Guidance for Creating Authorizations, Support of Teaming, and Billing for the use of 02-Telehealth (LVV) Place of Service during the Continued Pandemic

This guidance is intended to help teams accurately and consistently create authorizations that promote correct practice and efficient billing for the work performed. This practice includes all providers, including interpreters. **It is imperative that all aspects of this update are followed to avoid claims being denied**.

Effective with **Dates of Service beginning January 1, 2021**, all instructions provided in this memorandum must be followed in order to correctly create authorizations and for appropriate reimbursement of authorized services. These changes will impact the way many people currently submit claims so please read this memo in its entirety and follow the stated instructions for creating authorizations and submitting claims. Failure to comply with the instructions below will result in Payees receiving a denial of claims submitted that indicates the following:

The authorization number is required to properly adjudicate this claim.

Creating the Authorization(s):
The outcomes on the Individualized Family Service Plan (IFSP) are the key factor for helping teams determine the appropriate frequency, duration and setting of services. The Service Coordinator (SC) is charged with creating accurate authorizations that reflect the intended services so that interventionists can provide and submit claims for the services provided as outlined in the IFSP.

As the pandemic has shifted our methods for supporting families, we have also shifted how our existing systems can be used (given their current capacities) to support this work. These new billing requirements will assist interventionists with submitting claims that can be processed and reimbursed without issues.

During this unprecedented time, the team that creates the IFSP not only determines the services necessary to support the functional outcomes, but also carefully considers the needs of all team members to determine the best method for service delivery. The following guidance defines the various options, describes how to properly create authorizations, and provides instructions for how to bill using the appropriate authorization and codes.

To improve communication with those supporting families beyond early intervention (EI), IFSP Development time/authorizations can be used/created to support team members' interactions with certain people outside of the IFSP team when the family has consented to an exchange of information. This enhanced use of IFSP Development time is allowed to help families as they transition between EI services (change in team members); as they transition out of EI services (to the Local Education Agency for a child turning three Early Head Start, or Head Start Programs); and as they participate in other early childhood programs such as Home Visiting programs, Child Care, etc.

The team must obtain consent from the family to permit interactions with other appropriate programs supporting the child that are not necessarily listed as part of the IFSP team.

Reimbursement will be based on the place of service listed on the authorization.

The SC must create authorizations that match the intended services listed on the IFSP. The service delivery method should also be discussed, and the authorization should be created to match the intended service, including the intended Place of Service. Based on EI Principles and federal requirements to serve families in natural environments, most direct services are authorized as **offsite** using the following Place of Service codes:

- 12 (Home) if the provider would normally go to the home,
- 03 (Day Care) if the provider would normally go to the childcare, or
- 99 (Other) if the services would be delivered in another location where the child/family typically goes that supports achievement of the functional outcome(s).

Some outcomes require a non-natural environment for their achievement. When that is the case, the Service Coordinator typically authorizes the **onsite** Place of Service to be:

- 11 (Service Provider Location) when the family will come to the location of the provider or
- 62 (EI Program) if the family will bring their child to a program with other children experiencing developmental delays/disabilities.

During the continuing Pandemic, the Place of Service on the authorization will continue to be the intended location of the service. Providers are permitted to utilize LVV (Place of Service 02) to render service as appropriate. When limited In-Person visits are an option, the team should discuss using LVV to the maximum extent possible to reduce the risk or a hybrid of In-Person and LVV based on the unique needs of the child/family.

Submitting Claims:

Claims submission for services must be documented and match the true location of service delivery whether it be in-person or LVV, in a clinic setting or on the phone. As stated earlier, the reimbursement will be based on the authorized service place of service.

Changes Effective with Dates of Service Beginning January 1, 2021

Non-QClaims (including paper submission):

When a direct service is delivered using LVV, the claim submitted must indicate the Place of Service 02 and follow the guidelines listed below:

The authorization number, without special characters or dashes, should be billed in Box 23 of the CMS 1500 claim form.

- Authorization number appears as 123456-791-001-00 on the paper authorizations. However, Providers should only enter 791001 (which is the unique authorization number not including the child's EI # or suffix) in Box 23.
- Do not include the prefix (child's EI #) or the suffix (last two digits of the auth number)

AUTH NUM: 123456-791-001-00

- Bill one authorization number per claim. Dates of service listed on the claim must be covered by the authorization number listed.
- The Place of Service billed on the claims should be 02 (teletherapy).

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
791001

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. # | NPI

QClaims Users Only:
The authorization number without special characters or dashes should be billed in Box 19 on the CMS 1500 claim form screen.

- Authorization number appears as 123456-791-001-00 on the paper authorizations. However, Providers should only enter 791001 (which is the unique authorization number not including the child's EI # or suffix) in Box 19.
  - Do not include the prefix (child's EI #) or the suffix (last two digits of the auth number)

    AUTH NUM: 123456-791-001-00

  - Bill one authorization number per claim. Dates of service listed on the claim must be covered by the authorization number listed.
  - When an Associate Provider must be billed as well, enter the authorization number into box 19 as described above followed by a comma (,) and the Associate Provider's name (see image below).

NOTE: Box 23 of the CMS 1500 claim form is reserved for Interpretation/translation use (instructions for interpretation/translation claims below the sample).

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE NPE 17a. 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
791001, Associate Provider's Name

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From To | B. PLACE OF | C. | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) | E. DIAGNOSIS | F. | G. DAYS | H. EPSDT | I. ID. | J. RENDERING

Interpreter/translator claims will continue to have the two-position code of the discipline the service was provided for in Box 23. The interpreter/translator must follow the requirement to place the authorization number in Box 19. Effective with dates of service on or **after January 1, 2021**.

If you have any questions on properly completing the CMS1500, you may contact the CBO Help Desk at 1-800-634-8540.