Description
837	Health Care Claim: Professional

CSC Covansys will make available the following files/transactions:

Number	Description
835	Health Care Claim Payment/Advice
278	Health Care Services Review Response

Trading Partner Agreement General Information

The CSC Covansys Trading Partner Agreement (TPA) establishes a formal relationship that allows CSC Covansys and its trading partners to exchange electronic transactions using EDI transactions. A TPA is not required if the agency is only using PAM. The TPA outlines the roles and responsibilities that bind both CSC Covansys and its trading partner, to ensure secure electronic transmissions.

Any Early Intervention provider or agency that is a direct sender of batch electronic transmissions to CSC Covansys must complete the CSC Covansys Trading Partner Agreement. Trading partners must also complete the Certification Statement for Submitting Data Submission form as part of this agreement. Copies of the Certification Statement for Submitting Data Submission forms and instructions for their completion are found in the Early Intervention System Billing Manual.

CSC Covansys receives an original copy of the TPA, an email will be sent to the EDI contact named in the document. CSC Covansys requires the execution of its own TPA with all entities that are sending direct transmissions. The CSC Covansys Trading Partner Agreement is comprehensive and should address any issues or legal concerns of our trading partners.

Appendix A

Louisiana EDI Testing Procedures For Providers/Agencies

(NOTE: additional information on EDI claims can be found on page 12 of this document)

1. A provider, who expresses interest in electronic transactions, must complete the following steps:
 - a. Enter all requested information, and sign a Trading Partner Agreement (TPA) – It can be downloaded from the following website:

<http://www.eikids.com/la/matrix/>
 - b. Sign a “Certification Statement for Providers Submitting Electronic Claims” located on the website under Provider Enrollment Forms.
2. Companion Guides (guides which specify CSC Covansys data requirements), are available on the Service Matrix and Provider Module websites. All files must adhere to the HIPAA Implementation Guides and Addenda, which can be purchased from Washington Publishing at the following website:

<http://www.wpc-edi.com>
3. Providers/Payees who have submitted a properly completed Trading Partner agreement will be contacted. The EDI helpdesk will let the providers/payee know how to submit 837P files using the File Distribution System. The 837P files must adhere to the requirements set forth in the Implementation Guide as well as the CSC Covansys Companion Guide which is located on the Service Matrix. The EDI helpdesk is not capable of troubleshooting 837 files, so the providers/payees will need to have internal assistance for that. We will examine your files, and let you know whether they pass the requirements. Each error or problem will cause the file to be rejected. If your files are properly formatted to begin with, this testing procedure should not take very long.
4. After completion of the testing, the provider will be set to LIVE status for submitting 837 files. Log into the Service Matrix. Under Edit Service Matrix, they should see an additional icon titled “HIPAA Files”. If they do not see the additional icon:
 - a. Make sure they log in with their administrative account and password. Each agency is issued a standard password and an administrative password. The administrative password is the one they use to edit information.
 - b. If they are logged in with their administrative password, contact the Early Intervention Support Group at edi@csc.com.

After the provider clicks on “HIPAA Files” icon, they will be taken to our File Distribution System (FDS) screen. In the upper right of the grid, there is a blue circle with a white question mark. This is “Help” and it will guide the provider step-by-step through the process.

After the provider clicks on “HIPAA Files” icon, they will be taken to our File Distribution System (FDS) screen. In the upper right of the grid, there is a blue circle with a white question mark. This is “Help” and it will guide the provider step-by-step through the process.

The 837 files that are uploaded are generally processed in real time. There can be a delay of up to 30 minutes, but it is the responsibility of the provider to confirm that the files were successfully processed, and to correct and resubmit any claims that were not accepted. Results can be viewed on the FDS website

5. Other Transactions: The electronic authorization (278) and the remittance advice (835) are transactions created by EarlySteps. Providers can start downloading these files as soon as the EDI helpdesk sends notification that testing can begin. These files are also available from the FDS website. There is a HIPAA INBOX icon in the upper left hand corner next to the HELP icon. Authorization and remittance advice files are stored here and available to be downloaded. The providers are in control of requesting “Live” status by notifying EarlySteps when they have completed their testing. Each transaction is monitored separately and should be implemented one at a time.

Questions regarding this process should be directed to Early Intervention Support Group using edi@csc.com. This mailbox is monitored on a regular basis.

Appendix B

CFO Quick Reference - Billing Instructions

1. Log in with your user ID and password at www.laeikids.com
2. At the top of the page click **Provider Account Management**
3. Click **Provider Billing**
4. Click **Search**
5. Click **Authorizations**
6. You can search for authorizations by the child's name or by your name. The child's name must be spelled exactly for the authorization to be found.
7. If you search by provider name, a list of your active authorizations will appear. If you don't see a particular authorization, you must uncheck the box **Show Active Only**. This will pull up any expired or cancelled authorizations. You can still bill on these within the dates the authorization was active.
8. Click the **magnifying glass icon** under **Detail** beside the authorization you want to bill.
9. Click **Claim Entry** at the bottom of the page.
10. Click **Enter Service Line**.
11. A new box will pop up. Enter the information with the red asterisk (*). **Service Date**, **EI code** (this is already entered for you), **CPT code** (click on the magnifying glass and select the code that appears), **Units** (1 unit = 15 min), and **Charges** (total charges for that session).
12. Click **Add to Claim**.
13. Repeat **11** and **12** for any additional dates of service.
14. When you have entered all dates of service click **Close**.
15. Review the information. If you need to make changes, click the **magnifying glass icon**, change any information necessary and click **Update Claim**. Then click **Close**.
16. When all information is correct click **Submit**.
17. **Repeat** the process for the next authorization.

Additional Information:

Pay attention to your frequency (x's per month) and your start/end dates and click on Authorization detail to know which authorizations are for ongoing services, IFSP meetings, and Evaluations. Pop Up blocker must be turned off for this program to run effectively. Be patient after each click to allow time for the next screen to pop up.

An algorithm is used to calculate a specific number of units per authorization based on Start/End Date and Frequency/Intensity. You can verify your units by clicking **Unit Summary** on each authorization. You may not bill for more units than you are authorized.

You can also check the status of your claim immediately after you bill. Follow steps 2-4 and at step 5 choose **Claims**.

Denial Reasons:

Authorized procedure limit exceeded = exceeded allotted # of units

Charges are Medicaid Eligible = verify Medicaid status each month and bill Medicaid

Child not eligible for the program = IFSP expired prior to the team meeting (contact Regional Coordinator)

Over resubmission filing limit = claims must be billed within 60 days of service being provided

Duplicate charge = you previously billed for this date of service (check previous claims to confirm)

Not authorized on dates indicated = you billed on the wrong authorization, check your start/end dates on all authorizations and rebill on the correct authorization.

Frequently Asked Billing Questions

1. **Question:** I can't find my authorization(s). It disappeared.

Answer: Go to Authorization List and remove the check mark in the "Search Filter" where it states, "Show Active Only" in the block. All authorizations (active, discontinued and expired) will be displayed.

2. **Question:** I got a denial reason "*Not authorized on dates indicated*".

Answer: Look at the start and end date of the authorization(s) to ensure that service dates are within the authorization period.

3. **Question:** I received a denial reason "*Authorization cancelled/discontinued*". How do I know when an authorization(s) have been cancelled/discontinued before I bill.

Answer: Go To Authorization Detail and see if anything if there is a date next to Authorization Status and Date. You can also see the status on the authorization list after removing the check mark in the box described in Question 1.

4. **Question:** I received a denial stating "*Over resubmission filing limit*". Not sure what that means.

Answer: Claim(s) must be submitted within 60 days from the date of service. Any claims submitted after 60 days, will be denied.

5. **Question:** I got a denial reason "*Authorization procedure limit exceeded*". What does that mean?

Answer: All authorized units have been used. Go to Authorization Detail view unit summary at the bottom of page, which will show number of units authorized, used and remaining.