

## FAQS ABOUT BILLING INSURANCE

### **1. If you are a provider and the child you are currently providing services for only has insurance, is it up to the provider to bill insurance before billing CBIS? What are the steps they need to go through?**

If a family indicates that they want to use their insurance, providers must attempt to bill the family's insurance company for all therapeutic intervention services [with the exceptions noted in 911 KAR 2:200, Sect. 5(10)] BEFORE billing CBIS. Providers must contact the insurance company, using information provided to them by the ISC/PSC from the FS Financial Information Form (Resource 10). If the insurance company issues a verbal denial, the provider must fully document with a staff note. There must be enough information (name, position, extension of person spoken to, content of conversation, etc.) so that someone else could contact that person and verify what was documented in the note. Providers should bill the insurance company and get an explanation of benefits (EOB) from them. When providers bill CBIS, they must attach a copy of the EOB or, in the case of a verbal denial, a copy of the staff note, to their invoice. Providers who bill insurance have 60 days from the date on the EOB to bill CBIS. They must bill CBIS manually by using the CBIS Billing Form (Download it at <http://cbis.louisville.edu>). By following the instructions that accompany the form, providers may bill CBIS for insurance co-pays, deductibles and the difference between what insurance paid and the state maximum rate (or the provider's usual and customary rate, whichever is lower). This is called "balance billing." The total invoice – including co-pays, deductibles and balance billing – will be paid up to the state maximum rate for the service.

Providers who are not used to billing insurance should contact other providers who are more experienced at billing insurance, and/or the insurance company for billing information. Finding and attending insurance billing training is strongly encouraged.

Note: Program evaluators will expect to see evidence of attempts to bill it.

If a provider receives a denial by a family's insurance company, it is valid for the duration of the plan period. The provider must attempt to bill insurance once for each plan period. If a provider is added by amendment during the plan, then a denial by a family's insurance company is valid for the remainder of the plan period.

If a provider bills the insurance company but hasn't heard anything in 60 days from the date of billing, then the provider should call the insurance company and try to get a verbal denial. If they will not issue a verbal denial, then the provider should document this with a staff note in the child's record. Then the provider must attach a copy of the note and proof of insurance billing to the CBIS invoice and bill First Steps in full.

**2. What is the procedure if a provider has already been paid by First Steps for a service, but later bills and receives payment from insurance?**

- a. This process is a manual, not an electronic process because of the attachment(s) that must accompany the invoice. Please resubmit the invoice to CBIS using the CBIS Billing Form (This can be downloaded from <http://cbis.louisville.edu>. Then click on the “Download Forms” link. Scroll down until you come to the CBIS Billing Form link).
- b. In the “Amount Paid by Third Party” column, enter the amount that insurance paid for that service.
- c. In the “Total Invoice Amount” column, put the total amount for the service: either the maximum state rate or your usual and customary rate. CBIS will deduct the amount paid by insurance from the provider’s next check, allowing for co-pays, deductibles and the difference between what insurance paid and either the state rate or the provider’s usual and customary rate (called balance billing), whichever is lower.
- d. Place a check in the column that says, “Check if Resubmittal.”
- e. In the “CBIS Event No. of Previous Submittal” column, use the same CBIS event number that was given on the original paid claim (The event number was provided on the remittance advice).
- f. Attach a copy of the EOB (Explanation of Benefits) from the insurance company to the CBIS Billing Form. CBIS cannot process your claim without it.
- g. Providers should not send any checks to CBIS or to the state!

**3. What if the parents do not want to use of their insurance?**

Families may choose whether or not they want to use their insurance, with the following exceptions: a) Families whose children are dually covered by Medicaid and private insurance have already agreed to have their private insurance billed as a condition of accepting Medicaid; and b) Families who were already using their insurance for a medical service before entering FS should continue to use it for that service (First Steps is the payor of last resort). However, if the IFSP team deems it appropriate, the child may also receive an early intervention service from the same discipline, in addition to what they were already receiving. In those cases FS will pay for the *additional services*. Early intervention and medical service providers should collaborate and coordinate with each other to provide the least amount of intrusion into the family’s life.

**4. If the parents agree to have insurance billed, do they have to pay co-payments? If insurance pays, will families receive their Family Share payments back?**

Per 2:200, Sect. 5 (9), families who use their insurance are not responsible for insurance co-pays. They are, however, responsible to pay their Family Share fee upfront until/unless the insurance payments received by the provider(s) in a calendar year meet or exceed their Family Share obligation for that same calendar year. The EOB dates – not the dates of service - must be before or on December 31<sup>st</sup> in order to count for the Family Share obligation for that calendar year. Families are responsible to provide documentation (a copy of the EOBs) to the DPH Family Share Administrator. They will receive a refund of what they have paid towards their Family Share, after providing the Family Share Administrator with the parent's name that should appear on the refund check and that parent's social security number.

Because of the timeframe in which insurance payments have to be received in order to count toward the family's annual Family Share obligation, providers need to be timely, accurate and complete in their insurance billing.

Providers are expected to bill CBIS for a family's insurance co-pays and deductibles, as long as the total invoice does not exceed the state maximum rate. Under no circumstances are FS providers to collect insurance co-pays and/or deductibles from FS families.

**5. If a child is dually covered, whom does the provider bill first, insurance or Medicaid? Do they also bill CBIS?**

Providers must bill insurance and receive the EOB or some other approved written denial (Medicaid will not accept documentation of a verbal denial). Providers are not required to bill Medicaid after they bill insurance (This is an automatic CBIS process). They should follow the procedure for billing CBIS outlined in the answer to question #1.

**6. Are agencies supposed to bill Medicaid first and then CBIS?**

Providers are expected to bill CBIS for children who have Medicaid/KCHIP. CBIS will in turn bill Medicaid. First Steps is the only authorized Medicaid provider for early intervention services.

**7. If an eligible child receives all services at the hospital or other clinical setting which is not a natural environment, does the hospital (or clinic) bill First Steps or Medicaid? Parents chose the setting.**

First, First Steps services require a justification to be made on the IFSP documenting the reason(s) that services are not being delivered in the natural

environment (Family choice, safety concerns and the fact that insurance companies are more likely to pay in a clinic/office setting are NOT acceptable justifications). Second, whether the hospital bills First Steps or Medicaid depends upon whether this service is a medical service or a developmental service. If it is determined that the hospital will be providing a developmental service and a justification has been written on the IFSP explaining the reason(s) why this service cannot be provided in the natural environment, the hospital may bill First Steps.

**8. Are all providers required to bill insurance, regardless?**

The regulation applies to agencies and independents alike who provide therapeutic intervention services. Per 2:200, Sect. 5(10), which references 2:130, Sect. 2(9)(g) 2.j., k., or l., the only therapeutic intervention providers who are not required to bill insurance are developmental interventionists, developmental associates, teachers of the hard of hearing and teachers of the visually impaired. Service coordinators are also exempt from billing private insurance because they do not provide therapeutic intervention services.

Insurance is NOT to be billed for evaluations and assessments – only for therapeutic intervention.

(NOTE: In the future a developmental interventionist and a developmental associate may be required to bill insurance.)

**9. What is the procedure when insurance makes payments directly to the family rather than to the provider?**

Procedure When Providers Need to Collect Insurance Payments from the Family:

a. If the provider is notified that insurance has made a payment to the family, but the family has not paid the provider, the provider should first attempt to collect the payment directly from the family. Perhaps a letter is in order, stating the amount that is due, to whom the check should be made out, where the check should be sent, and the date that payment is due. Also request a copy of the EOB if you do not have one. Some providers feel comfortable enough to talk to the family directly. Face-to-face is best, so that the family could write out a check right there, if possible. The provider could offer to make a copy of the EOB and send the original back to the family. Depending upon where the provider is, s/he could go to a post office or a grocery store, make a copy and come right back, if these places are close by. If this is not feasible, the copy would need to be made at the office. For shorter distances, the provider may want to bring back the original in person. For longer distances, the provider may want to mail the EOB

back, ensuring that there is an additional copy at the office in case the original gets lost in the mail.

b. If the family does not respond to the provider's request for payment, the provider should notify the PSC, who can contact the family and attempt to obtain payment for the provider. The provider should provide the PSC with all the information that is needed, e.g., a copy of the letter that was sent to the family, a copy of the EOB if you have one, instructions on who to make out the check out to, etc. Work out with the PSC how you will receive the payment: by mail or in person.

c. If the family does not respond to attempts by the provider and the PSC to collect payment, the provider has the right to initiate formal collection procedures. The provider should also notify the Financial Administrator in Frankfort (502-564-3756). The Financial Administrator will write a letter to the family, notifying them that they will not receive a refund of their Family Share payments unless they pay the provider the amount that insurance paid them. If the family notifies the Financial Administrator that they have paid the provider, the Financial Administrator will first verify this with the provider before approving the Family Share refund.

#### Procedure for Providers After Receiving Payment from the Family:

a. Using the CBIS Billing Form, bill CBIS for co-pays, deductibles and the amount between what insurance paid and the state rate, or your usual and customary rate, whichever is lower. Attach the EOB to your invoice. You have 60 days from the date on the EOB to bill CBIS.

b. In the event that the 60-day deadline has passed due to the fact that the family did not provide you with payment and the EOB in a timely manner, contact the First Steps Financial Administrator in the Central Office in Frankfort at 502-564-3756 for approval to have the deadline waived.

#### Responsibilities for the Family:

a. The family shall deposit the payments and make out the checks to the provider.

b. The family shall provide the provider with a copy of the "Explanation of Benefits" (EOBs), if the provider is not receiving them from the insurance company directly. The EOB must, at least, have the date(s) of service on it in order for CBIS to process it. If the EOB does not have this information, either the provider or the family will need to contact the insurance company to obtain this information.