WV Birth to Three CFO Frequently Asked Questions

In an effort to supply information to Payees and their enrolled practitioners, we have compiled some of the most common issues received in the CFO call center. The following compose the most frequently asked questions:

1. If I miss a date of service will the system reduce the amount of billable units authorized?

No. The number of billable units is only reduced after a claim has been successfully processed.

2. What is a unit?

A unit is a measure of time – for most authorizations each unit will be composed of 15 minutes. Services are recorded for the child record using the WV Birth to Three Intervention, Service Coordination or Teaming Activity notes, including the actual minutes of face-to-face service. However, for claims purposes the service must be billed in units. Minutes of service ore rounded by the following rule: 8 minutes and up round to 1 unit and 7 minutes or less round down to zero. For example, 35 minutes of service would be rounded to 2 units.

3. How does the system translate the textual service description on the authorization?

The system receives the authorization from the RAU and translates the authorization into a 'bucket' of billable units. As the Practitioner presents successful claims to the CFO the system reduces the number of billable units in the authorization's 'bucket'. A calculator is provided by the CFO for you to calculate the number of billable units in the authorization. It is available at **http://wv.eikids.com** under the "Help" tab. The authorization reflects the intensity/frequency of evaluation/assessment services and/or the services identified on the child/family's IFSP.

4. What is a duplicate claim?

A payment has already been made for the procedure authorized on the date of service filed on the claim. Verify that the correct date of service and procedure was used to file the claim.

5. What are common authorization number errors?

The authorization numbers are preprinted on the authorization by the CFO. If you submit claims using forms other than what is provided by the CFO or submit paper HCFA forms – please make sure the authorization number is complete and in the correct format (A012345678-9).

NOTE: Avoid using an authorization that has been cancelled. A discontinued authorization can be used up to the date of discontinuance.

6. What is Denial Reason 12, "Authorized procedure limit exceeded"?

This denial reason states that the number of units authorized for the procedure has been exceeded. This Denial Reason is also used if the dollar amount is exceeded on a claim for Assistive Technology.

NOTE: Other Denial Reasons:

- Denial Reason 11 "Procedure code given not authorized". The procedure claimed was inconsistent with the procedure authorized. Please verify that the procedure code is the same on the claim as on the authorization form.

- Denial Reason 4, "Not authorized on dates indicated". The date of service on the claim was inconsistent with the date or date range authorized. Please verify that the date of service given is within the date range on the authorization for the procedure being billed.

7. What missing information causes a claim rejection?

A missing authorization number will cause a claim rejection. NOTE: This number is available on the authorization.

8. Are there any common problems with practitioner account numbers?

Make sure the practitioner account number is complete and in the correct format. NOTE: The practitioner account number should be correct on the authorization and match what is submitted on the claim.

9. What errors frequently cause line item rejections?

Denial Reason 15 - "No intensity provided in units" or the number of units claimed was not recorded on the claim
Denial Reason 17 - "No charges provided" or the claim did not contain the amount billed
Denial Reason 11 - "Procedure code given not authorized" or procedure claimed was not authorized
Denial Reason 4 - "Not authorized on dates indicated" or the date of service was not in the date range authorized.

10. Where will I find the procedure code to file on the claim?

Claim procedure code must match the Authorization procedure code or the line item will reject. Refer to the authorized procedure code to ensure payment of the line item.

11. How important is the practitioner specialty?

Each line item is checked to ensure the authorized practitioner performed the services. The practitioner specialty is validated and must be active for the date of service submitted on the claim.

12. What other reasons could cause my claim to be denied?

Denial Reason 5 - "Child not eligible for program".
Make sure the correct date of service is used. This date is critical for correct payment and could be related to many denial reasons.