

Questions and Answers from Early Intervention Insurance Assessment Webinar

October 2015

The following is a list of answers to questions received during and shortly after the *Insurance Webinars* held in October 2015 to assist CFCs, EI Stakeholders and Providers in understanding and further clarifying the use of insurance in Early Intervention. As stated during the Webinar, this information does not reflect a policy change.

The questions and answers are grouped by categories to make this a useful tool. You may also find additional information, such as the recorded [Webinar on Insurance](#), on the EI Training Program website at <http://eitp.education.illinois.edu>. This website is updated regularly with additional resources.

Forms

Q1. Can you confirm that the *Consent to Use Private Insurance/ Healthcare Plan Benefits and Assignment of Rights* is NOT to be sent to CBO as the choice will be reflected in V-stone on the authorization for this situation?

A1. The consent does not need to be sent to CBO as the benefits verification process will be completed prior to the need to obtain consent for employer self-funded plans. In fact the benefits verification process will let you know for which plans you need to obtain consent.

Q2. After reviewing the new PII form and consent insurance form, there is confusion about when to present the form and the explanation of insurance billing/decline etc. There were also many questions about how to complete the forms. I think we need specific info on filling out the forms appropriately if...when... then mark ... box and sign or don't sign. Visual examples of complete forms are helpful.

A2. DHS is piloting a checklist of sorts to help service coordinators understand when certain forms are appropriate or required. This will be released very soon!

Q3. If a family does not sign the *CFC Acknowledgement to Decline Exemption for Tax Savings Account* form, is it correct that the HSR/HSA will automatically be utilized? Are there changes to the process of declining the Tax Savings Account Exemption? For example, if previously a parent had declined the Exemption because the HSA was already drained, they may then submit a new Exemption request to get the exemption back in place when the HSA is filled again at new plan year (Jan 1).

A3. There were no changes to the ability of a parent to decline the Tax Savings Exemption if they understood their account was depleted for that particular plan year and then reapply for the Exemption in time for the new plan year to start. The SC would have to work very closely with the family and providers to ensure all steps are in place in time to avoid any additional costs to the family or loss of funds in their tax savings account.

Q4. We currently have a form called *Consent to Store and Utilize Personally Identifying Information (PII)*. I no longer see this (stand-alone) form with the new manual forms. There is *Consent to use PII& Public Benefits*, but I just want to make sure I am not missing something and that PII is now only associated with the Public Benefits form?

A4. At the request of the CFCs, we combined the consent for PII use and the consent for Public Benefits to save a little paper but the PII is really more about us getting their information into Cornerstone. The rationale was that the Medicaid process happens through Cornerstone so the two data systems talk to each other and we needed their Informed Consent. So you did not miss anything, we just have one form instead of two!

Q5. When will we get the updated forms that were described in the webinar?

A5. They were released to CFCs with the copies of the new Procedure Manual.

Processes

Q6. When changes occur and there is a 45-day Exception approved, time will be given (assuming it doesn't go beyond the 45 days exception) to follow through on the requirements of the benefits verification (BV), correct?

A6. Correct. After submitting the *CFC Fax Cover sheet for Insurance Benefits verification Requests/Updates* indicating there is an update to insurance benefits as outlined in Chapter 10 and receiving the 45-day Exception approval, the SC has "up to" 45 days to determine if a change in providers is necessary based on the results of the new BV. If no provider change is necessary, the provider may resume billing insurance appropriately – even if this process takes less than 45 days. The 45-day Exception just allows a cushion of time to perform all of the necessary work but doesn't prohibit the process from going more quickly.

Q7. Does the 5 day BV timeline apply for an HMO?

A7. The 5-day response time applies to all insurance BV requests but the CBO is aware of a limited number of plans that may take some extra processing time and will work with the SC in those few instances.

Q8. What do service coordinators do when the family's insurance changes but the service coordinator is not notified until months later?

A8. It is recommended that service coordinators work to avoid this situation by checking in with families on a regular basis about changes to insurance. It is also recommended that they remind providers to check with families on a monthly basis to see if the family has had changes to their insurance plan. When the SC is informed of the change, the SC must perform the same required steps as if they were told timely. The time-period between is handled based on the specific "change". Example if insurance coverage ended 2 months prior, the provider would be able to bill CBO for those dates past the end date of insurance after the BV change process is completed and the Lapse Date is known to CBO.

Q9. Can the SC please receive the 45 day exception immediately upon receipt of the change of insurance? Clarification: Once an SC submits an insurance change to CBO it would be nice to receive the 45 day exception form back immediately... sometimes it is several days or we don't receive it at all, yet providers won't continue without having a copy of it. So the question is: how soon after the change of insurance is submitted can we expect the exception form to be sent to us?

A9. The 45-day Exception is approved based on the Update indicated on the BV form. Proper use of the *CFC Fax Cover sheet for Insurance Benefits verification Requests/Update* is vital to the appropriate actions taken by the CBO. If no Update in Section 3 of the form is indicated, the CFC will not receive a 45-day Exception. If the family changes insurance, the CBO can't release the 45-day Exception until they verify the Lapse date which sometimes takes a while. If the update is to gain insurance for the first time, the 45-day Exception is sent the same day.

Q10. Just for clarification: the initial insurance BV consists of the insurance card and the fax cover sheet only?

A10. Yes, the initial private insurance BV process requires copies of the front and back of the insurance card and the *CFC Fax Cover sheet for Insurance Benefits verification Requests/Updates*.

Q11. Wondering if we can still provide consent at initial BV submission if family/SC does not yet know/have the information regarding whether or not it is self-funded and whether they can decline or not?

A11. It is not appropriate to obtain consent without knowing the results of the initial BV and/or whether or not the child is eligible for early intervention services. Families should have information about the BV results as well as what services are being recommended so that they can provide informed consent about insurance use.

Q12. The BV only displays the first few providers. Will CBO be providing the full list in the future?

A12. Per request of the CFCs when the BV process was implemented, they do not want the full list as it may be 50 or more providers. The decision to limit the list and sample it with each pull was done to keep the process manageable. If a SC would like another list to assist the family in keeping to the In-Network providers, they can request additional names from the CBO Insurance Processor.

Families

Q13. Previously DHS said they would provide a memo to families explaining the changes so it wasn't a surprise when SCs started these new procedures with current families. Are they still planning to get this out to families? Will you offer talking points to explain the change with families?

A13. DHS has developed a memorandum for SCs to share with families who are affected by the change. This memorandum is specifically for families who previously had the option to decline use of their private insurance but who will no longer have this option with the implementation of the new manual. At the family's next annual, they will need to consent to continue services in Early Intervention.

Q14. If a parent has both public and private insurance can they decline either?

A14. A parent can decline use of either type of insurance within the policy/procedures EXCEPT- If a child enters Early Intervention already on public and private insurance, the parent cannot decline the use of public benefits. The private benefits would be subject to the remaining policies/procedures

Q15. Can you touch on the families that are classified as "undocumented immigrants" who are unable to apply for any benefits and their right to receive services?

A15. In any instance that the family has no private or public benefits (for any reason), any services outlined on the IFSP are available and authorizations should indicate no insurance.

Q16. I think it is confusing on why a parent would not want to consent to use insurance if it is an employer self-funded insurance plan. Why would a parent decline? What are the ramifications for families to consent to insurance if they have an employer self-funded plan? Why would a family want to refuse to use their insurance in this case?

A16. Families may want to consent to use their employer self-funded insurance plan. The reason that this group of plans is treated differently at this point in time is because these plans are not currently subject to the same no cost protections guaranteed by law for other types of private insurance. In some cases, utilization of their benefits can lead to increased group costs which

may ultimately get passed along to all employees. Each family will need to consider the consequences of utilizing their insurance benefits. While the Affordable Care Act and federal ERISA laws have established most of the same assurances as the Statute in Illinois, federal regulations require we obtain consent to know the family is fully informed and makes the best decision for their family.

Q17. If a family has both private and public insurance, do they pay a family fee?

A17. Children covered by Medicaid (public insurance), would not have a family fee imposed on them based on the assumption their income qualifies them for the Medicaid coverage.

Q18. Is it true that the only way for families to pay is by check or money order?

A18. It is true that for Family Participation Fee installments, the only method is a check or money order. (Families can utilize "bill pay" processes at their financial institutions for recurring payments if available but must watch the change in account # when the annual IFSP occurs as the Family Fee account number changes.)

Q19. In the spirit of family choice, how do you retain a provider once the insurance changes during an existing IFSP? Given they no longer qualify to serve.

A19. In that same spirit, we allow the family to choose when choices are available. If insurance use or availability of providers limits the choices to one, we have done as best we can in getting Early Intervention services to the family.

Q20. How will the family be notified that insurance will not be covering the service once a Post Billing waiver is approved? Will the CFC receive a copy of the post billing waiver?

A20. At this time, the CFC does not receive a copy of the post-billing waiver. The family should receive an Explanation of Benefits from their insurance company stating that the service is not covered. This information is what the provider sends to the CBO to have the post-billing waiver issued. DHS is considering a method to have that information shared with the CFCs so the CFC and families know and can understand any affects this has on service delivery and/or family fees.

Q21. For families that have already declined insurance before 11/1/15 what is the timeline for obtaining consent if they have an employer self-funded plan?

A21. As stated during the webinar, service coordinators should plan to review the change for families with non-employer self-funded plans prior to their next annual IFSP so that any questions can be addressed and any necessary paperwork can be completed prior to the start of the next IFSP.

Q22. If families decline an exemption, how often must we review the decline with them and have them sign the form to decline the exemption?

A22. The family needs to make a decision about the utilization of an exemption when their initial service plan is developed, when changes are made to the plan, and when a new plan is initiated. It would be best practice to have the family provide the information about the plan year and ensure they notify the SC when it is time to put the Exemption back in place.

Private insurance

Q23. Need clarification that for families with non-employer self-funded plans direct services subject to fees are never authorized until the family assigns insurance benefits; this includes DT services. Ann said she wanted to clarify, but DT is subject to fees, and procedure manual says all Direct Services subject to fees. Would a family be able to have DT if they refused to use insurance?

A23. A family's compliance with early intervention requirements is necessary regardless of the services on the initial IFSP, so needed consents should be obtained prior to the initiation of any services. Since a family's needs will likely change during their time in early intervention, securing the necessary consents at each point facilitates the process and helps the family become an "informed" participant.

Q24. For employer self-funded plans, will families continue to have the opportunity to consent or decline for specific services, or just overall consent for the plan?

A24. Yes, they will continue to be able to consent/decline specific services.

Q25. What is the difference between employer self-funded and non-employer self-funded? Please clarify the definition of employer self-funded.

A25. Employer Self-Funded Plans are plans for employees where the employer uses their own funds/personnel to fund the costs of the benefits. Typically the employer contracts with a known health plan to coordinate the claims process. Non-Employer Self-Funded Plans means an employer contracts with an insurance company to both fund the cost of the benefits as well as coordinate the claims process.

Q26. So the only real difference in procedure between employer self-funded and non-employer self-funded is we have to get the consent for employer self-funded?

A26. Yes, that is the primary difference. Consent is still needed for employer self-funded.

Q27. How will we know if it is an employer self-funded vs an individual self-funded plan?

A27. This information will be provided as part of the CBO benefits verification process. The BV response indicates if a plan is employer self-funded and it will also indicate if a plan is an "Individual plan (not part of a group)" which equates to the Individually Purchased/Non-Group plans explained in Chapter 10.6 that would qualify for an Exemption.

Q28. Clarification, so if the family has an employer self-funded plan, we have to get waivers?

A28. No. Employer self-funded plans simply require consent for use. If a family consents to use, then the determination of whether or not a waiver is applicable needs to be made. If a family does not consent, the authorization should indicate the insurance was declined (same process currently used).

Q29. What if a family has a non-employer self-funded plan and does not give consent or allow use of their plan. Would they be able to still receive services?

A29. As stated in 10.3.1, families whose children are enrolled under private insurance plans that are not Employer-Self Funded must allow use of their benefits to assist in meeting the costs of covered EI services and AT devices. The only services that they could receive would be those provided at public expense, evaluations/assessments, ISFP development, and service coordination.

Q30. Are larger employers more likely to have employer self-funded plans?

A30. Not necessarily, there is not a proven formula for determining the likelihood of a plan being employer self-funded so it is best to utilize the information obtained through CBO's initial benefits verification process.

Waivers and exemptions

Q31. When calling in-network providers, how long should SC wait to hear back from the provider to determine if we need to submit for a waiver? A set guideline should be put in place for how long a SC should need to wait to hear back from an in-network provider listed on the BV before submitting their waiver request to CBO. This will avoid a delay in the request as the CBO has sent some back in the past because the SC hadn't heard back from the provider(s) yet. Maybe 2 business days??

A31. DHS has never established a time-frame mainly because it felt that CFCs were likely to know their providers better than anyone. Best Practice would probably say that if a SC has not

heard back in 2 business days, the SC can case note the fact they have received no response and move forward with the process. Be sure proper documentation of all activities is completed.

Q32. Do waivers still require an individual provider's name?

A32. Ideally, yes, but an initial waiver can be issued for a discipline based on the results of the initial CBO benefits verification process. The SC will need to send the payee's name and tax identification number as soon as an available provider has been identified. A provider must have a waiver with their payee information on it prior to beginning services.

Q33. When changing providers who have a waiver, can we send in the name and ID# of the new provider via email to CBO or do we have to complete a completely new waiver? Example, if the original speech on the waiver returns the case and we identify a new speech we would have to complete a new BV, make all necessary calls and then submit the waiver?

A33. When a provider with a waiver must be changed, the steps may vary based on the waiver type. In the case of no in-network provider, a new waiver would have to be obtained because there may be an in-network provider available at that time. Overall, it would behoove the SC to submit a new request for a BV in case things have changed since the original BV.

Q34. If the CBO sends a waiver at the initial IFSP. Why do they sometimes deny the waiver at the annual?

A34. This would generally happen if there has been a change to the family's benefits or a change in the availability of providers within their network. A change in benefits can occur even within the same company. Example: Aetna may still be the carrier but their benefits changed at the renewal so they no longer have to limit themselves to in-network providers or other provider restrictions.

Q35. If a service coordinator extends the IFSP, will the waivers still be honored by CBO? CBO has told us that we no longer need to notify them when an IFSP is extended. They informed us that when an IFSP gets extended in the cornerstone system, waivers, exemptions, etc. are automatically extended on their end as well so we do not need to notify them any longer. However, the webinar information just stated that CBO does need to be notified. Can you please clarify? Can you submit a heat ticket when an extended IFSP does not have a timely waiver extension submitted?

A35: The CBO should be notified when the IFSP is extended so that waivers can be updated. The CBO confirmed that they have always needed to have notification. While information from Cornerstone on extended IFSP dates is sent to the CBO system, there is no method for pulling that data on any routine to know to extend any waivers. The SC must send an e-mail to their

CBO Insurance Processor with all of the information of new IFSP end date, provider name, tax ID#, child's name and EI#, waiver and discipline so CBO can extend appropriately.

Q36. Once we have waivers for an out-of-network provider, are we to continue looking for in-network providers in order to switch?

A36. If an in-network provider becomes available, the family should be informed so that they can make an informed decision about switching as it may impact their family fee. It is not expected that the SC continue to call/contact in-network providers on a daily basis but if the SC would become aware of an in-network provider (maybe the in-network provider now has an opening so calls the SC), the process to move the family to the in-network provider must be done.

Q37. Will the PA35 screen be updated to allow the service coordinator to enter whether they applied for a waiver or the waiver was declined by CBO in the drop down menu?

A37. No. However, DHS is in discussions to have a data feed transfer of the waiver information back to Cornerstone. The process is more a matter of timing than availability. With the work that SCs do every day they may not see the information as timely as they would like which is why we have had issues with pursuing this (but we will continue to pursue).

Q38. Can SV07 screen entry be updated to have options beyond "no private insurance", "private insurance bill", and "insurance declined"? Perhaps an option for "waiver" or "exemption"?

A38. See #37 – same response.

CBO

Q39. What paperwork does the CBO require when the payee/provider is located and must be added to a waiver that has been issued for only the discipline?

A39. The SC must send via Secure Webmail to their CBO Insurance Processor the rendering provider's name, tax ID#, child's EI# and waiver discipline so CBO can correctly apply the information to the correct waiver. It is not necessary to resend the waiver request.

Q40. After we receive the benefit verification information back from the CBO, do we then have to submit the consent for insurance form after the family signs it to the CBO?

A40. No, the consent does not need to be sent to the CBO. After obtaining consent, the service coordinator would need to review the plan to determine the need for waivers or exemptions and

to understand any provider restrictions. The authorizations need to reflect the proper billing source based on the results of this review.

Q41. Will CBO/DHS require a provider to enroll in a family's insurance? Specifically, I have a provider who is often the only one covering a remote area for home based therapy. If she does not enroll in the family's insurance will CBO pay the provider?

A41. Neither CBO nor DHS will require providers to enroll. However, it may be in the provider's best interest to enroll with an insurance group as it may provide a higher rate of reimbursement. If there are no in-network providers available that meet system requirements, the CBO will pay the provider for authorized services.

Other questions

Q42. Can we get a list of the MCOs?

A42. They are listed in section 10.1.5. The list of known MCOs for Medicaid coverage are:

- Aetna Better Health
- Blue Cross Blue Shield Greater Chicago
- County Care
- Family Health Network
- Harmony
- Health Alliance Connect
- IlliniCare
- Meridian
- Molina

Q43. Who would be the EI specialist for CFCs?

A43. The current EI Specialist for all CFCs is Colleen Cunningham of the Bureau.

Q44. Wouldn't it be simpler if CFC's had no involvement with insurance?

A44. It might be simpler, but private insurance is a valuable funding stream for Illinois' early intervention system. As a result of private insurance use, Illinois is able to serve many more children who need services. Aggravating as it is, it is a vital source for continuing the valuable services we offer to the many children we serve.

Q45. What should we do about providers that pick insurance children over public insurance children? Also, what should we do if a provider chooses to see a child privately

to bypass the wait list that we have in the area because there are children on the list with public aid? This is becoming more of an issue because of the state not paying providers and they are able to get some money from insurance children.

A45. Providers attest through item 24 in the Payee Agreement that they will “accept all children for early intervention services without discrimination, including but not limited to children with public or private insurance”. Perhaps reminding them of this commitment will help. It is always the choice of the family to receive Early Intervention and it is our task to ensure families are well informed of the program and the benefits of the program that may extend beyond just therapy.

Q46. What are "no cost protections"?

A46. No cost protections are described in Chapter 10 of the manual:

Effective June 28, 2013, State law provides the following assurances regarding the use of Non Employer Self-Funded plans to pay for Part C services:

1. cannot count toward or result in a loss of benefits due to annual or lifetime caps;
2. cannot negatively affect the availability of health insurance;
3. cannot be used to discontinue health insurance; and
4. cannot be used as a basis for increasing health insurance premiums.

Q47. The providers are stating they are going through the process of BV on their end with for example Coventry. Coventry is taking months to provide denial to provider so they can then move on to bill EI. The provider wants to get paid but is not getting timely response from insurance company to begin services. Provider is telling family to decline use of insurance so they can begin providing service. A current issue with decline is the provider is unsuccessful in obtaining a denial from insurance so they tell the family to decline in order to receive services.

A47. If providers are encountering billing difficulties, the provider could utilize the free CBO Insurance Billing Unit to allow the CBO to work closely with a specific insurance plan carrier which may help avoid the delays. The ability for a family to decline will no longer be an option for families unless they have an employer self-funded plan. It is definitely not the correct method to ensure payment for a provider.

Q48. Is there a way for providers to obtain the information needed in a more timely manner? Can you email information to CFC managers about Department of Insurance information and insurance company requirements?

A48. Section 919.50 within the Illinois Unfair Claims Law and Regulations outlines the responsibilities of Insurance companies when making determinations on provider claims. If

providers are having difficulty with a particular company, they can contact the Department of Insurance via their message center: <https://mc.insurance.illinois.gov/messagecenter.nsf>
Another resource is the free CBO Insurance Billing Unit.