MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
EARLY INTERVENTION

Reimbursement Policy Manual
for Early Intervention and Autism Services

July 2018

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GENERAL INFORMATION

A. Introduction

The MA DPH Reimbursement Policy Manual for Early Intervention and Autism Services is a document for EI agency and program staff responsible for the coordination of benefits of Early Intervention and Service Delivery Reporting (SDR) to the Department of Public Health. It is also a resource for practice management system developers, providing service delivery file specifications, definitions and file format requirements. This manual provides information on Massachusetts Department of Public Health (DPH)'s billable EI services, payment sources, and service delivery processing requirements.

B. Payer Information

A payer source is an organization or insurance that covers the cost of services delivered to Early Intervention clients by certified Early Intervention programs in Massachusetts. Massachusetts has developed a system of diverse payers to ensure a viable and sustainable EI system.

Payers of EI services in MA include:

- Commercial health insurance companies, including Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs)

  Massachusetts General Laws (MGL) chapter 721 mandates that all Massachusetts commercial insurance, including HMOs and PPOs, must cover the cost of EI services as part of their basic benefits package if fully insured. Out-of-state health plans and self-insured employer group plans are not required to follow Massachusetts state mandates.

- MassHealth, including MCOs and ACOs

  In Massachusetts, Medicaid and the Children's Health Insurance Program (CHIP) are combined into one program called MassHealth. MassHealth offers health and dental benefits to Massachusetts residents.

- The Massachusetts Department of Public Health (DPH)

  DPH is the payer of last resort for Early Intervention services and covers the cost of EI services for children who are uninsured and costs that are appropriately denied by an insurance.

C. DPH role – Payer of Last Resort

EI agencies/programs must follow established procedures and/or billing rules (including efforts to resolve denied claims) as defined by all insurance, including commercial insurance and MassHealth, in order to secure reimbursement for EI services from the appropriate insurance PRIOR to submission of claims to DPH for payment. All charges to DPH should be fully justified as appropriate charges.

EI agencies must:

1. Document all services to meet clinical, billing and reporting needs. Individual client records must be available to DPH staff for routine monitoring.
2. Verify the child's insurance, including the EI benefit for each insurance, on a regular basis and maintain insurance documentation in the child's EI record. This allows insurance changes to be updated for billing purposes.
3. Maintain documentation from the guardian(s) confirming an uninsured status or request to decline access to the child's insurance.
4. Submit all services and claims to the appropriate insurance.
5. Justify the reason for submission of charges to DPH for insurance denials based on the insurance adjustment reasons.
6. Submit a Service Delivery Report (SDR) each month to DPH that includes all services completed for EI clients, regardless of payer, and charges to DPH.
7. Respond to the DPH remittance file according to guidance in this manual.
8. Submit adequate and appropriate support documentation for pended SDR records based on guidance in this manual.
9. Maintain all documentation of service delivery for a minimum of seven years. This includes individual client records, remittance advises, EVS checks, etc.

DPH, as the payer of last resort will deny claims to DPH that are pended if support documentation shows that:

- Additional information was requested by the insurance
- Child is not on DPH non-covered insurance file; Insufficient documentation
- Claim is currently pended for review by the insurance
- Claim was paid by the insurance according to support documentation
- Correctable denial for the insurance
- Documentation does not match the denial reason
- EI agency/program missed insurance billing deadline
- Insufficient documentation for payment justification
- Insufficient or no documented follow-up with the insurance

D. Insurance Verification Requirements

Verification of Insurance Eligibility

DPH requires that EI agencies/programs verify insurance member eligibility for MassHealth, MassHealth MCO's and ACO's, and commercial insurance prior to service provision to ensure that claims are submitted to the appropriate payer.

EI agencies/programs must verify the child's insurance on a regular basis and maintain insurance documentation in the child's EI record. This allows the agency/program to update insurance changes for billing purposes.

Verification of EI Benefit Coverage

EI agencies/programs must determine the EI benefit coverage for each insurance type. It is important to find out if a commercial insurance plan is fully or self-insured, federal, under the GIC or a union and whether or not the plan covers EI. This information is included as part of the service delivery record submitted to DPH and can help in expediting DPH payment.

Verification of Insurance Plan Options (HSA, HRA, FSA, MSA, etc.)

During the insurance eligibility verification process, EI agencies/programs must determine if a family has an insurance plan with an option such as:

- HSA (Health Savings Account plan)
- HRA (Health Reimbursement Account)
- FSA (Flexible Spending Account)
- HRA (Health Reimbursement Arrangement)
- MSA (Medical Savings Account), etc.

EI agencies/programs must ensure that these plans are NOT billed for co-pays, co-insurance or deductibles. Massachusetts law mandating insurance to pay co-pays, co-insurance and deductibles do not apply to these types of insurance options.

IMPORTANT: *The Early Intervention program must inform the subscriber to contact the benefits office of their employer to then contact their insurance company to ensure that* the child's insurance is not using these account monies for the payment of EI services*, including co-pays, co-insurance and deductibles.*

E. Units of Service

A service unit is the basis on which Early Intervention services are reported and reimbursed. A full unit of service for DPH reporting is one hour of service provided to an enrolled child and/or family member. The service delivery or billing date is the date that the service was delivered.

EI agencies/programs are required to bill units in fifteen-minute increments within the billing restrictions for each service. *EI agencies/programs may only bill for full fifteen-minute segments; thus a twenty-minute service would be billed as a 0.25 unit.*

NOTE: A MassHealth unit of service is 15 minutes of service provided to an enrolled child.
1 DPH unit of service = 4 MassHealth units of service

GENERAL EARLY INTERVENTION SERVICES

A. Service Types & Rates

The following provides the EI rates effective for service dates on or after 7/1/2017:

	Rate/Hour	
Service Type	**FY18**	**FY19**
Home Visit	$89.40	$94.00
Intake Visit	$89.40	$94.00
Center Individual Visit	$74.96	$78.64
EI Only Child Group	$26.12	$27.40
Community Child Group	$34.32	$36.00
Parent Group	$33.52	$35.16
Assessment (and Evaluation)	$119.92	$125.84
CHA Screening	$104.48	$109.64

B. DPH EI General Services Billing Requirements

EI agencies/programs are required to submit claims and SDR that accurately reflect the services that are provided to children and families enrolled in Early Intervention in Massachusetts. The following provides DPH codes and billing requirements for each of the Early Intervention services.

> In submitting SDR records to the Department the EI agency/program is attesting to the following: All records, invoices related documents, and equivalent electronic transmissions submitted to the Department of Public Health shall be under the pains and penalties of perjury as true, correct and accurate as attested by the Executive Director or Chief Financial Officer of the Agency.

DPH CODES & BILLING REQUIREMENTS: EI GENERAL SERVICES	
Service Description	***Billing Requirements***
Home visit DPH Code: A Service distinction code (DENNUM): 1 *(identifies service as a regular home visit)* CMS code: H2015 Setting code: H01 or H02 FY18 rate/hour: $89.40 FY19 rate/hour: $94.00	• 2 hours per session per day maximum • If a child is deemed ineligible, 2 hours (1 or 2 EI Specialists) of service can occur after the completion of the assessment for the purpose of reviewing the evaluation/assessment results and transitioning the child and family out of the EI program. • There are no restrictions on the number of home visit sessions per day

DPH CODES & BILLING REQUIREMENTS: EI GENERAL SERVICES	
Service Description	***Billing Requirements***
Home Visit/Co-treatment DPH Code: A Service distinction code (DENNUM): 1 *(identifies service as a regular home visit)* CMS code: H2015 Setting code: H01 or H02 FY18 rate/hour: $89.40 FY19 rate/hour: $94.00	• 2 hours per session per EI Specialist maximum • One co-treatment per month per enrolled child. • Billed by 2 different disciplined EI specialists
Intake Visit DPH Code: I Service distinction code (DENNUM): 1 *(identifies service as a regular home visit)* CMS code: H2015 Setting code: H01 or H02 FY18 rate/hour: $89.40 FY19 rate/hour: $94.00	• Must occur prior to all other services • 2 hours maximum per enrollment per EI program. • 2 staff allowed if do not exceed the 2 hour maximum • All hours must occur within two weeks of one another
Assessment Home Visit DPH Code: A Service distinction code (DENNUM): 3 *(identifies service as an assessment home visit)* CMS code: H2015 Setting code: H01 or H02 FY18 rate/hour: $89.40 FY19 rate/hour: $94.00	• 2 hours per EI specialist per session per day maximum
IFSP Home Visit DPH Code: A Service distinction code (DENNUM): 2 *(identifies service as an IFSP home visit)* CMS code: H2015 Setting code: H01 or H02 FY18 rate/hour: $89.40 FY19 rate/hour: $94.00	• 2 hours per session per day maximum • A waiver for reimbursement is **NOT** required if two staff of the same discipline participate in a home visit meeting

DPH CODES & BILLING REQUIREMENTS: EI GENERAL SERVICES	
Service Description	***Billing Requirements***
Center-Based Individual Visit DPH Code: B Service distinction code (DENNUM): 1 *(identifies service as a regular Ctr Visit)* CMS code: T1015 Setting code: V01, V02 or V03 FY18 rate/hour: $74.96 FY19 rate/hour: $78.64	• 2 hours per session per day maximum • If provided in conjunction with child group services: o Maximum is two hours o Combination of time for the center individual and group service must not exceed the scheduled duration of the group
Center-Based Visit/Co-treatment DPH Code: B Service distinction code (DENNUM): 1 *(identifies service as a regular Ctr Visit)* CMS code: T1015 Setting code: V01, V02 or V03 FY18 rate/hour: $74.96 FY19 rate/hour: $78.64	• 2 hours per session per day maximum • One co-treatment per month per enrolled child • Billed by 2 different disciplined EI specialists
IFSP Center-Based Visit DPH Code: B Service distinction code (DENNUM): 2 *(identifies service as an IFSP Ctr Visit)* CMS code: T1015 Setting code: V01, V02 or V03 FY18 rate/hour: $74.96 FY19 rate/hour: $78.64	• 2 hours per session per day maximum • Waiver for reimbursement is **NOT** required if two staff of the same discipline participate in a home visit meeting
Child Group: Community DPH Code: M Service distinction code (DENNUM): 2 *(identifies service as a Community Group)* CMS code: 96153 Setting code: C02 FY18 rate/hour: $34.32 FY19 rate/hour: $36.00	• Combination of time for both Community & EI-Only Group services o 2.5 hours per week maximum o 2 sessions per week maximum • Billing is based on the attendance of each individual child, not on the scheduled duration of the group (i.e. a child arriving half an hour late for a two-hour group is billed for one and one-half hours of child group) • If provided in conjunction with a center-based individual service: Combination of time for the center individual and group service must not exceed the scheduled duration of the group

DPH CODES & BILLING REQUIREMENTS: EI GENERAL SERVICES	
Service Description	***Billing Requirements***
Child Group: EI-Only DPH Code: N Service distinction code (DENNUM): 1 *(identifies service as an EI-Only Group)* CMS code: 96153 Setting code: C01 FY18 rate/hour: $26.116 FY19 rate/hour: $27.40	• Combination of time for both Community & EI-Only Group services o 2.5 hours per week maximum o 2 sessions per week maximum • Billing is based on the attendance of each individual child, not on the scheduled duration of the group (i.e. a child arriving half an hour late for a two-hour group is billed for one and one-half hours of child group) • If provided in conjunction with a center-based individual service: Combination of time for the center individual and group service must not exceed the scheduled duration of the group
Parent Group DPH Code: D Service distinction code (DENNUM): N/A CMS code: T1027 Setting code: P01 FY18 rate/hour: $33.52 FY19 rate/hour: $35.16	• 1.5 hours per session maximum • 1 session per week maximum • Sibling groups are billed as parent groups and must meet all parent group requirements
Initial Assessment DPH Code: G Service distinction code (DENNUM): N/A CMS code: T1024 Setting code: S01 or S02 FY18 rate/hour: $119.92 FY19 rate/hour: $125.84	• 10 hours maximum in the first year of EI services in MA
On-going Assessment DPH Code: H Service distinction code (DENNUM): N/A CMS code: T1024 Setting code: S01 or S02 FY18 rate/hour: $119.92 FY19 rate/hour: $125.84	• 10 hours maximum per year (New assessment hours are available *one year from the date of the first billed assessment service)* • If the child does not have any assessment hours left after the 10 hour maximum then bill assessment services as an assessment home visit

DPH CODES & BILLING REQUIREMENTS: EI GENERAL SERVICES	
Service Description	***Billing Requirements***
Comprehensive Health Assessment (CHA) DPH Code: E Service distinction code (DENNUM): N/A CMS code: T1023 Setting code: S01 or S02 FY18 rate/hour: $104.48 FY19 rate/hour: $109.64	• **Child must be enrolled in EIPP** • 1.5 hours per session maximum • One session per enrollment maximum • A nurse or social worker are required to provide this service • More than one person may bill for a *CHA Screening* as long as the total billing time does not exceed 1.5 working hours. • A child can be referred to EI for a CHA service up to six times between a child's birth and their first birth date at 2, 4, 6, 8, 10 and 12 months of age. • Last CHA: The 12-month CHA can be provided up to and including 30 days after the date of the child's one-year birth date *Note: It is IMPORTANT that the EI vendor check with the child's insurance regarding how many hours of the service should be billed. MassHealth and commercial insurance are mandated to pay for only 1.0 hour of a CHA service. DPH may be billed for the additional 1/2 hour as a partial pay adjustment.*

C. Waiver for Reimbursement

A waiver for reimbursement is a request to DPH by the EI agency/program for reimbursement for EI services that do not follow the EI Billing Requirements. Waivers for Reimbursement must be submitted and approved prior to providing the requested service(s) in order for the EI program/agency to submit claims and SDR for that service. DPH reserves the right to deny payment for services rendered where a Waiver for reimbursement was not requested and approved prior to submission of the SDR to DPH.

See *Appendix 4, "Waiver for Reimbursement Request Form and Instructions"*

The following provides the reason for the different waiver for reimbursement requests:

Code #	WAIVER FOR REIMBURSEMENT
1	Co-Treatment more than 1 time per month.
2	Child group more than 2-½ hours per week.
3	Home visit exceeds two hours in duration.
4	Two staff of the same discipline provides same service on same day. This also applies to 1 staff doing 2 home visits to a child on the same day.
5	Center-based individual visit exceeds two hours in duration.
6	Assessment hours exceed ten per year.
7	"Clinical Judgment" extended for another 6-month period.
8	Billing allowed for additional staff – excluding IFSP meetings.
9	Child is receiving services from more than one EIP.
10	Increased Parent Group Billing.

Code #	WAIVER FOR REIMBURSEMENT
11	Family receiving services prior to the birth of a child.
13	Child receiving services on or past the child's 3rd birthday.
14	Family does not want their name transmitted to DPH through the EIIS system.
15	Family receiving services following the death of the enrolled child.

D. Service Providers

All billable EI agency/program staff must have an approved Certification Tracking form from DPH in order to provide and bill for EI services in MA. The requirements for certification as an Early Intervention Specialist are specified in the EI Operational Standards. The following provides the list of the EI professional disciplines in Massachusetts:

DPH Code	Provider Description
AA	Developmental Specialist (as stated under categories a, b and c of the EI Operational Standards)
BB	Developmental Specialist (as stated under category d of the EI Operational Standards)
CS	Mental Health Counselor
MT	Music Therapist
NS	Nurse
NU	Nutritionist
OA	Occupational Therapy Assistant
OT	Occupational Therapist
PA	Physical Therapy Assistant
PT	Physical Therapist
SW	Social Worker
SA	Speech Language Pathology Assistant
SP	Speech and Language Pathologist
SS	Specialty Provider
AS	SSP Specialty Provider[1]

[1] *Additional billing requirements for SSP Specialty Providers can be found under the Early Intervention Autism Specialty Services section*

DPH Billing requirements for Therapy Assistants:

- The therapy assistant codes (OA, PA and SA) are for DPH reporting purposes only. Services rendered by a therapist assistant would be billed to insurance under the existing CMS professional discipline code that the assistant position falls under.
- Both a licensed professional discipline and a therapy assistant under the same discipline can provide the same type of service for a child on the same day; services will not be considered duplicative for DPH. The exception to this is for an IFSP home visit. A licensed professional discipline and a therapy assistant can attend an IFSP home visit and both can bill for this service.

- A home visit with the therapy assistant and his/her supervisor for the purposes of supervision would be billable only for the licensed therapist providing supervision.
- Therapy Assistants do not perform initial evaluations or ongoing assessments.
- MassHealth does pay for services provided by occupational therapy assistants and physical therapy assistants
- MassHealth does not cover services rendered by speech/language pathology assistants. These services should be billed directly to DPH

  If MassHealth is the secondary insurance for a service rendered by a speech/language pathology assistant then bill to the primary insurance. Any charges denied by insurance are then billed to DPH directly.

- Blue Cross /Blue Shield does not cover services rendered by therapy assistants. These services must be billed directly to DPH

EARLY INTERVENTION AUTISM SPECIALTY SERVICES

A. Introduction

This section of the document will provide information and billing requirements specific only to autism specialty services that differ from general EI services.

Children enrolled in EI programs that receive a diagnosis of Autism Spectrum Disorder (ASD), conferred by a physician or licensed psychologist and included in the child's record, are eligible to receive Early Intensive Behavioral Intervention (EIBI) services. There are three DPH-approved service models for EIBI services currently being utilized in Early Intervention:

- Applied Behavior Analysis (ABA)
- Early Start Denver Model (ESDM)
- DIR/Floortime

The DPH has approved specific SSP agencies to provide EIBI services for children with ASD. However, SSP agencies do not bill commercial insurance, MassHealth or DPH directly for children under three years of age. Each of the EI programs contracts with one or more SSP agencies providing autism services for children under three in their geographical area. Once a contract is in place the SSP provider can then invoice their services to the EI program and the EI program then bills the appropriate payer.

B. Insurance Verification Requirements

Prior Authorizations

Determination of autism as a benefit: The insurance company must be contacted to determine if the child's insurance has an Autism benefit. For insurance where Autism is not a covered benefit for the child, claims must be sent to DPH directly (do NOT submit the claim to the insurance first). If the insurance covers Autism, you must then determine whether a Prior Authorization (PA) is required. MassHealth does not require a PA; other insurance may not need a PA as well.

Insurance requiring a prior authorization: EI programs should have a process in place between themselves and the SSP to acquire the prior authorization.

- EI programs must follow the requirements set forth by each insurance under the child's PA prior to submitting charges to DPH
- EI programs can bill DPH before the prior authorization is in place. IMPORTANT: EI billing staff must be informed of the approval outcome and all billing must be re-directed from DPH to the insurance company if approval has been received.

Other Insurance Requirements

- Maximums: varies by insurance

- Several in-state and some out-of-state insurance provide behavioral and mental health services under a partnership with United Behavioral Health (UBH), Beacon Health Strategies (BHS) or ComPsych. Once a prior authorization for Autism Specialty Services has been approved by one of these entities, an Early Intervention program will bill UBH, BHS or ComPsych for autism services for children covered under these insurances.

    - Insurance payer (data field name: TPPCODE)

        70 (United Behavioral Health)
        71 (Beacon Health Strategies)
        74 (ComPsych)

c. Services
SSPs provide home-based services in accordance with the EI Operational Standards (EIOS). Descriptions and other details of these services can be found in the EIOS document.

C. CMS/CPT Service Codes and Rates

All insurances using CMS and CPT codes define services according to the definitions found in the American Medical Association CPT Assistant guidance. The insurance will provide specific guidance regarding their requirements as defined under these codes.

ABA Service Rates

The following rates apply to Autism Specialty Service Providers who provide ABA services. These codes and rates are used by MassHealth and most commercial insurance. At this time, BC/BS and ComPsych are the only exception.

All Payers (hourly rates) except BC/BS and ComPsych

DPH Code	CMS Code	Service Description	Rate/Hour
S	H0031-U2	ASSESSMENT: Assessment and case planning for home services by a licensed professional *(includes preparation of assessment report)*	$111.36
S	H0032-U2	SUPERVISION: Supervision for home services by a licensed professional	$111.36
S	H2012-U2	PARENT TRAINING: Parent training for home services by a licensed professional	$111.36
S	H2019-U2	DIRECT TREATMENT BY A PARAPROFESSIONAL: Direct instruction by a paraprofessional working under the supervision of a licensed professional	$58.92

Note: the CMS service modifier is not required when reporting to DPH.

Note: Tufts Health Plan (commercial) & United Behavioral Health/Optum-the H0031 (Assessment) and H0032 (Supervision) codes must be reported to both Tufts Health Plan (commercial) and United Behavioral Health/Optum under an hourly, not quarterly, duration. DPH, MassHealth and other insurance, including Tufts Health Plan Public, will accept a quarterly rate.

Floor Time Rates

Autism Specialty Service Providers that provide Floor Time services bill DPH directly under the H2019, Direct Treatment, code and rate for all services provided as shown above. Supervision, assessment and parent training for these SSP providers are all billed to DPH under this lower rate.

BC/BS and ComPsych EI Autism Service Rates

The following rates apply to Autism Specialty Service Providers who provide ABA services for a child receiving BC/BS or whose autism services are paid through ComPsych.

DPH Code	*DPH Equiv*	CPT Code	Service Description	Rate BC/BS	Rate Com Psych	Unit
S	*H0031*	0359T	ASSESSMENT	$895.00		Flat
S	*H0031*	0359T-52*	RE-ASSESSMENT	$445.00		Flat
S	*H0031*	G9012	TREATMENT PLANNING	$112.00		Per hour
S	*H2019*	0364T *(1st 30 mins)*	DIRECT TREATMENT BY A PARAPROFESSIONAL	$33.00	$48	Flat
S	*H2019*	0365T *(each add 30 mins)*	DIRECT TREATMENT BY A PARAPROFESSIONAL	$29.00	$48	30m
S	*H0032*	0368T *(1st 30 mins)*	SUPERVISION	$60.00	$60	Flat
S	*H0032*	0369T *(each add 30 mins)*	SUPERVISION	$52.00	$60	30m
S	*H2012*	0370T	PARENT TRAINING	$112.00	$100	Per hour

**EI programs use the "52" modifier when billing BC/BS and use "5" as under the service distinction code (data field: DENNUM) to report to DPH.*

D. DPH EI Autism Billing Requirements

Billing Requirements for all Insurances

- The CMS/CPT service code that best fits an autism service must be determined by the appropriate clinical staff
- Services rendered by Autism Specialty Service Providers utilizing an ABA or ESDM model are billed to commercial insurance or MassHealth
- Services rendered by Autism Specialty Service Providers utilizing the Floortime model are billed directly to DPH
- Do NOT submit claims to insurance if the service does not meet insurance requirements. ***IMPORTANT:*** This differs from general EI services which require that claims be sent to the insurance in order to obtain the denial.
- If a prior authorization is in process the EI agency/program may bill DPH for autism services rendered. Once the prior authorization is in place all service charges must be directed to the insurance.
- Maximum hours of service per week: 30 hours
    - Combination of assessment/treatment planning, supervision, and direct instruction
    - *IFSP entries should not exceed 30 hours per week in total for ASD EIBI services (ABA, ESDM, Floortime)*
- Two or more specialty disciplines can provide an SSP service on the same day

IMPORTANT: SSP billing differs from general EI due to the prior authorization and insurance should be billed the appropriate charges according to the prior authorization.

Additional DPH Billing Requirements:

- There are no DPH Requests for Reimbursement allowed for the payment of services that go over the maximum hours
- Do NOT bundle services when reporting to DPH
- Submit services to DPH if the service does not meet insurance requirements
- Reporting of CMS/CPT code for MassHealth and commercially insured children:
    - Original transaction: Report all original Autism Specialty Services that were billed to an insurance using the insurance CMS/CPT code and rate
    - Full denial transfer from insurance: Report all transfer transactions with insurance denial information using the insurance CMS/CPT code and rate
    - Full transfer of charges to DPH: Report all transfer transactions having a DPH charge using the DPH CMS code
    - Partial transfer to DPH: Report all partial denials to DPH using either the DPH CMS code or the insurance CMS/CPT code
- Do not report the service modifier associated with any CMS code
- Report the service modifier under the DPH service distinction code (date field name: DENNUM) for the re-assessment service when BC/BS is the payer (The CPT modifier of S5 is reported to DPH as "5" under the service distinction code-DENNUM) for the CPT code of 0359T
- Include the DPH SSP agency code on each autism service record

E. DPH SDR Autism Codes

The following codes used for the Service Delivery Reporting (SDR) file submitted monthly to DPH by EI agencies/programs are specific to Autism specialty services.

Description	***DPH Codes***	***Notes***
Autism Specialty Service *(SERVICE)*	S	
CMS Service Code *(DMACODE)*	H0031 (Assessment) H0032 (Supervision) H2012 (Parent Training) H2019 (Paraprofessional Direct Treatment)	
Service setting *(SECONDARYPRG)*	K01 = specialty service provided in the child's home K02 = specialty service provided in a natural setting outside the child's home *(e.g., child care center, playground, etc.)* K03 = specialty service provided in a non-community setting *(e.g., EI site, specialty provider site)*	

Description	*DPH Codes*	*Notes*
Professional Discipline *(PROFDISC)*	AS	*The provisional certification form will state SS*
Autism Specialty Service Provider *(INSAMT)*	201 Amego 202 Applied Behavioral Learning Services 102 Beacon Services 203 Behavioral Concepts 103 Building Blocks-NE Arc 105 Children Making Strides 106 HMEA 101 May Center 109 New England Center for Children 112 Pediatric Development Center 206 RCS Behavioral & Educational Consulting 110 REACH-ServiceNet 207 Reach Educational Services 209 Boston Behavioral Learning Center (BBLC) 205 Make a Difference in Children	

F. Service Providers

Staff qualifications

Services provided by an Autism Specialty Provider are delivered by individuals meeting the credentialing requirements specified in the DPH Operational Standards and who have knowledge and expertise in treating infants and toddlers with ASD. Direct services are provided by a paraprofessional who is supervised by a Licensed Board Certified Behavior Analyst with the credential, BCBA, LABA. An LABA without a BCBA cannot do supervision.

Licensed Requirement

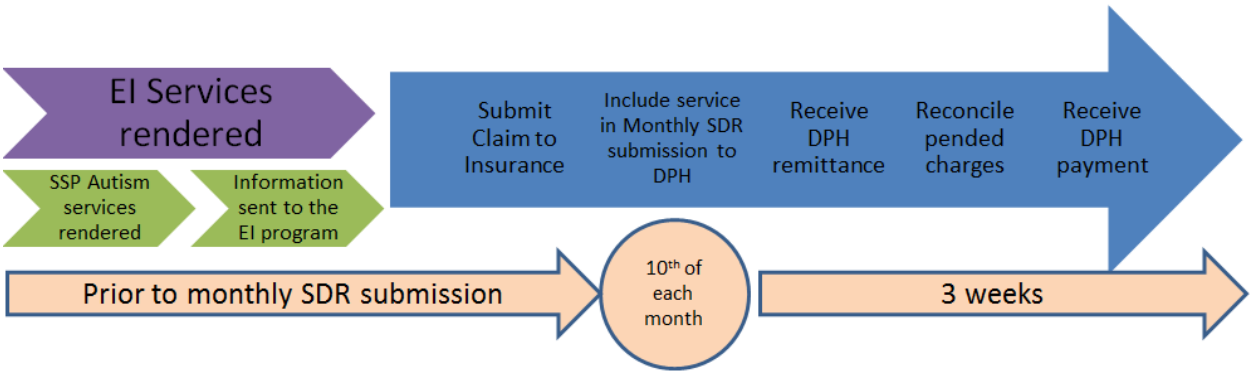
On January 8, 2013, Chapter 429 of the Acts of 2012 was enacted, requiring licensure for applied behavior analysts (ABAs) and assistant applied behavior analysts (AABAs). Therefore, only a BCBA, LABA (licensed professional) can bill at the higher rate.

Supervision definition

Autism supervision is clinical supervision of the paraprofessional by the licensed BCBA that provides face-to-face instruction during a client session for the purpose of enhancing and supporting best clinical skills that will lead to improved outcomes. The following provides the DPH Supervision Guidance Recommendation:

> It is expected that supervision by a BCBA to a paraprofessional will be provided at the 1:10 ratio (one hour of supervision to ten hours of direct service). The supervision of paraprofessionals providing direct ABA services to a child may require that both the direct service provider and the supervisor be present at the same time during the home visit. DPH will monitor data for each of the SSP agencies regarding supervision practices.

MONTHLY SDR CYCLE



EI agencies/programs must justify the reason a charge is submitted to DPH for direct billing of services as well as submission of denied charges from MassHealth and commercial insurance.

A. Reporting Charges to DPH

Appendix 1, "Reasons for DPH Payment" provides additional information on each of the reasons for submission of a charge to DPH for both general and autism services along with the appropriate DPH reason code.

The DPH reason codes used to explain a charge being submitted to DPH should be based on the guidance in this manual and match the insurance adjustment reason codes used on the EOB (Explanation of Benefits or Statement of Accounts) or EOP (Explanation of Payments) from the insurance.

DPH Reasons for Payment

The following provides all reasons for the billing of both general and Autism SSP charges to DPH:

- Co-payments/Deductibles
- Credit to DPH
- Family is between Insurance Coverage *(child is considered insured during this time period)*
- Insured but not Eligible *(child is considered insured during this time period)*
- Insurance Cap Limits
- Insurance maximum has been exceeded
- Non-covered benefit (general EI only)
- Parental Refusal to Access Insurance
- Professional discipline is not reimbursable to insurance (general EI only
- Uninsured
- Waiver for Reimbursement (general EI only)
- Other

The following provides additional reasons for the billing of Autism SSP charges to DPH:

- Authorization is in progress
- Authorization was denied
- Autism contract has not yet been established
- MassHealth children who do not meet the MassHealth requirements for payment of autism services
- MassHealth as secondary insurance if not billing the primary insurance
- MassHealth Family Assist Premium
- Non-ABA service
- Non-covered benefit (DPH reason code differs from general EI)

See *Appendix 1, "Reasons for DPH Payment" for additional detail*

B. Submitting the SDR

Prior to including services in the monthly Service Delivery Report (SDR) the EI agency/program must submit them as a claim to the child's insurance company ensuring that all insurance guidelines have been followed**.**

The Service Delivery Report (SDR) File

A service delivery report (SDR) file is extracted from an EI agency/program's practice management or billing system conforming to DPH's service delivery transmission specifications and uploaded to the EI Transaction Validation Processing (TVP) website. The SDR file reports an EI program's services and subsequent service activity, such as insurance denials, that occurred during a given calendar month. SDR files that comply with DPH specifications are the only acceptable data that can be uploaded and transmitted.

See *Appendix 6, "EI Service Delivery Reporting File Specifications"*

EI TVP Website

The TVP website provides summary and validation reports to allow the vendor to pre-check service delivery data before transmittal to DPH. The website encrypts all data for privacy during upload and transmission to the Department.

See *Appendix 2, "EI TVP Website Instructions"*

Monthly Submission Deadlines

EI agencies/programs must submit the electronic SDR file through the EI TVP website by the 10th of the month. If the 10th falls on a weekend or holiday the deadline becomes the next working day.

Fiscal Year Deadlines

The deadline for electronic supplemental claims to be submitted is March 10th of each year. If this deadline cannot be met, the EI agency/program must submit a written request to the DPH EI Fiscal Manager for an extension.

Credits to DPH can be submitted until July 10th of each year. After this deadline any credits that an EI agency/program receives from other payers where DPH has also paid should be included on a check made to the "Commonwealth of Massachusetts" and submitted to the DPH EI Fiscal Manager. Contact the DPH EI Fiscal Manager for further details regarding credit payments after a fiscal year deadline.

C. DPH Remittance

DPH sends out a monthly remittance email at the end of PV processing for each EI program that provides DPH invoice totals and outcome results for the following records:

- New service delivery records submitted to DPH
- Previously submitted service delivery records which have been:
    - Re-processed for payment
    - Status has changed (e.g., updated from Pended to Accept)

An outcome of a record on the remittance files will show the status of the record after being processed through DPH's business rules. Definitions of the DPH status follow:

Status	Description
Accept	Passed all DPH business rules
Denial	Failed due to submission after the DPH deadline
Denied	Failed due to service that meets insurance requirements
Not Processed	Rejected due to duplication of billing system primary key
Pended	Failed due to inappropriate reason for DPH payment/support documentation is required for payment approval
Reject	Rejected due to failure of one or more REJECT business rules
Suspend	Failed business rule when matched to EIIS client record
Waived Pend	Failed business rule due to no Waiver for reimbursement present or service does not match waiver request

The remittance email includes the following files:

- Letter to EI agency/programs of any new SDR information & remittance instructions
- Payment voucher totals for all active fiscal years (cumulative)
- File of all accepted, pended, suspended or denied SDR records
- File of all rejected SDR records

Records that remain in a pended, denied or suspended status are included in the monthly remittance file until their status changes or until the supplemental close of the fiscal year. The following records are remitted to EI programs only once:

- Record with a PV reference number
- Rejected records

Also see additional information under:

Appendix 3, "DPH Business Rule Codes"
Appendix 5, "Remittance Information"

D. Reconciliation of Pended SDR Records

A service record has a pend status when a DPH approval is required to release payment.

Support Documentation

Submit documentation is required for approval to release payment when the DPH remittance shows one of the following pended or denied error codes:

Error code	Description
4C	Reason is not appropriate for a MassHealth client
5B	Co-payment/deductible reason code for a fully-insured client)
5K	Reason for charge is non-covered benefit but client is not included in override[1] or DPH insurance table[2]
5P	Reason for charge shows lapse in service or other issue but client is not included in DPH insurance table
S6	Autism service for client that meets MassHealth requirements

[1] *Override History: listing of approved clients, insurance and reason codes that will automatically approve other matching records).*

[2] *The DPH insurance table lists children whose insurance plan does not cover EI as a benefit.*

Support documentation submitted to DPH must reflect the most current remittance outcome and fully justify the appropriateness of charges pended at DPH. Early Intervention programs must demonstrate through documentation that all attempts at securing reimbursement from insurance for families have been exhausted.

Do NOT submit documentation:

- Prior to receiving the DPH remittance showing the reason for the pended/denied status
- When a denial from an insurance is in a "pended" status by the insurance
- When documentation has already been sent
- When the record has been rejected by DPH (any record included on the DPH reject remittance file)

EXAMPLES of appropriate documentation for the corresponding dates of services include:

- Copy of the pended/denied records from the DPH remittance file with the client's ID, date of service and error code (4C, 5B, 5K, 5P, S6)
- Insurance specific eligibility verification, including
    - MassHealth EVS (Eligibility Verification System) scans
    - HIPAA verification 270/271
- EOB (Explanation of Benefits or Statement of Accounts) or EOP (Explanation of Payments)
- Documented correspondence (i.e., email) or verbal confirmation with the insurance specifying Early Intervention that includes trace/tracking/verification reference number
- Employer non-covered account or group number
- Electronic non-covered reports from insurance
- Appeals

Sending Support Documentation to DPH

Send support documentation via SecureMail to the EI Fiscal Manager:

- Go to the SecureMail login screen: https://ppsecuremail.state.ma.us/encrypt
- Send to: steve.mccourt@eohhs-sfed.state.ma.us

Support Documentation Deadline

The deadline for the submission of support documentation sent to the DPH EI Fiscal Manager for the prior fiscal year is May 1st of the current fiscal year.

E. DPH Payments

DPH Approvals and Denials

If DPH approves an SDR record a PV reference number will be included and remitted.
If DPH does not approve the record the reason for the denial will appear under one or both of the following data fields on the remittance file:

- Error code column (*see "Appendix 3: DPH Business Rule Description & Codes"*)
- O_Status column (text for reason of denial by EI Fiscal manager)

The PV Reference Number

The PV reference number is found under the data field, PV, for all records in your Remit file that state "NO ERROR". Using the PV reference number, you are able to identify which DPH charges received payment on a specified check. You must sum the charges to DPH (data field name: Billing_DPH) column for each PV (e.g., VEN*YYMMDD*R*FY*) to get this amount.

PV Reference Number on MassFinance & EFT Statement

Additional characters stating the four-character fiscal year are added to the beginning of the PV reference number on payment vouchers submitted to the comptroller for the purpose of being able to identify the appropriate fiscal year within the state's MMARS system. The four-character fiscal year is NOT included as part of the PV reference number on your remittance file. It will be seen as part of your PV reference number within the Mass Finance web site and on your EFT statement.

PV reference number on remittance email files: VEN*YYMMDD*R*FY*
PV number under Mass Finance and EFT statement: YYYY VEN*YYMMDD*R*FY*

Payment Timeline

PVs are submitted to DPH's Central Accounting office for payment processing within approximately one week after the monthly SDR submission deadline and, in general, a vendor should receive receipt of an electronic check and EFT statement within two weeks of receiving the DPH remittance email.

CONTACT INFORMATION

If you have any questions about the service delivery payment voucher or remittance processing please contact the following DPH EI staff:

Jean Shimer
jean.shimer@state.ma.us
(617) 624-5526

- SDR files & TVP website
- Rejected records
- Remittance files
- PV amounts

Steve McCourt
steve.mccourt@state.ma.us
(617) 624-5954

- Insurance questions
- Support Documentation
- Unpaid PVs

APPENDICES

APPENDIX 1: Reasons for DPH Payment

- General Information
- Reasons for DPH Payment – General EI Services
- Reasons for DPH Payment – Autism Services

APPENDIX 2: TVP Website Instructions

- EI Vendor Requirements
- TVP Website Instructions
- TVP Website Validation Instructions

APPENDIX 3: DPH Business Rule Description & Codes

- General Information
- Business Rule Descriptions & Codes

APPENDIX 4: Waiver for Reimbursement Request Form and Instructions

- Waiver for Reimbursement Request Form
- Instructions on Completing the Waiver for Reimbursement Form

APPENDIX 5: Remittance Information

- Remittance Email and Files
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APPENDIX 1

MA DPH Reimbursement Policy Manual for Early Intervention and Autism Services

REASONS FOR DPH PAYMENT

Contents

General Information

Each reason for a DPH payment is communicated to the Department through a reason code submitted on an SDR record having a DPH charge. The DPH reason code must correspond to the adjustment reason code provided in the remittance from the insurance. If there are multiple adjustment reason codes remitted from the insurance then submit the most appropriate reason code to DPH based on what has been remitted.

Reasons for DPH Payment – General EI Services

General EI Services		
Reason for DPH Payment	**DPH Reason code to be used**	**Notes**
Co-payments/Deductibles	1 (Deductible amount) 2 (Co-insurance) 3 (Co-payment amount)	
Credit to DPH	63 (Correction to a prior claim) 123 (Payer refund due to over payment) 125 (Payment adjustment due to submission/billing error)	*Use for DPH credits when DPH has paid and the insurance comes back and pays the charge* *Use on SDR unit or partial payment adjustment records (transfer records) only*
Family is between Insurance Coverage *(child is considered insured during this time period)*	26 (Expenses incurred prior to coverage) 27 (Expenses incurred after coverage terminated) 28 (Coverage not in effect at time service was provided)	*The primary insurance must be reported to DPH on this SDR record* *Use on SDR unit or partial payment adjustment records (transfer records) only*

General EI Services

Reason for DPH Payment	DPH Reason code to be used	Notes
Insured but not Eligible *(child is considered insured during this time period)* Coverage by a plan is not in effect for a specific time	141 (Claim spans periods of ineligibility) 177 (Recipient is ineligible on this date of service)	Use when the coverage by a plan is not in effect for a specific time or the child is covered under MassHealth but is deemed ineligible for payment of services *The primary insurance must be reported to DPH on this SDR record* *Use 177 on SDR unit or partial payment adjustment records (transfer records) only*
Insurance Cap Limits	119 (Benefit maximum has been reached)	
Insurance maximum has been exceeded	B14 (payment denied due to insurance maximum has been exceeded)	*Use for a MassHealth or insured child who receives more hours of a service than is allowed by the insurance in one day* *CHA Assessment service for EIPP-referred child where MassHealth only pays for 1.0 hour (bill DPH for the extra 1/2-hour under this reason code)* *Use on SDR unit or partial payment adjustment records (transfer records) only*

General EI Services

Reason for DPH Payment	DPH Reason code to be used	Notes
Non-covered benefit	96 (non-covered benefit or charge)	*Use for MassHealth and commercially insured child where the service is not a covered benefit* *Use for commercially insured children under TriCARE or a federal plan. DPH will automatically pay for these services.* *Services will pend at DPH. Support documentation received and approved will generate a DPH history of approvals. Therefore, support documentation is needed only for one of the charges having a 96 reason code (all other 96 charges for this child will be approved based on this one approval).*
Parental Refusal to Access Insurance	D06 (Family refused to access insurance)	*The EI program must submit a letter to the DPH EI Fiscal Manager (along with the child's DPH client ID) stating the family's decision not to use their insurance for EI services*
Professional discipline is not reimbursable to insurance	52 (The rendering provider is not eligible to perform the service billed)	*Use for MassHealth child when professional discipline is a Speech Language Pathology Assistant (SA)* *Use for BC/BS child when professional discipline is a therapist assistant*

General EI Services

Reason for DPH Payment	DPH Reason code to be used	Notes
Uninsured	D05 (Uninsured code)	*Use when child has been verified as not MassHealth eligible* *The EI program must submit a letter to the DPH EI Fiscal Manager (along with the child's DPH client ID) stating that the family is uninsured*
Waiver for Reimbursement	D01 (Prior authorization for reimbursement)	*See Appendix 4, "*Waiver for Reimbursement Request Form and Instructions"
Other	50 (Deemed not medically necessary by payer) D99 (Other)	
Other (Denials only)	32 (Our records indicate dependent is not an eligible dependent as defined) 33 (Insured has no dependent coverage) 39 (Services denied at the time authorization/ pre-certification was requested) 45 (Charges exceed contracted fee arrangement) 62 (Payment denied for absence of pre-certification/ authorization)	*Use on SDR unit or partial payment adjustment records (transfer records) only*

Reasons for DPH Payment – Autism SSP Services

Autism SSP Services

Reason	Reason code to be used	Notes
Authorization is in progress	D07 (prior authorization is in progress)	*Use for commercially insured children, including children who have MassHealth as a secondary insurance, when autism services are provided before a prior authorization or clinical approval is in place.* *Autism services having a date that is greater than 14 days after the initial autism face-to-face autism specialty visit date will pend. No DPH history of approvals will be created after a review of documentation. Therefore, every individual service after this 14-day grace period will need support documentation.*
Authorization was denied	D08 (authorization was denied)	*Use for commercially insured children, including children who have MassHealth as a secondary insurance, when the prior authorization for services is denied by the insurance.* *Autism services using the D08 reason code will pend at DPH. DPH history of approvals after a review of documentation will be created. Therefore, support documentation is needed only for one of the services having a D08 reason code (all other D08 services will be approved based on this one approval).*

Autism SSP Services

Reason	Reason code to be used	Notes
Autism contract has not yet been established	D11 (autism contract has not yet been established)	*Use for commercially insured children when the contract with the insurance for autism services has not been authorized or established* *Not allowed for the following insurance with whom the EI agency/program should already have a contract in place:* • *Aetna* • *BC/BS of MA* • *Cigna* • *Fallon Community Health Plan* • *Harvard Pilgrim* • *Health New England* • *Neighborhood Health Plan (not MassHealth MCO: NHP)* • *Tufts Health Plan (not Tufts Health Plan Public)* • *United Behavioral Health/Optum*
MassHealth children who do not meet the MassHealth requirements for payment of autism services	D09 (autism specialty service does not meet insurance requirements/No prior authorization initiated)	*DPH will automatically pay when the primary insurance is one of the following MassHealth products:* • *MassHealth: Children's Medical Security Plan (CMSP)* • *MassHealth: Basic* • *MassHealth: HSN (Health Safety Net)* • *MassHealth: HSN-Partial* • *MassHealth: Essential* • *MassHealth: CommCare* • *MassHealth: CarePlus* *IMPORTANT: Do not submit a claim for specialty services to MassHealth in order to receive a denial prior to submission to DPH; instead submit the claim directly to DPH using a reason code of D09.*

Autism SSP Services

Reason	Reason code to be used	Notes
MassHealth as secondary insurance if not billing the primary insurance	D09 (autism specialty service does not meet insurance requirements/No prior authorization initiated)	*If MassHealth is the secondary insurance then MassHealth will not pay for services without an appropriate denial from the primary insurance. An EI program would not bill the commercial insurance for the following reasons:* • *No Prior Authorization* • *Prior Authorization is not approved* • *Service does not meet primary insurance requirements* *With no insurance denial to submit to MassHealth, these services should be billed directly to DPH.*
MassHealth Family Assist Premium	D09 (autism specialty service does not meet insurance requirements/No prior authorization initiated)	*Autism specialty services for MassHealth Family Assist Premium children are payable by MassHealth. However, an EI agency/program may not know if the Family Assist product is the Premium plan until after billing MassHealth. Therefore, it is expected that if a child is covered under Family Assist that the EI program bill MassHealth for autism specialty services. This should occur when Family Assist is the primary or secondary insurance. DPH will pay autism specialty service charges for denials from Family Assist. However, DPH will pay autism specialty services when billed directly to DPH (original charges) for Family Assist clients when the client does not meet the MassHealth requirements.*
Non-ABA service	D09 (autism specialty service does not meet insurance requirements/No prior authorization initiated)	*Use for SSPs utilizing a DIR/Floortime model (Specialty Service Provider is REACH Servicenet or PDC)* *Bill these autism services directly to DPH; DPH will automatically pay for these services.*

Autism SSP Services

Reason	Reason code to be used	Notes
Non-covered benefit	D25 (Autism service is not a covered benefit)	*Use for commercially insured child where autism is not a covered benefit* *Bill DPH directly (do not submit charge to the insurance)* *Services will pend at DPH. Support documentation received and approved will generate a DPH history of approvals. Therefore, support documentation is needed only for one of the charges having a D25 reason code (all other D25 charges for this child will be approved based on this one approval).*

APPENDIX 2

MA DPH Reimbursement Policy Manual for Early Intervention and Autism Services

TRANSACTION VALIDATION INVOICE PROCESSING (TVP) WEBSITE INSTRUCTIONS

Contents

EI VENDOR REQUIRMENTS

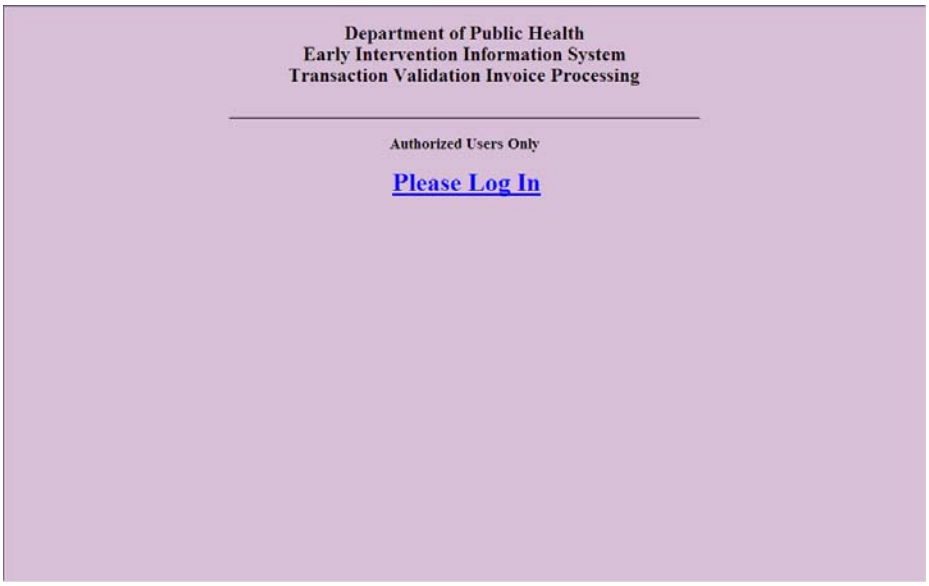
An EI agency/program needs the following in order to access and submit SDR files to DPH:

- Website browser *(i.e., Internet Explorer)*
- TVP login and password

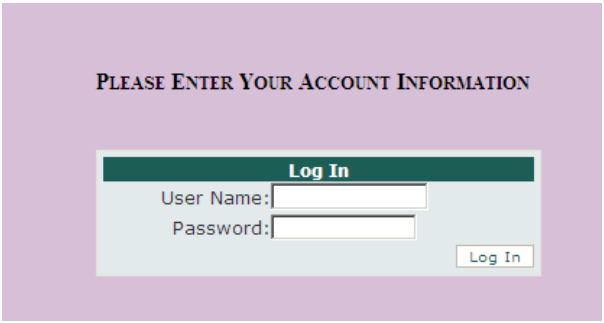
TVP WEBSITE INSTRUCTIONS

1. Go to the https://tvp.dph.state.ma.us/tvp/ website.

   Click **Please Log In**

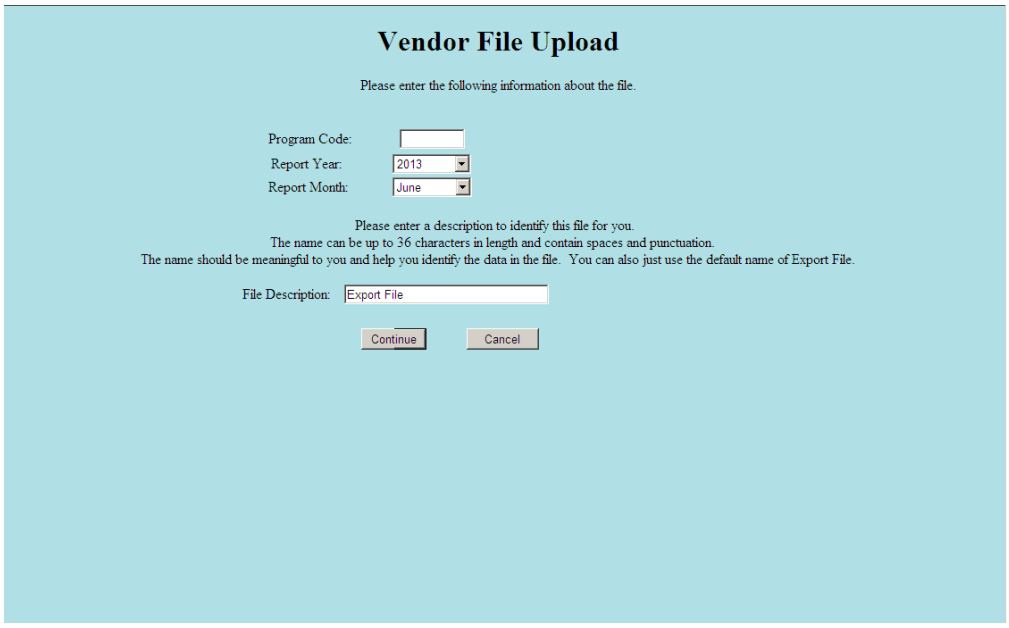


2. Type in your username and password, then click on the ***Log In*** button.

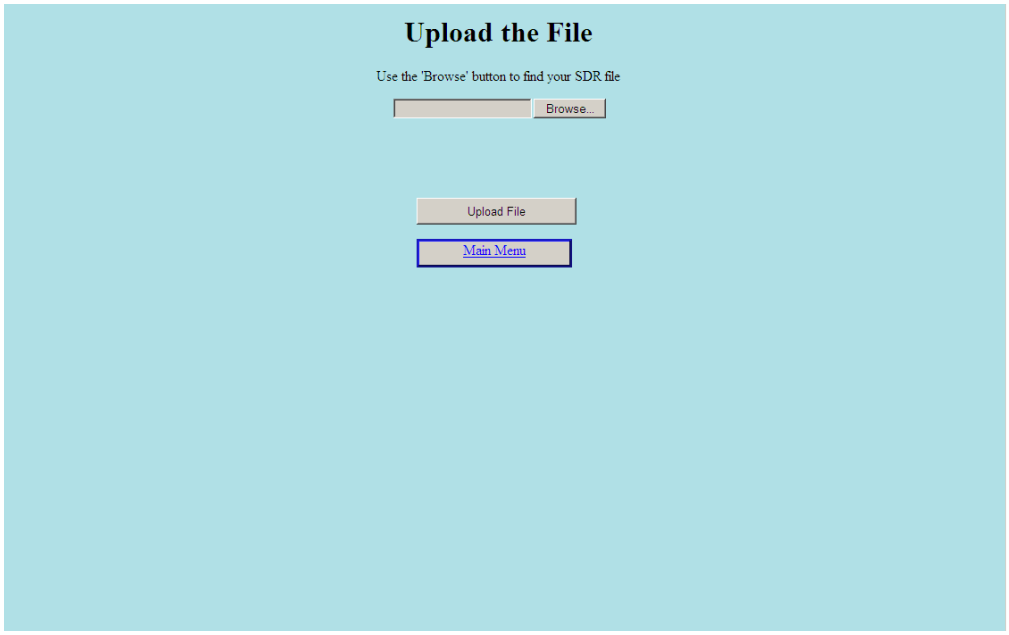


3. Click Upload New Data File.

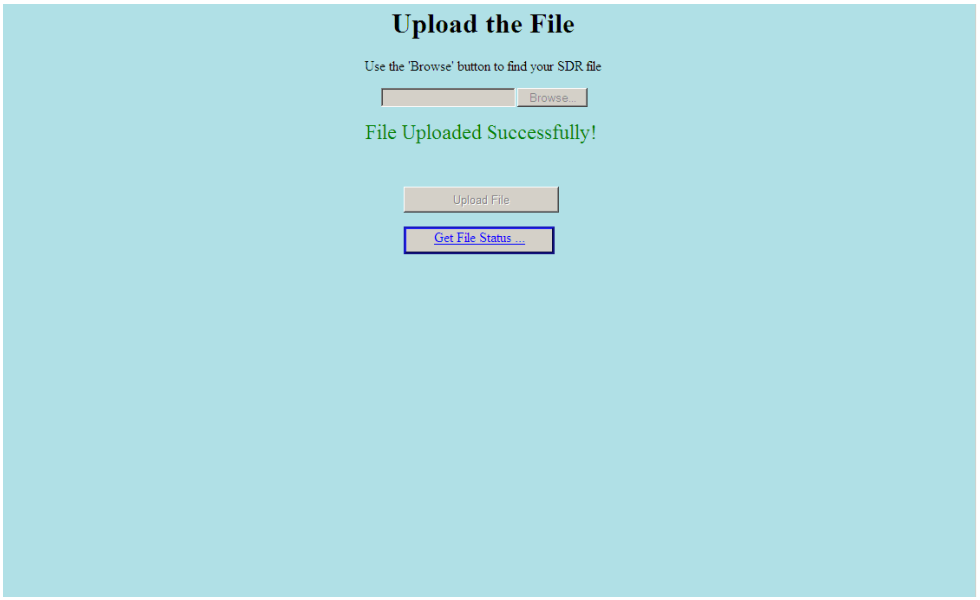
4. Enter your Program Code, the Report Year and Report Month. You can keep the file name of *Export File* or enter a file name under *File Description* such as *PRG99JUN*. This is an arbitrary label for this file during your session on the website. Click the **Continue** button.



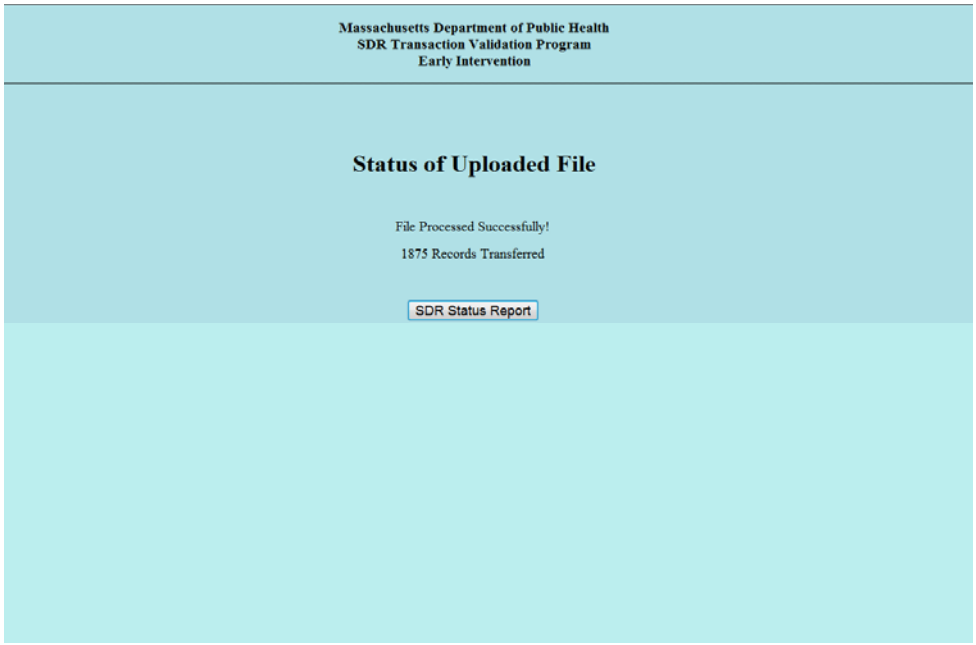
5. You will now upload your SDR file from your computer or network up to the website. This is the file you have exported from your practice management software or billing system Click the **Browse** button, locate your file and then double click the file. Click the **Upload File** button. Uploading may take a little while, depending on the file size and activity on the Internet.



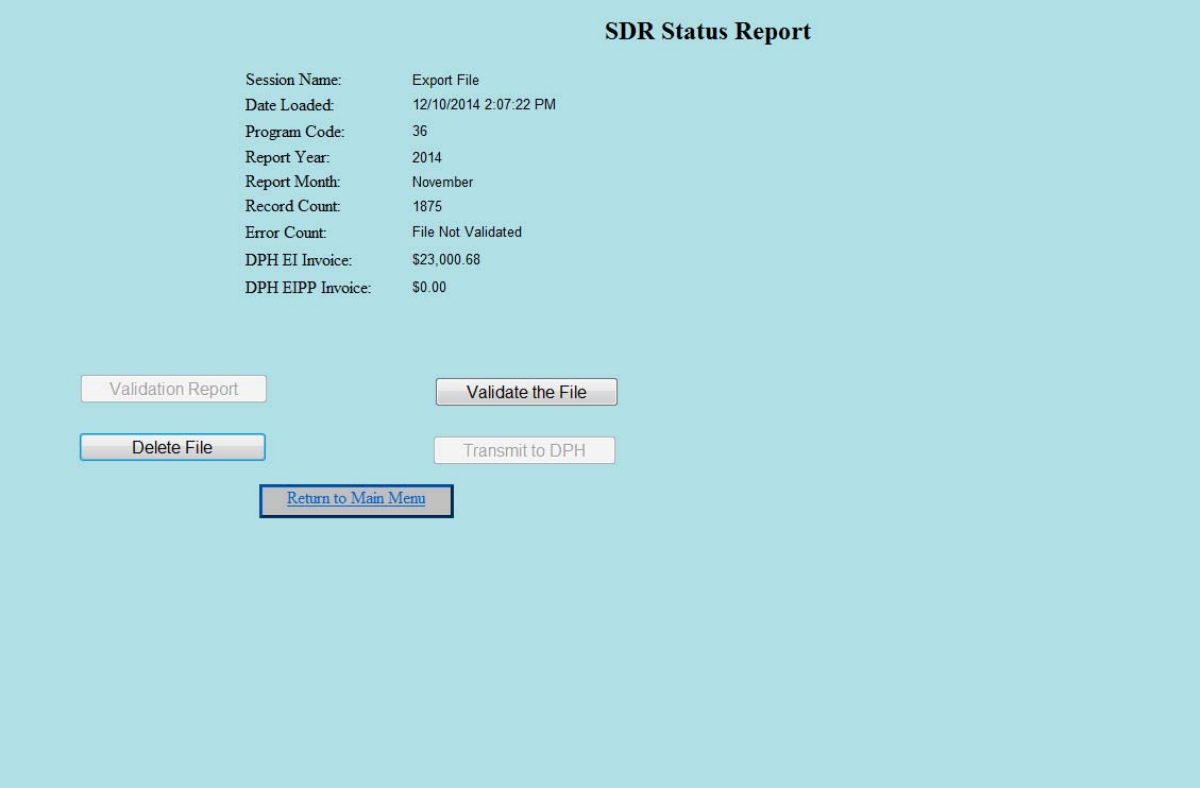
6. You will receive a message that your file has been uploaded successfully. Click the Get File Status button. PLEASE be patient. This may take a few seconds to complete.



7. The File Status page provides you with the number of records that are in your file. Click the **SDR Status Report** button to go to the *SDR Status Report* page.



8. The SDR Status Report provides you with information about your file. Click the **Validate File** button.



The SDR Status Report provides a summation of the records uploaded to the TVP website, including a DPH Invoice total (total amount charged to DPH). The electronic service delivery file or report is, in essence, the bill to DPH of services delivered and reported for a given reporting month for an EI program. Compare the DPH EI Invoice and DPH EIPP Invoice totals on the SDR Status Report with the total amount being billed to DPH based on reports from your practice management or billing system. Both the DPH Invoice amounts and your system total amount should be the same. If there is a discrepancy, you will need to identify the reason for this.

The SDR Status Report can be printed and used for documentation purposes.

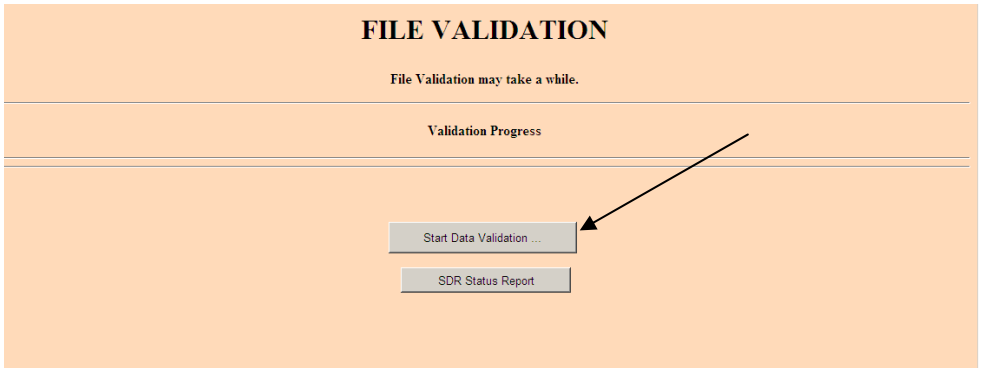
Definitions of Fields on the SDR Status Report

- *Session Name: The arbitrary name you assigned to this session*
- *Date Loaded:* the date that the file was uploaded to the website.
- *Program Code:* the DPH designated EI program code of the file uploaded.
- *Report Year:* the calendar year that you are reporting to DPH for services delivered. This information is based on what you entered on the previous screen under the reporting year question.
- *Report Month:* the calendar month that you are reporting to DPH for services delivered. This information is based on what you entered on the previous screen under the reporting month questions.
- *Record Count:* The total number of records uploaded.
- *Error Count:* The number of errors after validating your file. If the file has not been validated then this will be stated.
- *DPH EI Invoice:* Total EI (including autism) charges to DPH charge.
- *DPH EIPP Invoice:* Total EIPP (including autism) charges to DPH charge.

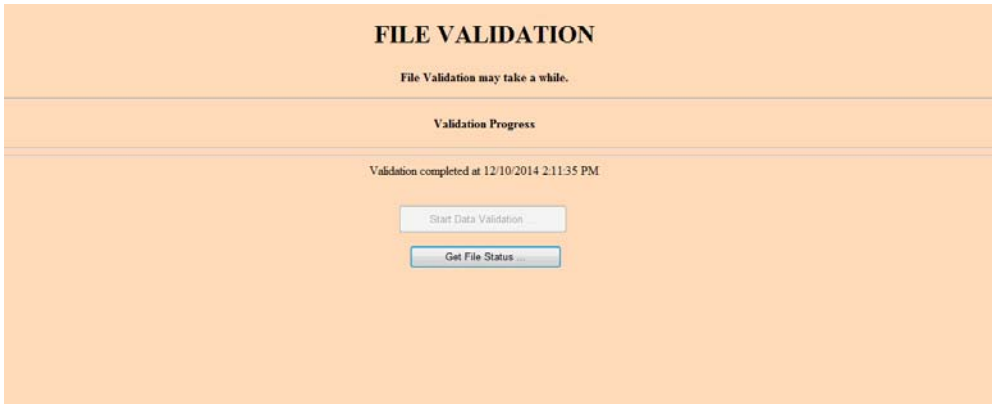
9. Click the *Start Data Validation* button. The validation of records is a two-phase process:

   Error Identification: The first process identifies errors on your data file (records with illogical or missing data). This process will search for errors and provide a counter showing how many records have been processed. If there are no errors this process will search for warnings and potential problems on non-DPH insurance records
   Recording Results: This process takes a little while to record any errors or warnings for the validation report.

   Make sure you click the *Start Data Validation* button.



   Once completed the *Validation completed* message should appear. Click the **Get File Status** button.



10. This will bring you back to an updated SDR Status Report which provides you with a validation message.

    Validation Report

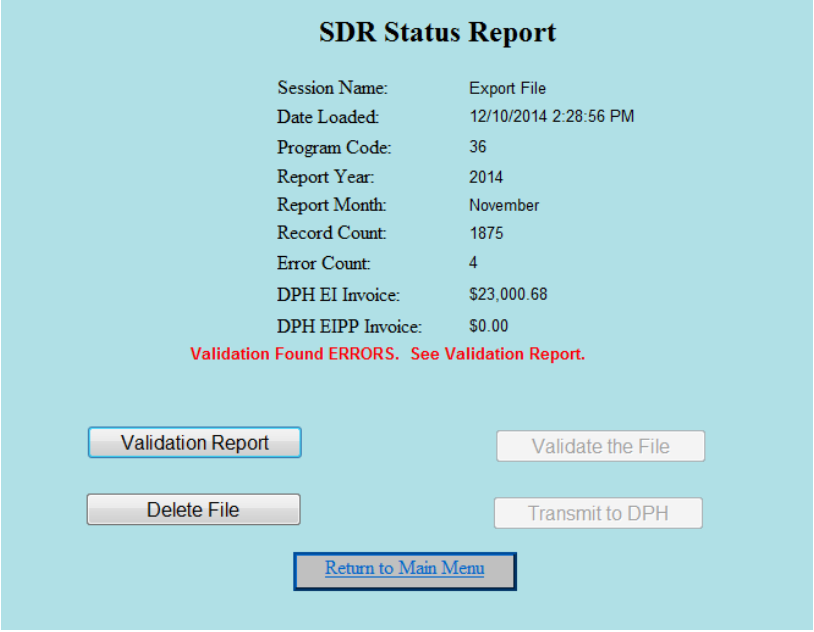
    The validation report is an "exception report" that identifies problem claim records such as incomplete data or inconsistent information within a claim record. One or more service records identified on this report as having an error prevents an EI agency/program from transmitting the entire SDR file of records to DPH. *Appendix III, "EIIS Website Validation Identification Instructions"*, provides a list of all EI TVP website errors along with suggestions for resolution of claim records with these errors.

    The validation report may also identify claim records having warnings. Warnings do not block submission of files, but they are noted on the website's Validation Report so that the EI agency/program can review and/or correct them. DPH warns an EI agency/program of these records because they may lead to other billing issues. For example, some warn of errors that may lead DPH or insurance to reject claims.

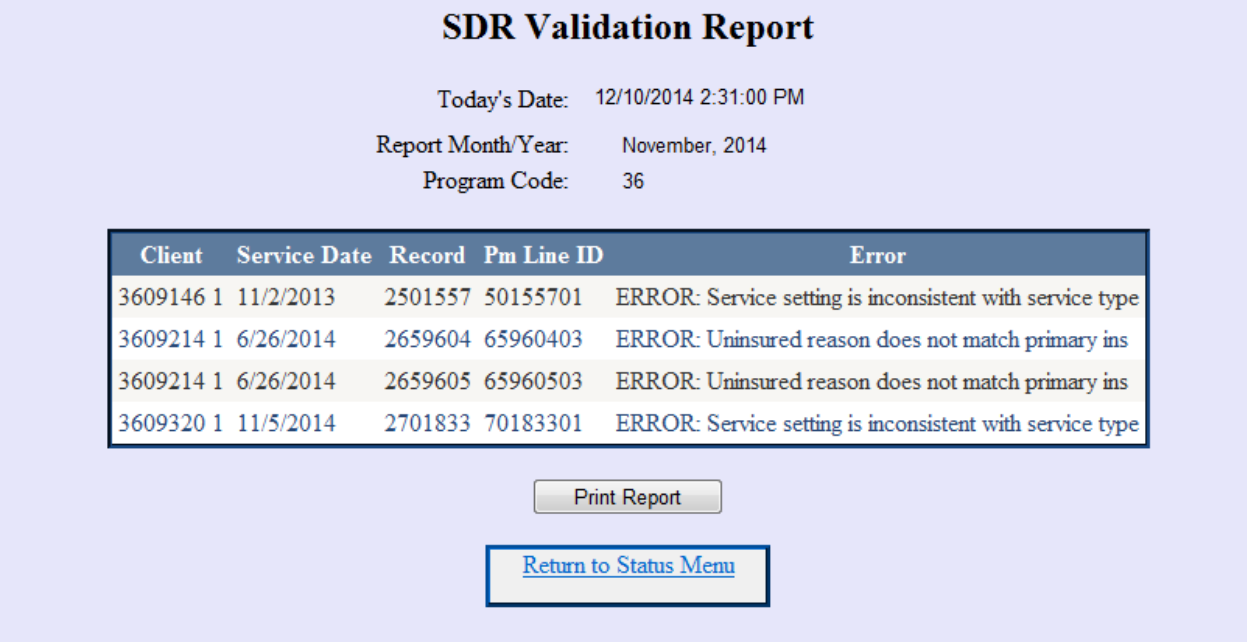
    The Validation Report cannot identify all errors that may cause DPH to reject claims. For example, the report cannot check whether the same claim is a duplicate of one submitted at an earlier date. DPH checks for duplicate and other problematic claims after the file is transmitted.

    After running the validation report the EI agency/program must make corrections of problem claim records on their practice management or billing systems and re-upload the corrected file to the EI TVP website. The validation report must be generated again to verify that no fatal errors exist.

    A. File Has Errors:
    - If the validation found errors then click the **Validation Report** button.



- The *Validation Report* can be printed out. If the report has multiple pages then you will need to select each page and click the *Print Report* button. Each error is recorded separately. Therefore, if the same record has three errors then each error is recorded in this report on a separate line.



SDR Validation Report

Today's Date: 12/10/2014 2:31:00 PM

Report Month/Year: November, 2014

Program Code: 36

Client	Service Date	Record	Pm Line ID	Error
3609146 1	11/2/2013	2501557	50155701	ERROR: Service setting is inconsistent with service type
3609214 1	6/26/2014	2659604	65960403	ERROR: Uninsured reason does not match primary ins
3609214 1	6/26/2014	2659605	65960503	ERROR: Uninsured reason does not match primary ins
3609320 1	11/5/2014	2701833	70183301	ERROR: Service setting is inconsistent with service type

Print Report

Return to Status Menu

- *The Pm Line ID*
  The PM Line ID is a service line identifier that your practice management or billing system generates that (a) uniquely identifies each service delivery record or line within a given fiscal year, and (b) provides a sequencing of service activity for services with multiple transactions or records (the greater the Pm Line ID the more recent the activity).

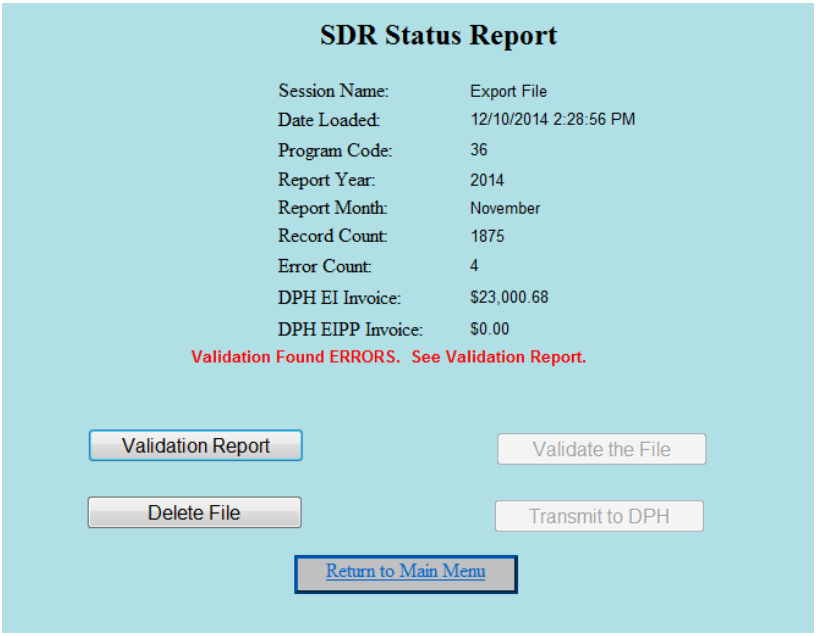
  The Pm Line ID differs between practice management systems. The ARPlus system generates the Pm Line ID by using the last 6 characters of the record # plus a counter (01, 02, 03, etc.). The counter provides a sequencing of the payer events that occurred for a service (see example above). However, the Pm Line ID is not unique per record and the counter number (01, 02, 03, etc.), may be repeated as additional activity occurs.

  The Thom and other practice management systems use a counter to identify each unique record. The Thom Pm Line ID is unique per record activity and uses the Pm Line ID during the upload process of the DPH remittance file to connect to the correct service and activity in the Thom billing system.

- Click the Return to Status Menu button after you have finished printing out all necessary pages.

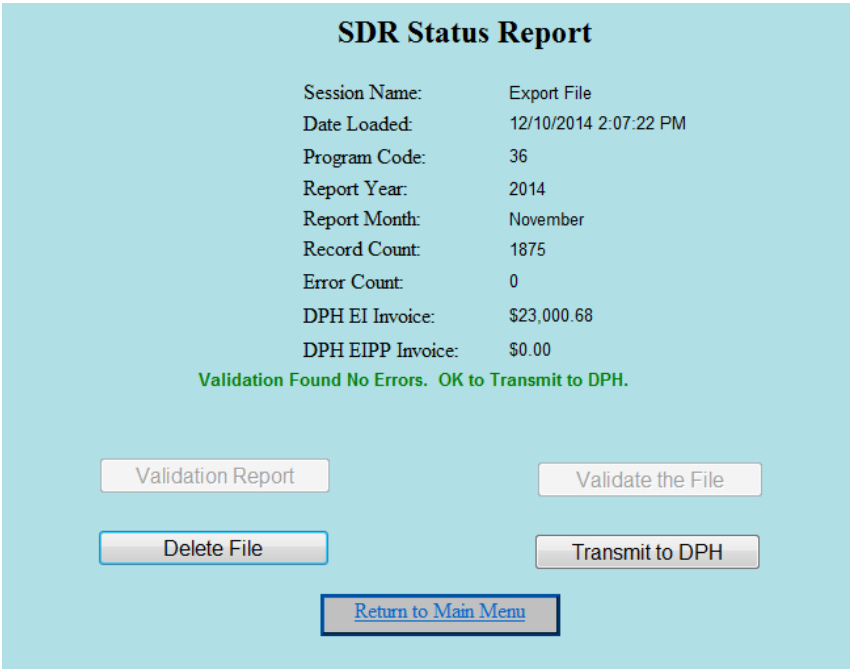
  No further processing of this file on the website will be allowed until these claims have been corrected. Use the Validation Instruction Sheet *(see Appendix III of the EI Service Delivery Reporting Requirements and Reimbursement for Services manual)* to provide guidance in identifying the reason for the error. Corrections should be made to your billing or practice management system.

- You will not be able to transmit your data file until you run the *Validation Report* and the *Transmit to DPH* option is highlighted. Click the **Delete File** button if your file had problems. Once the errors have been corrected in your billing or practice management system you can upload another file.

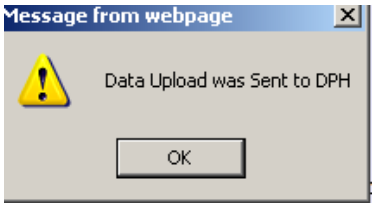


B. File Has No Errors - Transmitting the SDR File and Confirming the DPH Receipt

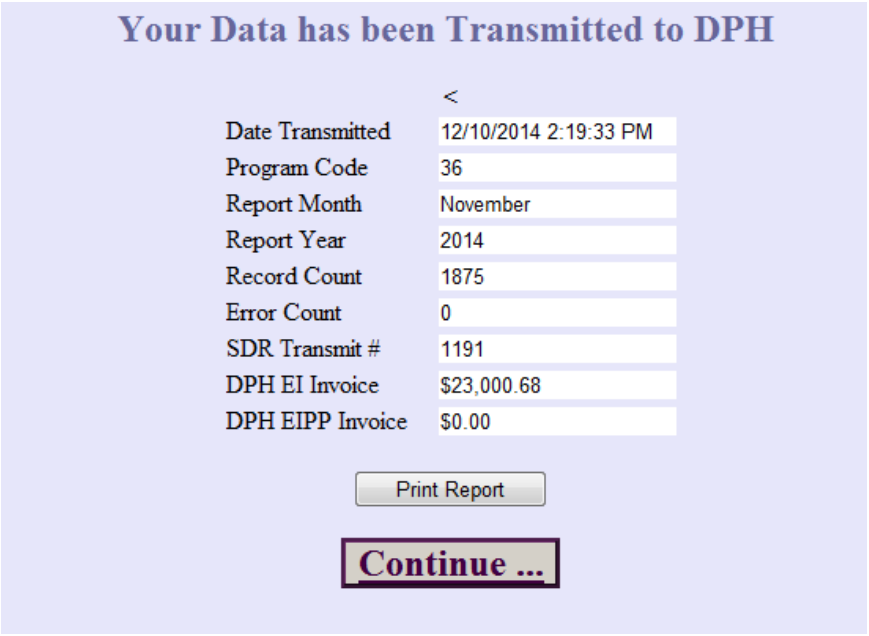
- If the validation did not find errors then click the *Transmit to DPH* button.



- A small screen will appear notifying you that the submission has been completed.
- Click **OK**.



- The following screen will appear

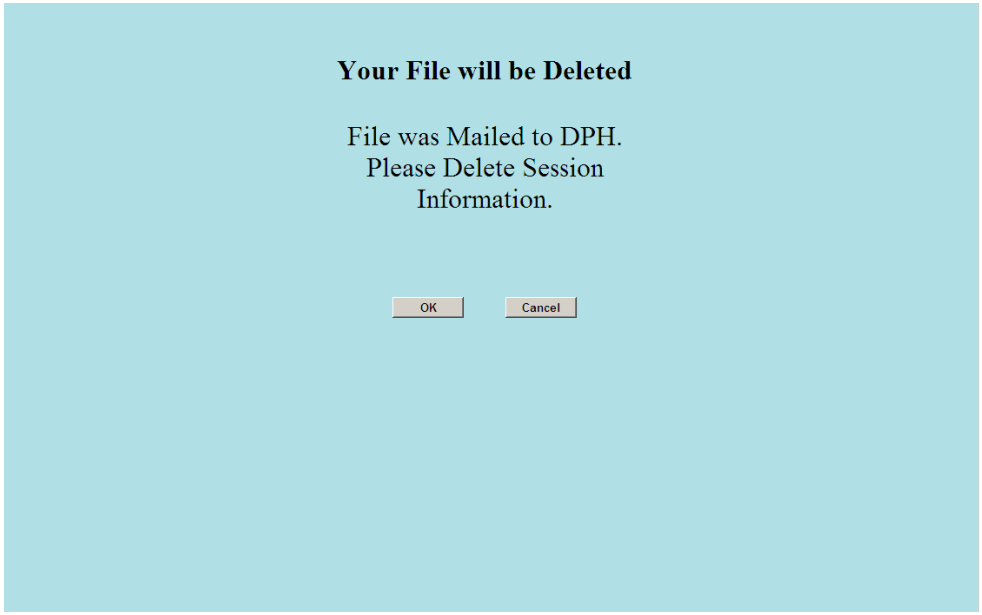


- Click **Print Report** so that you have documentation of the file that you have transmitted. This print-out provides a record of the program code, report month, report year, number of records in the file, the date of transmission and the SDR Confirmation # information for this file. The SDR Confirmation # identifies a successful transmission of your uploaded SDR file to the web server. Keep this as a record of file transmission to DPH.

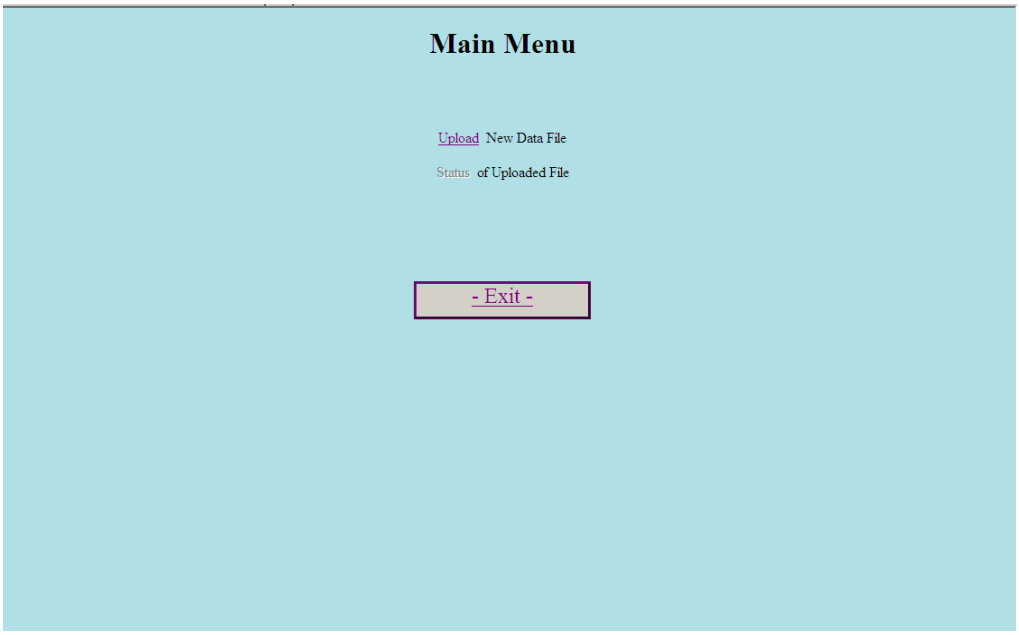
  This file is the *ONLY* invoice DPH will accept for payment. The EI agency/program submits this file under all the legal strictures that apply to paper invoices and payment vouchers. All files submitted shall be under the pains and penalties of perjury as true, correct and accurate as attested by the Executive Director or Chief Financial Officer of the Agency. The EI agency/program must ensure appropriate security of their own systems so that only authorized staff can submit the electronic invoices.

- Click **Continue** in order to delete the file for this session.

- Before deleting, you will be asked to confirm that this is what you wish to do. Click **OK**.



- This will bring you back to the Main Menu. You can now either upload another file or exit from the website.



11. Keeping a Backup File: The data file you uploaded to the website can be kept in a directory or folder on your computer as a backup record. If there are any problems with a transmission or any questions regarding the data content, you will have a backup data file for your use.

    If there are any problems with a file transmission or any questions from DPH regarding the data content, you will have a backup data file for your use. Failure to maintain a backup of each transmission to DPH may result in lost claims if anything were to happen to these data.

12. Other Information
    a. *Changing your password*. You are not able to change your password. If you forget your password or would like to change it then contact Jean Shimer at DPH at (617) 624-5526.
    c. *Getting help*. Contact Jean Shimer at DPH at (617) 624-5526 or jean.shimer@state.ma.us if you have any questions or need help with this website.

TVP WEBSITE VALIDATION INSTRUCTIONS

Error and Warning Messages

The Validation Report on the EI TVP website identifies service delivery (SDR) records with errors or warnings. An error will need to be corrected prior to transmitting the file to DPH. Warnings identify potential problems with the record but will allow the transmission of your SDR file to DPH. The following provides the list of all possible errors and warnings along with additional information for how to correct them.

ERROR/WARNING MESSAGE	POSSIBLE DATA FIELDS NEEDING CHANGE	DESCRIPTION OF PROBLEM
ERROR: Charge is not based on the unit rate (Assessment)	SERVICE SDRDATE HOURS x CHARGE	Multiplying the HOURS by the rate for Assessment (based on the date of service) does not match the CHARGE.
ERROR: Charge is not based on the unit rate (CHA Assessment)	SERVICE SDRDATE HOURS x CHARGE	Multiplying the HOURS by the rate for CHA Assessment (based on the date of service) does not match the CHARGE.
ERROR: Charge is not based on the unit rate (Community Group)	SERVICE SDRDATE HOURS x CHARGE	Multiplying the HOURS by the rate for Community Group (based on the date of service) does not match the CHARGE.
ERROR: Charge is not based on the unit rate (Ctr-Individual)	SERVICE SDRDATE HOURS x CHARGE	Multiplying the HOURS by the rate for Center-Individual visit (based on the date of service) does not match the CHARGE.
ERROR: Charge is not based on the unit rate (EI Only Grp)	SERVICE SDRDATE HOURS x CHARGE	Multiplying the HOURS by the rate for EI Only Group (based on the date of service) does not match the CHARGE.
ERROR: Charge is not based on the unit rate (EIPP sv)	SERVICE SDRDATE HOURS x CHARGE	Multiplying the HOURS by the rate for an EIPP service (based on the date of service) does not match the CHARGE.
ERROR: Charge is not based on the unit rate (Home visit)	SERVICE SDRDATE HOURS x CHARGE	Multiplying the HOURS by the rate for Home visit (based on the date of service) does not match the CHARGE.
ERROR: Charge is not based on the unit rate (Parent Group)	SERVICE SDRDATE HOURS x CHARGE	Multiplying the HOURS by the rate for Parent Group (based on the date of service) does not match the CHARGE.
ERROR: DPH Charge is not based on the unit rate (Autism)	SERVICE SDRDATE HOURS x CHARGE	Multiplying the HOURS by the rate for Autism (based on the date of service) does not match the CHARGE.
ERROR: EIPP service date problem (prior to or after current FY)	SERVICE SDRDATE	The service date (SDRDATE) for an EIPP service type (SERVICE is P, V, T or U) is missing or is prior to or after the current fiscal year.
ERROR: Excessive hours to DPH/no waiver	SERVICE HOURS WAIVERNO	• HOURS for a home visit (SERVICE is A), Center-individual (SERVICE is B) or Intake (SERVICE is E) exceeds 2 hours • HOURS for a child group (SERVICE is N or M) exceeds 2.5 hours • HOURS for a parent group (SERVICE is D) exceeds 1.5 hours • HOURS for an Assessment exceeds 10 hours • A record with excessive HOURS is acceptable if there is a waiver authorization number (WAIVERNO)
ERROR: Hours & charge inconsistency	HOURS CHARGE	• HOURS is negative but CHARGE is positive • HOURS is positive but CHARGE is negative

ERROR/WARNING MESSAGE	POSSIBLE DATA FIELDS NEEDING CHANGE	DESCRIPTION OF PROBLEM
ERROR: Incorrect 2ndary insurance code	PRIMARY SETTING	• If the PRIMARY insurance is a commercial insurance then the 2ndary insurance (SETTING) must be blank or a MassHealth plan • If the PRIMARY insurance is a MassHealth plan then the 2ndary insurance (SETTING) must be blank
ERROR: Incorrect autism professional discipline	SERVICE PROFDISC	If the service type is an autism specialty service then the professional discipline must be an autism specialty provider (PROFDISC = AS)
ERROR: Incorrect Autism Rate for BCBS (< 10/1/12016)	SERVICE TPPCODE SDRDATE HOURS x CHARGE	The HOURS x CHARGE for an autism service for a BC/BS client must match to $61.52, $48.52 or $97.00
ERROR: Incorrect Autism Rate for BCBS (> 10/1/12016)	SERVICE SDRDATE TPPCODE DMACODE/DENNUM CHARGE	The CHARGE for an autism service for a BC/BS client does not match BC/BS rate (based on date of service)
ERROR: Incorrect Autism Rate for BCBS-ComPsych	SERVICE TPPCODE DMACODE CHARGE	The CHARGE for an autism service for a BC/BS – ComPsych client does not match BC/BS – ComPsych rate
ERROR: Incorrect autism reason	REASON DMACODE	A charge to DPH using REASON code D07, D08, D09, D10, D11, D22, D23, D24 or D25 is not an autism service
ERROR: Incorrect Autism Reason Code for Primary Insurance	REASON DMACODE PRIMARY SDRDATE	• Reason code D23 does not have Tufts as the primary insurance • Reason code D24 does not have BC/BS as the primary insurance • Reason code D11 does not have commercial or Tufts/-GIC as primary insurance • Reason code D07 or D08 cannot have CIGNA or Aetna/US Health Care as the primary insurance
ERROR: Incorrect Autism Reason for non-commercially insured	REASON PRIMARY	Reason codes D07, D08, D10, D11, D22, D22, D23, D24 and D25 are only allowed when the primary insurance is a commercial insurance
ERROR: Incorrect client ID	CLIENT	The CLIENT ID is blank, incomplete or contains symbols
ERROR: Incorrect client referral number	REFERRAL	The REFERRAL number is not a number.
ERROR: Incorrect CMS/CPT for “K” service	SERVICE DMACODE	A “K” (Supervision) autism service must have a CMS/CPT service code (DMACODE) of H0031, H2012 or H2019 (prior to 12/31/2016)
ERROR: Incorrect co-treatment code	COTRTMT SERVICE	The COTRTMT must be "No" (COTRTMT is 0) or "Yes" (COTRTMT is 1) when SERVICE is a home visit (SERVICE is A) or center-individual (SERVICE is B)
ERROR: Incorrect CPT code for BCBS Payer (Autism)	SERVICE TPPCODE SDRDATE DMACODE	CPT codes for BC/BS autism services must be 0359T, G9012, 0364T, 0365T, 0368T, 0369T or 0370T

ERROR/WARNING MESSAGE	POSSIBLE DATA FIELDS NEEDING CHANGE	DESCRIPTION OF PROBLEM
ERROR: Incorrect CMS Code for Payer (Autism)	SERVICE DMACODE TPPCODE (not BC/BS) SDRDATE	• CMS code (DMACODE) for autism services must be H2019 • CMS code for services on or after 3/1/2016 must be H2019, H0031, H0032 and H2012
ERROR: Incorrect EIPP CMS/CPT service code	SERVICE DMACODE	EIPP services must have a CMS code (DMACODE) of H2015, G0154 or T1027
ERROR: Incorrect EIPP reason code	REASON	The REASON must be P10 for an EIPP SERVICE (SERVICE is P, V, T or U)
ERROR: Incorrect Ins Addendum (TPPAUTH) for UBH/BHS/ComPsych Payer	TPPCODE PRIMARY TPPAUTH TPPELIG	The insurance addendum code when United Behavioral Health (UBH) or Beacon Health Strategies (BHS) is the payer must be the same as the insurance addendum code of the primary insurance
ERROR: Incorrect Ins Addendum code (TPPAUTH)	TPPCODE TPPAUTH	The payer (TPPCODE) is a commercial insurance and the insurance addendum code (TPPAUTH) must be: 1 (fully insured), 2 (self-insured/ASO), 3 (federal), 4 (HAS/HRA/FSA), 5 (Union/Local/Trade Association), 6 (GIC) or 9 (unknown)
ERROR: Incorrect Ins Addendum code (TPPELIG)	PRIMARY TPPELIG	The PRIMARY insurance is a commercial insurance and the insurance addendum code (TPPELIG) must be: 1 (fully insured), 2 (self-insured/ASO), 3 (federal), 4 (HAS/HRA/FSA), 5 (Union/Local/Trade Association), 6 (GIC) or 9 (unknown)
ERROR: Incorrect Ins addendum for reason 119	REASON TPPELIG	The REASON code of 119 (Benefit maximum has been reached) can only be used for fully insured (TPPELIG = 1) insurance plans
ERROR: Incorrect insurance payer code (tppcode)	TPPCODE	The payer code (TPPCODE) must be blank or 0, 2, 6, 8, 18, 20, 21, 22, 24, 25, 26, 27, 28, 34, 35, 36, 38, 40, 41, 42, 43, 44, 47, 48, 49, 50, 51, 60, 61, 62, 63, 64, 65, 66 and 88 *(see the code sheet for insurance)*
ERROR: Incorrect payment code	PAYMENT	The payer type (PAYMENT) is not D, M, X, H or I
ERROR: Incorrect PM Line ID	PMLINEID	One or more of the 8 characters of the program line ID (PMLINEID) is blank or is not numeric
ERROR: Incorrect primary ins (DPH) for sv billed to TPP	PRIMARY TPPCODE	When the primary insurance is DPH then the payer must be DPH
ERROR: Incorrect primary insurance code	PRIMARY	The PRIMARY insurance must be blank or 0, 2, 6, 8, 18, 20, 21, 22, 24, 25, 26, 27, 28, 34, 35, 36, 38, 40, 41, 42, 43, 44, 47, 48, 49, 50, 51, 60, 61, 62, 63, 64, 65, 66, 67, *88 (see the code sheet for insurance)*
ERROR: Incorrect professional discipline	SERVICE PROFDISC	• An EI service (SERVICE is A, B, D, E, G, H, M or N) must have a professional discipline (PROFDISC) of DS, AA, BB, SS, NS, OT, PT, SP, CS or SW • an EIPP service (SERVICE is P, V, T or U) must have a professional discipline (PROFDISC) of NS, SW or MH
ERROR: Incorrect professional discipline for service	SERVICE PROFDISC	• A professional discipline (PROFDISC) of DS, AA, BB, SS, NS, OT, PT, SP, CS or SW must be for an EI service (SERVICE is A, B, D, E, G, H, M or N) • A professional discipline (PROFDISC) of NS, SW or MH must be for an EIPP service (SERVICE is P, V, T or U)
ERROR: Incorrect program code	PRGCODE CLIENT (1st two chars)	The program code (PRGCODE) is blank, not a number or does not match the 1st two characters of the CLIENT ID
ERROR: Incorrect reason (P10) for an EI child	REASON CLIENT	Reason code of P10 is allowed for EIPP clients only

ERROR/WARNING MESSAGE	POSSIBLE DATA FIELDS NEEDING CHANGE	DESCRIPTION OF PROBLEM
ERROR: Incorrect reason code	REASON SDFORM	• The following reason codes can be used on both initial and transfer records (SDFORM B, C, D or E): 001, 002, 003, 050, 052, 096, 109, 141, 149, D01, D02, D05, D06, D07, D08, D09, D11, D22, D23, D24, D25, D99 and P10 • The following reason codes can be used on transfer records only (SDFORM=D or E): 026, 027, 028, 032, 033, 039, 045, 062, 063, 123, 125,177 and B14 • The following reason codes can be used on partial payment transfer records only (SDFORM=E): D10 and D20 *(See the code sheet for reasons)*
ERROR: Incorrect reason for autism intake	REASON SERVICE	The only acceptable REASON code for an autism intake service is either a D05 (uninsured child) or D09 (autism service does not meet insurance requirements)
ERROR: Incorrect reason for DPH charge for non-ABA SSP	INSAMT (SSP code) REASON	Reason code D09 is the only code to be used for autism services for PDC and REACH specialty providers
ERROR: Incorrect reason for non-ABA SSP	INSAMT (SSP code) REASON	Reason codes D07, D08, D10, D11, D2, D23, D24 and D25 cannot be used for autism services for PDC and REACH specialty providers
ERROR: Incorrect reason for uninsured child	REASON PRIMARYINS	The only acceptable REASON codes for an uninsured child include D05 (uninsured child), D06 (family refused access to insurance) and P10 (EIPP service)
ERROR: Incorrect report month/report year	REPMONTH REPYEAR	• The reporting month (REPMONTH) must be 01 to 12 • The reporting year (REPYEAR) is not correct
ERROR: Incorrect sdform	SDFORM	The service delivery form type (SDFORM) is not: • B (service date occurs during this reporting year/month) • C (service date occurs prior to this reporting year/month) • D (unit rate payer adjustment/transfer) or • E (partial payment adjustment/transfer)
ERROR: Incorrect service for EIPP mom	CLIENT SERVICE	An EIPP client is allowed services V (EIPP initial home visit), P (EIPP home visit) T (Lactation consultation) and U (Nutritionist)
ERROR: Incorrect service distinction code (DENNUM)	SERVICE DENNUM	• The SERVICE type is a community child group (SERVICE is M) and the service distinction code (DENNUM) is blank or not 2 • The SERVICE type is an EI-only child group (SERVICE is N) and the service distinction code (DENNUM) is blank or not 1 • The SERVICE type is a Home visit (SERVICE is A) or Center-Individual and the service distinct code (DENNUM) is not 1, 2 or 3
ERROR: Incorrect service setting code	WAIVER	The service setting code (WAIVER) is not H01, H02, V01, V02, V03, C01, C02, P01, S01 or S02
ERROR: Incorrect service type code	SERVICE DMACODE	• The SERVICE type is not A, B, D, E, G, H, M, N, P, V, T or U • The SERVICE type is E, P, V, T or U for a non-EIPP program
ERROR: Incorrect SSP code	DMACODE INSAMT (SSP code)	Autism service must have an SSP code of 101, 102, 103, 105, 106, 109, 110, 112, 201, 202, 203, 204, 205, 206, 207, 208 or 209

ERROR/WARNING MESSAGE	POSSIBLE DATA FIELDS NEEDING CHANGE	DESCRIPTION OF PROBLEM
ERROR: Incorrect SV/PAYMENT code for UBH/BHS/ComPsych Payer	TPPCODE PAYMENT SERVICE	United Behavioral Health (UBH), Beacon Health Strategies and ComPsych must have a PAYMENT code of I (commercial insurance) for autism services only
ERROR: Incorrect text for "Other" payer	TPPCODE TPPCODE8	The payer (TPPCODE) is "Other" (TPPCODE is 88) and the "Other" text field (TPPCODE8) should be re-coded (e.g., TPPCODE is 88 and TPPCODE8 is "HCHC" should be re-coded to TPPCODE is 20) *(see the Code Sheet for)*
ERROR: Incorrect use of D09 autism reason code	REASON SDRDATE PRIMARY SERVICE TPPELIG (ins addendum) INSAMT (SSP code)	A reason code of D09 for autism services are allowed for the following: • SSP is PDC or REACH • MassHealth is primary or 2ndary insurance • Commercial insurance: intake service, Champus/TriCARE or federal
ERROR: Incorrect use of D10 reason	REASON SDRDATE PRIMARY TPPCODE	A reason code of D10 (contractual obligation) for autism services prior to 10/1/2016 are allowed for BC/BS only
ERROR: Incorrect use of D22 reason code	REASON SDRDATE	A reason code of D22 (Non-BCBA clinician provided an autism service where insurance requires BCBA for service) is allowed for autism services prior to 12/31/2016 only
ERROR: Ins Addendum (TPPAUTH) does not match TPPcode	TPPAUTH TPPCODE	• The insurance addendum code is "Union/Local/Trade Association plan" (TPPAUTH is 5) and the payer code (TPPCODE) is "Champus/TriCARE" (TPPCODE is 40) • The insurance addendum code is "Group Insurance Commission (GIC)" (TPPAUTH is 6) and the payer code (TPPCODE) is not 20, 21, 22, 24, 27 or 66
ERROR: Ins Addendum (TPPELIG) does not match Primary ins	TPPELIG PRIMARY	• The primary insurance addendum code is "Union/Local/Trade Association plan" (TPPELIG is 5) and the PRIMARY insurance code is "Champus/TriCARE" (code of 40) • The primary insurance addendum code is "Group Insurance Commission (GIC)" (TPPELIG is 6) and the PRIMARY insurance code is not 20, 21, 22, 24, 27 or 66
ERROR: Ins member ID problem (primary8)	PRIMARY8 PRIMARY	• The child's primary insurance member ID is either missing or does not contain one or more numbers (exception is for Aetna clients) • Child is uninsured (primary insurance is DPH) and should not have an insurance member ID
ERROR: Insurance should not be '88'	TPPCODE TPPCODEOTHERNAME	If the TPPCODE (payer) is 88 (Other) then the text (TPPCODEOTHERNAME) cannot be an insurance that is on the DPH insurance list *(see code sheet for insurance)*
ERROR: Last character of client ID is not numeric	CLIENT	The last character of the client ID is not numeric
ERROR: Missing charge	PAYMENT CHARGE	The service delivery form type (SDFORM) is B, C or D and the payer type is DPH (PAYMENT is D) and the CHARGE is $0.00
ERROR: Missing PARTDPH charge	SDFORM PARTDPH	The service delivery form type (SDFORM) is a partial payment adjustment/transfer (SDFORM is E) and the DPH cost adjustment amount (PARTDPH) is $0.00
ERROR: Missing record number	RECORDNO	The record/transaction number is missing

ERROR/WARNING MESSAGE	POSSIBLE DATA FIELDS NEEDING CHANGE	DESCRIPTION OF PROBLEM
ERROR: Missing service date	SDRDATE	The service date is missing
ERROR: Missing text for "Other" payer	TPPCODE TPPCODE8	The payer (TPPCODE) is "Other" (TPPCODE is 88) and the "Other" text field (TPPCODE8) is blank *(see code sheet for insurance)*
Negative charge on Initial service record	SDFORM CHARGE	The service delivery form type (SDFORM) is B or C (initial record) and the CHARGE is negative
ERROR: Partial transfer has hour/charge	SDFORM HOURS CHARGE	The hours and charge on a partial payment adjustment record (SDFORM is E) should be 0.00
ERROR: Prg code entered does not match File Prg code	PRGCODE PRGCODEFILE (code user entered in TVP)	The program code in the file does not match to the program code entered on the TVP website by the user
ERROR: Reason code 052 but not Assistant prof disc	PROFDISC PRIMARY REASON SDFORM	• If the reason code is 52 (rendering provider is not eligible to perform the service) and professional discipline is a speech therapist (PROFDISC is SA) then the PRIMARY or secondary insurance must be MassHealth (PRIMARY is 2, 6, 8, 34, 35, 38, 43, 44, 47, 48, 49, 50, 51 or 67) OR • If the reason code is 52 and professional discipline is a speech, occupational or physical therapist assistant (PROFDISC is SA, OA, PA) then the PRIMARY insurance must be BC/BS
ERROR: Reason code 63,123,125 w/DPH positive charge amount	REASON CHARGE	If the REASON code on a record billed to DPH is 63, 123 or 125 (payment refund/adjustment/correction) then the CHARGE must be negative
ERROR: Reason code not allowed for autism sv	SERVICE REASON	The REASON code of D25 must be used for autism services when "Benefit or claim is not covered" (reason code 96 cannot be used for autism services)
ERROR: Reason code P10 but not EIPP (P,V,T,U) service	REASON SERVICE	The REASON code is P10 (EIPP service) but the SERVICE is not an EIPP service (SERVICE is P, V, T or U)
ERROR: Reason code P10 but not EIPP client	REASON CLIENT	The REASON code on a record is P10 (EIPP service) but the CLIENT is not an EIPP mom
ERROR: Reason D01 or D02/No waiver#	REASON PRGCODE WAIVERNO	Reason code D01 and D02 are allowed if there is a waiver authorization number
ERROR: Secondary service/No waiver#	PRGCODE CLIENT WAIVERNO	The first two characters of the CLIENT ID must match to the program code unless there is a waiver authorization number

ERROR/WARNING MESSAGE	POSSIBLE DATA FIELDS NEEDING CHANGE	DESCRIPTION OF PROBLEM
ERROR: Service code is inconsistent w CMS/CPT service code	DMACODE SERVICE	The CMS/CPT service code (DMACODE) is not consistent with the SERVICE type: • If the SERVICE type is a home visit (SERVICE is A, I, P, V, T, U) then the CMS/CPT service code (DMACODE) must be H2015 • If the SERVICE type is a center- individual (SERVICE is B) then the CMS/CPT service code (DMACODE) must be T1015 • If the SERVICE type is an EI-only child group (SERVICE is N) then the CMS/CPT service code (DMACODE) must be 96153 • If the SERVICE type is a community child group (SERVICE is M) then the CMS/CPT service code (DMACODE) must be 96153 • If the SERVICE type is a parent group (SERVICE is D) then the CMS/CPT service code (DMACODE) must be T1027 • If the SERVICE type is an intake (SERVICE is E) then the CMS/CPT service code (DMACODE) must be T1023 • If the SERVICE type is an assessment (SERVICE is G or H) then the CMS/CPT service code (DMACODE) must be T1024
ERROR: Service date problem (prior to previous FY or after current FY)	SDRDATE	The service date (SDRDATE) is missing or is prior to the previous fiscal year or is after the current fiscal year
ERROR: Service Setting is inconsistent with service type	SERVICE (service type) WAIVER (service setting)	The service setting (WAIVER) does not match SERVICE: • If the SERVICE type is a Home Visit or an EIPP Home Visit (SERVICE is A, I, P, V, T or U) then the service setting must be H01 or H02 • If the SERVICE type is Center-Individual (SERVICE is B) then the service setting must be V01, V02 or V03 • If the SERVICE type is Child Group (SERVICE is M or N) then the service setting must be C01 or C02 • If the SERVICE type is Parent group (SERVICE is D) then the service setting must be P01 • If the SERVICE type is Assessment or CHA Assessment (SERVICE is G, H or E) then the service setting must be S01 or S02
ERROR: TPP Charge is not based on the unit rate (Autism)	SERVICE DMACODE SDRDATE HOURS x CHARGE	The autism rate reported for an insurance (BC/BS excluded) is not correct
ERROR: TPP/payer (tppcode) does not match payment	TPPCODE PAYMENT	The payer code and payment code do not match *(see code sheet for insurance):* • If the child is uninsured then the payer code (TPPCODE) must be 00 (DPH) • If the payer code (TPPCODE) is 2, 38, 43, 44, 47, 48, 49, 50 or 51 then the PAYMENT must be MassHealth (PAYMENT is M) • If the payer code (TPPCODE) is 6, 8, 34, 35 or 67 then the PAYMENT must be MassHealth MCO (PAYMENT is X) • If the payer code (TPPCODE) is 18, 20, 21, 22, 24, 25, 26, 27, 28, 36, 40, 41, 42, 60, 61, 62, 63, 64, 65, 66 or 88 then the PAYMENT must be commercial insurance (PAYMENT is I)
ERROR: Uninsured child but payer is an insurance	PRIMARY TPPCODE	If the PRIMARY code on a record is 00 (child is uninsured) then the TPPCODE insurance must be 00 (child is uninsured)

ERROR/WARNING MESSAGE	POSSIBLE DATA FIELDS NEEDING CHANGE	DESCRIPTION OF PROBLEM
ERROR: Uninsured reason does not match primary ins	REASON PRIMARY	If the REASON code is D05 (uninsured) then the PRIMARY insurance must be 00 (DPH)
WARNING: Excessive EIPP charges to TPP	SERVICE CHARGE	The CHARGE amount for an EIPP service (SERVICE is P, V, T or U) exceeds the standard rate
WARNING: Excessive hrs to TPP/no waiver auth #	SERVICE HOURS WAIVERNO	The HOURS on an insurance record (SERVICE is A, B, D, E, G or H) exceeds the standard
WARNING: Incorrect payer for EIPP prof discipline (LC,NU)	SERVICE PAYMENT	The EIPP Nutritionist and Lactation consultants should only be billed to DPH
WARNING: Incorrect payer for EIPP service (T,U)	PROFDISC SERVICE PAYMENT	The EIPP group and consultation services should only be billed to DPH

APPENDIX 3

MA DPH Reimbursement Policy Manual for Early Intervention and Autism Services

DPH BUSINESS RULE DESCRIPTIONS & CODES

Contents

General Information

Assigning Error Codes

When service delivery data (SDR) received from the TVP website are included in the database at DPH, a series of business rules are processed on them.

If the record passed all business rules, the error code data field will state "NO ERROR". If an SDR record does not pass a business rule then an error code is assigned to the record.

Note: The implementation of some business rules cannot be automated at this time. Some charges may be paid that later must be credited back to DPH. In addition, some types of compliance, such as compliance with insurance billing practices, can only be monitored on site. If discrepancies are identified after payment of claims has been made to the EI agency/program, the EI agency/program is required to return payments to the Commonwealth either as credits to DPH on an SDR file or as a check to the Commonwealth.

Claim and Line Status

Assigning the Line Status

The line status is assigned for each record based on the error code(s) on the individual SDR record. The following are the possible line statuses:

Status	Description
Accept	Passed all DPH business rules
Denial	Failed due to submission after the DPH deadline
Denied	Failed due to service that meets insurance requirements
Not Processed	Rejected due to duplication of billing system primary key
Pended	Failed due to inappropriate reason for DPH payment/support documentation is required for payment approval
Reject	Rejected due to failure of one or more REJECT business rules
Suspend	Failed business rule when matched to EIIS client record
Waived Pend	Failed business rule due to no Waiver for reimbursement present or service does not match waiver request

If a line has failed business rules that result in the line being both pended and suspended a line status of pended is always assigned. An EI agency/program must resolve both the pended and suspended issue prior to DPH payment.

Rejected records:

- Rejected records are moved to a different database at DPH
- Once rejected records are removed, the remaining records are processed for payment
- Rejected records are not included as part of a claim's history and are ignored in all future claim processing; they do not affect the status of the remaining records in the database.
- Not Processed rejected records: The record was rejected prior to being processed through the business rules at DPH

Assigning the Claim Status

Definition of a Claim**:** A claim is defined as a service by DPH. A claim includes all records or events for a child under a single session provided by a clinician. A claim can be one single record or can have multiple records if payer adjustments or transfers are reported to DPH.

DPH assigns claim status to each record based on the combination of all line statuses within a claim. If the claim has multiple lines and all lines within this claim have a line status of ACCEPT, a claim status of ACCEPT is assigned to all of the records. If a claim includes both a SUSPEND and PENDED line status then the claim status for all records will be PENDED, even though all status' need to be resolved by the EI agency/program.

DPH Reconcilement of Payments due to SDR Problems

At times, the EI agency/program may identify service delivery data that was transmitted to DPH in error. If these data were imported into the SDR database at DPH and claim records were processed for payment approval, DPH cannot delete these records. Instead, a reconciliation record will be created that will credit the payment to DPH. The O_STATUS data field on your remit will provide an explanation for the credit.

DPH may identify that charges were paid to a vendor incorrectly. A reconciliation record will be created by DPH to adjust for this payment.

Business Rule Descriptions & Codes

The following grid lays out the specific business rules applied to SDR records during the processing of these records for payment at DPH, the error code assigned to the business rule and the line status. Suggestions for resolutions of problems are also included.

EARLY INTERVENTION SERVICE DELIVERY SYSTEM
Business Rule Descriptions & Codes

ERROR CODE	BUSINESS RULES	LINE STATUS
NO ERROR	**Acceptable service record** All business rules passed for this record.	ACCEPT
20	**Problem record: Duplicate PMLINEID** The PMLINEID data field for this record already exists on a record previously submitted to DPH and so the record is considered to be a duplicate. No two records can have the same program code number and PMLINEID within the same fiscal year. What you should do: The generation of the PMLINEID and problems with this data field are specific to the billing system you are using. You may need to contact your technical support consultant for your billing system to resolve ongoing problems. Otherwise, do the following: • If it is a duplicate record to another record that has been accepted by DPH, do nothing • If it is not a duplicate record, resubmit the record, ensuring unique PMLINEID	Rejected as Not Processed
60	**Problem record: Program request to reject this record** Your program has contacted DPH to request the deletion or rejection of this record. What you should do: There is nothing to do with these records. See the O_STATUS data field on the remit file for this record for an explanation of the problem.	REJECT
61	**Problem record: Missing or incorrect data** DPH has identified that one or more data fields on this record has either missing or incorrect information. What you should do: See the O_STATUS data field on the remit file for this record for an explanation of the problem.	REJECT
63	**Late submission** NO ERROR, No payment due to receipt of record after the DPH fiscal year supplemental deadline (March 10th of each year). What you should do: Do nothing. DPH will not pay for services submitted past the deadline.	DENIAL

EARLY INTERVENTION SERVICE DELIVERY SYSTEM
Business Rule Descriptions & Codes

ERROR CODE	BUSINESS RULES	LINE STATUS
64	**EIPP Budget Cap amount exceeded** What you should do: Do nothing. DPH will not pay for EIPP services that have exceeded the maximum cap allocation.	DENIAL
2M	**Over or Underpayment: Incorrect charge** The charge on the adjustment record is greater or less than the charge on the original/initial service record What you should do: Review all transactions submitted for the service. If the problem continues notify Jean Shimer at (617) 624-5526 of any considerations regarding the service that would affect appropriate DPH payment.	REJECT
3A	**Duplicate original/initial service record** 2 or more DPH original/initial services with the same program code, client ID and referral #, service date, service type, service setting & professional discipline. No waiver authorization # on service record. What you should do: 1. If it is a duplicate record to another record that has been accepted by DPH, do nothing. 2. If the record was the same service provided by a professional of the same discipline as another service processed for this child, resubmit the record with the appropriate waiver authorization number.	REJECT
3B	**Duplicate original/initial service record** 2 or more original/initial services with the same program code, client ID and referral #, service date and record number. What you should do: If the service record is not a duplicate, resubmit the service record using another record number. Include waiver authorization # if needed.	REJECT
3C	**Duplicate cost adjustment service record** 2 or more cost adjustment service records with the same client ID and referral #, service date, insurance payer code and amount billed to DPH. What you should do: If these are legitimate records that have been rejected (this may happen when a service has a lot of activity associated with it) then contact Jean Shimer at DPH at (617) 624-5526.	REJECT

EARLY INTERVENTION SERVICE DELIVERY SYSTEM
Business Rule Descriptions & Codes

ERROR CODE	BUSINESS RULES	LINE STATUS
3E	**Duplicate original/initial service record, has a waiver** 2 or more waived original/initial services with the same program code, client ID and referral #, service date, service type, service setting & professional discipline. This rule excludes EI assessments. What you should do: DPH has denied approval. See the O_STATUS data field in the SDR remit file for the reason.	wPEND
3F	**Duplicate original/initial service record, has a waiver one only one service** 2 or more waived original/initial services with the same program code, client ID and referral #, service date, service type, service setting & professional discipline. This rule excludes EI assessments. What you should do: DPH has denied approval. See the O_STATUS data field in the SDR remit file for the reason.	wPEND
3T	**Duplicate non-DPH original/initial service record** 2 or more non-DPH original/initial services with the same program code, client ID and referral #, service date, service type, service setting & professional discipline. No waiver authorization # on service record. What you should do: 1. If it is a duplicate record to another record that has been accepted by DPH, do nothing. 2. If the record was the same service provided by a professional of the same discipline as another service for this child, resubmit the record with the appropriate waiver authorization #.	REJECT

EARLY INTERVENTION SERVICE DELIVERY SYSTEM
Business Rule Descriptions & Codes

ERROR CODE	BUSINESS RULES	LINE STATUS
4C	**Reason code for DPH payment is unacceptable** The reason code on a DPH service record is one of the following: 1 (Deductible amount) 2 (Coinsurance amount) 3 (Co-payment amount) 45 (Charges exceed contracted fee arrangement) 50 (Deemed not medically necessary by payer) 119 (Benefit maximum for this time period has been reached) D05 (Uninsured) AND the primary or secondary insurance code on the original/initial service record is one of the following: • MassHealth: CommonHealth • MassHealth: Family Assist • MassHealth: HSN • MassHealth: HSN-Partial • MassHealth: Standard • MassHealth: MCO: Fallon • MassHealth: MCO: Neighborhood Health • MassHealth: MCO: Tufts Health Plan Public • MassHealth: MCO: BMC Healthnet Plan (Boston Medical Center) What you should do: Submit support documentation to the EI Fiscal Manager for justification of DPH payment. *Note* Services with these reason codes are NOT matched to other services that were approved with support documentation. Therefore, every service date for 4C records needs support documentation to be submitted. *Approval/Denial* DPH re-remits all pended services unless payment has been approved. An approved service record will have a PV reference number. If approval has been denied then the denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file.	PENDED

EARLY INTERVENTION SERVICE DELIVERY SYSTEM
Business Rule Descriptions & Codes

ERROR CODE	BUSINESS RULES	LINE STATUS
5B	**Reason is Co-payment, Coinsurance, Deductible** The reason code on a DPH service record is one of the following: 1 (Deductible amount) 2 (Coinsurance amount) 3 (Co-payment amount) AND the primary insurance addendum information states one of the following: 1 (Fully insured) 9 (Unknown) AND the record does not match to DPH's 5B Overrides List (list of clients, primary insurance, and reason codes previously approved by the EI Fiscal Manager) AND the record does not match to DPH's Insurance file (list of clients and primary insurance) What you should do: Submit support documentation to the EI Fiscal Manager for justification of DPH payment. *Note* Support documentation should be sent only once for a 5B records having the same child, primary insurance & reason code. Approved overriding support documentation will automatically result in payment of all past and future 5B services. *Approval/Denial* DPH re-remits all pended services unless payment has been approved. An approved service record will have a PV reference number. If approval has been denied then the denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file.	PENDED
5J	**Incorrect use of Service Correction Reason Code** The charge to DPH is greater than $0.00 and the reason for DPH payment is one of the following: 63 (correction) 123 (payer refund) 125 (payment adjustment) What you should do: Re-submit the service record with the correct reason for DPH payment.	REJECT

EARLY INTERVENTION SERVICE DELIVERY SYSTEM
Business Rule Descriptions & Codes

ERROR CODE	BUSINESS RULES	LINE STATUS
5K	**Reason code and/or primary insurance in need of support documentation** Reason code on service record is one of the following: 28 (Coverage not in effect at time service provided) 50 (Deemed not medically necessary by payer) 52 (Rendering provider is not eligible to perform the service billed) 62 (Payment denied for absence of authorization) 96 (Non-covered charge) 109 (Claim is not covered by this payer) 119 (Benefit maximum has been reached) 177 (Recipient is ineligible on this date of service) B14 (Payment denied because only one visit per day is covered) D08 (Autism service – authorization was denied) D09 (Autism service does not meet insurance requirements/No PA initiated) D25 (Autism service is not a covered benefit) AND the record does not match to DPH's 5K Overrides List (list of clients, primary insurance, and reason codes previously approved by the EI Fiscal Manager) AND the record does not match to DPH's Insurance file (list of clients and primary insurance) *Exceptions* • DPH will pay where the child's primary insurance is one of the following: o Children's Medical Security Plan (CMSP) o Champus/Tricare o Federal plan o MassHealth: Basic o MassHealth: CarePlus o MassHealth: CommCare o MassHealth: Essential o MassHealth: HSN o MassHealth: HSN-Partial • DPH will pay when using a reason code of 52 for the following: o MassHealth client where the professional discipline is SA (Speech Language Pathology Assistant) o BC/BS client where the professional discipline is a therapist assistant • DPH will pay for autism SSP services provided by PDC or REACH (non-ABA services) <u>What you should do</u>: Submit support documentation to the EI Fiscal Manager for justification of DPH payment. *Note* Support documentation should be sent only once for a 5B records having the same child, primary insurance & reason code. Approved overriding support documentation will automatically result in payment of all past and future 5B services. *Approval/Denial* DPH re-remits all pended services unless payment has been approved. An approved service record will have a PV reference number. If approval has been denied then the denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file.	PENDED

EARLY INTERVENTION SERVICE DELIVERY SYSTEM
Business Rule Descriptions & Codes

ERROR CODE	BUSINESS RULES	LINE STATUS
5P	**Reason code and/or primary insurance in need of support documentation** Reason code on service record is one of the following: 26 (Expenses incurred prior to coverage) 27 (Expenses incurred after coverage terminated) 32 (Our records indicate dependant is not an eligible dependant) 33 (Insured has no dependent coverage) 39 (Services denied at time authorization was requested) 45 (Charges exceed contracted fee arrangement) 141 (Claim adjustment because claim spans eligible & ineligible periods of coverage) D07 (Authorization in progress for autism service/Pends if service date is more than 14 days from initial service) D99 (Other) AND the record does not match to DPH's Insurance file (list of clients and primary insurance) *Exceptions* • DPH will pay where the child's primary insurance is one of the following: o Children's Medical Security Plan (CMSP) o Champus/Tricare o Federal plan o MassHealth: HSN o MassHealth: HSN-Partial. <u>What you should do</u>: Submit support documentation to the EI Fiscal Manager for justification of DPH payment. *Note* Services with these reason codes are NOT matched to other services that were approved with support documentation. Therefore, every service date for 4C records needs support documentation to be submitted. *Approval/Denial* DPH re-remits all pended services unless payment has been approved. An approved service record will have a PV reference number. If approval has been denied then the denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file.	PENDED

EARLY INTERVENTION SERVICE DELIVERY SYSTEM
Business Rule Descriptions & Codes

ERROR CODE	BUSINESS RULES	LINE STATUS
6A	**Client is not registered into EIIS** The SDR client ID does not match to the EIIS client ID. What you should do: Identify the client in your billing system receiving these services. Contact the EIIS data manager at the EI program. 1. If the client has not been entered into EIIS, the EIIS data manager must enter this client into EIIS. 2. If the client has been entered into the EIIS data system under a different client ID from your billing system then: a. If the EIIS client ID is incorrect, the EIIS data manager must contact Linda Mosesso at DPH at (617) 624-5521 who will assist in updating the client ID in EIIS. b. If the SDR client ID is incorrect, the biller must notify Jean Shimer at DPH at (617) 624-5526 with the correct ID so that all services previously reported to DPH can be updated.	SUSPEND
6B	**EI service: Date of service is prior to EIIS referral date or after EIIS Last Service Date** The service date occurs before the EIIS Referral Date OR the service date occurs after the EIIS Last Billable Service Date. What you should do: 1. Verify that the date of service is correct. If it is correct contact the EIIS data manager. The data manager must correct the Date of Referral or Last Service Date in EIIS. 2. If the service delivery date is incorrect notify Jean Shimer at DPH at (617) 624-5526.	SUSPEND
6C	**Child's EIIS name, birth date and/ gender are missing** The gender, first name, last name or birthdate is missing or the first name is BABY in EIIS. What you should do: Contact the EI program's EIIS Client system manager. The EIIS manager must make sure that all data is complete and correct on the EIIS Referral screen.	SUSPEND

EARLY INTERVENTION SERVICE DELIVERY SYSTEM
Business Rule Descriptions & Codes

ERROR CODE	BUSINESS RULES	LINE STATUS
6E	**Child's third birth date, according to the EIIS date of birth, occurs prior to service date, no waiver** The service date occurs on or after the child's third birth date. What you should do: 1. Contact the EI program's EIIS Client system manager. The EIIS manager must verify that the birth date in the EIIS system is correct. If the birth date on the EIIS Referral screen is incorrect, the EIIS manager must make sure that this information is corrected in EIIS. 2. If the date of service is incorrect the EIIS manager or biller should contact Jean Shimer at (617) 624-5526 to update the service date.	SUSPEND
6F	**Child's third birth date, according to the EIIS date of birth, occurs prior to service date, has a waiver** The waived service date occurs on or after the child's third birth date. What you should do: DPH has denied approval. See the O_STATUS data field in the SDR remit file for the reason.	wPEND
6H	**CHA Assessment Service (Service = E) for a non-EIPP Referral** The EIIS referral source (Who suggested this family contact this EI program?) is either missing or something other than "EI Partnerships (EIPP)" AND The SDR Client ID does not match to a child in your EIPP program database What you should do: 1. If this child for this referral was referred by an EIPP program then do the following: a. Review the EIIS Referral screen to make sure that "Who suggested that this family contact this EI program" states "EI Partnerships (EIPP)". b. Contact the EIPP data manager to make sure that this child has been entered into the EIPP database. 2. If this child for this referral was not referred by an EIPP program then reverse out the claim and submit it again under the correct service type.	SUSPEND
6S	**Missing EIIS Autism Specialty Data** EIIS autism specialty data is missing or is incomplete. What you should do: Enter or complete the EIIS autism specialty data form and enter it into the EIIS Client system.	SUSPEND

EARLY INTERVENTION SERVICE DELIVERY SYSTEM
Business Rule Descriptions & Codes

ERROR CODE	BUSINESS RULES	LINE STATUS
7A	**Unit or cost adjustment service record received with no original/initial service record** There are two reasons for a 7A: • The original service transaction was never reported to DPH • The original service transaction was rejected as a duplicate service In both cases this will result in all adjustment records associated with that service to reject as a 7A What you should do: 1. If the original/initial service record was never sent to DPH, submit the original/initial service record and the adjustment records in your next transmittal. 2. If the original/initial service record was rejected as a 3a or 3T, resubmit the original/initial service record with the appropriate waiver authorization # along with the adjustment or transfer record.	REJECT
8A	**EIPP Service: EIPP Client is not registered** What you should do: Identify the client in your billing system receiving these services. Contact the EIPP data manager at the EIPP program. 3. If the client has not been entered into the EIPP database, the EIPP data manager must enter this client. 4. If the client has been entered into the EIPP database under a different client ID from your billing system then: a. If the EIPP client ID is incorrect then update the database with the correct ID. b. If the SDR client ID is incorrect, the biller must notify Jean Shimer at DPH at (617) 624-5526 with the correct ID so that all services previously reported to DPH can be updated.	SUSPEND
8B	**EIPP Service: EIPP Date of service is prior to the Intake Date or after the Discharge Date** What you should do: Verify that the date of service is correct. 1. If it is correct, contact the EIPP data manager. The data manager must correct the Intake or Discharge date in the EIPP data system. 2. If the service delivery date is incorrect notify Jean Shimer at DPH at (617) 624-5526.	SUSPEND
8C	**EIPP Service: Original/initial EIPP service can only be billed once per client enrollment** What you should do: Review service for appropriate corrections. Re-submit as a regular home visit.	REJECT

EARLY INTERVENTION SERVICE DELIVERY SYSTEM
Business Rule Descriptions & Codes

ERROR CODE	BUSINESS RULES	LINE STATUS
8F	**EIPP Service: EIPP home visits are not allowed after child turns 7 months of age** What you should do: Review the child's EIIS birth date and service dates for appropriate corrections.	REJECT
8J	**EIPP: Group service exceeds 10 sessions per calendar year** What you should do: Review the EIPP group services for appropriate corrections.	REJECT
8K	**EIPP Service: Service Delivery Date does not match to Home Visit Date** What you should do: Review the EIPP database to make sure that the home visit table includes this service record. If the record does not exist then enter this visit's data into the EIPP database. If the record does exist but the service date is incorrect in the EIPP database then update the EIPP home visit date. If the service date in your billing system is incorrect then (a) notify your biller to update the service with the correct service date AND (b) contact Jean Shimer to update the DPH database with the correct service date .	SUSPEND
9A	**Excessive child group service hours, no waiver** Child group service hours for a client exceed the maximum of 2-1/2 hours per week or two times per week. What you should do: If the service had a waiver from DPH then re-submit the adjustment or transfer records with the waiver authorization number.	REJECT
9C	**EI Intake Visit exceeds 2 hours per child enrollment (service = I)** An EI Intake visit for a client exceeds the maximum of 2 hours per session or 2 sessions per child enrollment or occurs prior to all other services or the second EI Intake visit occurs beyond 2 weeks of the initial EI Intake visit What you should do: If appropriate, submit with the appropriate hours.	REJECT
9E	**Excessive parent group service hours, no waiver** Parent group service hours for a client exceed the maximum of 1-1/2 hours per week or once per week. What you should do: If appropriate, re-submit with the appropriate hours	REJECT

EARLY INTERVENTION SERVICE DELIVERY SYSTEM
Business Rule Descriptions & Codes

ERROR CODE	BUSINESS RULES	LINE STATUS
9N	**Excessive child group service hours, with waiver** Waived child group service exceeds the maximum of 2-1/2 hours or occurs more than twice within a week What you should do: DPH has denied approval. See the O_STATUS data field in the SDR remit file for the reason.	wPEND
9P	**Excessive parent group service hours, with waiver** Waived parent group service exceeds the maximum of 1-1/2 hours or occurs more than once per week What you should do: DPH has denied approval. See the O_STATUS data field in the SDR remit file for the reason.	wPEND
9R	**Waived service** Reason code is D01 (clinical waiver) What you should do: DPH has denied approval. See the O_STATUS data field in the SDR remit file for the reason.	wPEND
9S	**Waived service** Reason code is D02 (services received at a secondary EI program) What you should do: DPH has denied approval. See the O_STATUS data field in the SDR remit file for the reason.	wPEND
9U	**Excessive center-based individual service hours, no waiver** Center-based individual service hours exceed the maximum of 2 hours per session. What you should do: Review service for appropriate corrections.	REJECT
9V	**Excessive center-based individual service hours, with waiver** Waived center-based individual service hours exceed maximum of 2 hours per session. What you should do: DPH has denied approval. See the O_STATUS data field in the SDR remit file for the reason.	wPEND

EARLY INTERVENTION SERVICE DELIVERY SYSTEM
Business Rule Descriptions & Codes

ERROR CODE	BUSINESS RULES	LINE STATUS
9W	**Excessive CHA Screening services** CHA service for child who is over 12 months of age OR The number of CHA assessment services exceeds the maximum of 6 between birth and 12 months What you should do: Review service for appropriate corrections.	REJECT
9X	**Excessive CHA service hours** CHA service exceeds EIPP standard: maximum of 1.5 hours per enrollment What you should do: Review services for duplication issue.	REJECT
9Y	**Excessive home visit hours, no waiver** Home visit hours exceed the maximum of 2 hours per session What you should do: Review service for appropriate corrections.	REJECT
9Z	**Excessive home visit hours, with waiver** Waived home visit hours exceed the maximum of 2 hours per session What you should do: DPH has denied approval. See the O_STATUS data field in the SDR remit file for the reason.	wPEND
S5	**Autism Specialty services exceed maximum of 30 hours per week** Autism SSP service hours (including assessments and treatment planning) exceed the maximum of 30 hours per week. What you should do: Review service for appropriate corrections.	REJECT
S6	**Child meets MassHealth requirements for payment of Autism Specialty services** This is an ABA service for a child whose primary insurance is MassHealth. DPH considers that MassHealth is the appropriate payer. The client's primary insurance and reason code are not included on DPH's S6 Overrides List of clients previously approved for DPH payment by the EI fiscal manager. What you should do: • If MassHealth is the appropriate payer then submit the charges to MassHealth and provide DPH with a credit. • If DPH is the appropriate payer then submit support documentation to the DPH fiscal manager.	DENIED

Claim and Line Status

Each service record is assigned a line status based on the error codes for that line. A service will have one original/initial service record and then can have multiple adjustment or transfer records (unit or cost adjustment records). Therefore, a service with multiple service records could have multiple line statuses. If a service record has a line status of ACCEPT but another transaction within the service has a line status of SUSPEND, PENDED or wvPEND the claim status for all the service lines within the service will state SUSPEND, PENDED or wvPEND.

Records that are rejected are handled differently. If one record within a claim that has multiple records states REJECT, that REJECT line will be removed from the main database. The REJECT record will not affect the status for the remaining claim records.

The following are definitions for the DPH line and claim status:

Status	Description
ACCEPT	The service line has passed all business rules. If the error code is 63 (receipt of service or charge occurs after EI or EIPP deadline) or 64 (exceeds EIPP budget cap amount) you do not need to do anything. DPH will not pay for services past the deadline or over the amount budgeted for the EIPP program.
SUSPEND	The service will be on hold, waiting for data (e.g., EIIS client registration) to be corrected and transmitted by the program. When the next month's service delivery is processed, if the correction has been made the service status will change to "accept" and be processed for payment.
PENDED	For error codes 4C, 5B, 5H, 5K or 5P you must submit appropriate support documentation and forward all questions to the DPH EI Fiscal Manager. DPH will re-remit after approval/denial. An approved service record will have a PV reference number; a denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file for this record.
wvPEND	For error codes 3E, 3F, 6F, 9N, 9P, 9R, 9S, 9V or 9Z you do not need to do anything. DPH will review the waiver for reimbursement for acceptability and will re-remit after approval/denial. An approved service record will have a PV reference number; a denied service record will state UNACCEPTABLE FOR PAYMENT in the O_STATUS data field on the remit file for this record.
DENIED	DPH Payment is denied due to service that meets insurance requirements.
DENIAL	Late DPH charge submission or Charges exceed DPH budgeted amount
REJECT	*No payment of the service will be made. Rejected services may be corrected by the EI program and resubmitted.*
NotProcessed	*No payment of the service will be made. A service record was rejected prior to being processed through the DPH business rules. These service records will have an error code of 20.*

APPENDIX 4

MA DPH Reimbursement Policy Manual for Early Intervention and Autism Services

WAIVER FOR REIMBURSEMENT REQUEST FORM AND INSTRUCTIONS

Contents

Massachusetts Early Intervention
Waiver for Reimbursement

Requestor

Date of Request:

Requestor First Name: Requestor Last Name:

Program: --Please Select--

Client Information

Child's First Name: Child's Last Name:

Birth Date:

Full Registration #:

Program Client ID # Referral #

Current Enrollment Information

EI Eligibility: --Please Select--

List all current services included on the IFSP (including transportation)

	Service Type	Frequency/Duration	Staff
+ -			
+ -			

Information Pertaining to this request

Explanation of extraordinary circumstances:

Type of Request: --Please

Select—

Requested dates of service

Start Date:

End Date:

Amount of additional hours requested Frequency: —Please Select—

☐ Program Director has approved this request

Note to Biller: Hours for services having a prior authorization that meet the EI Operational Standards maximum must be billed to the appropriate payer.

DPH use only

Instructions on Completing the Waiver for Reimbursement Form

Before Opening a Waiver for Reimbursement Form

1. Make a copy of your master PDF file.

   Document name: PrgXX_RequestforReimbursement.pdf

2. Rename the copied file. The file name must include your program number, the child's initials and the date that the request is being sent to DPH:

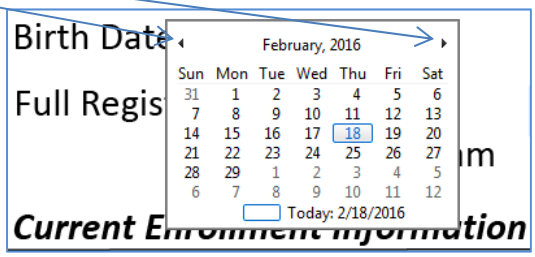
   Prg99_JM_2016_0218.pdf

   IMPORTANT: Do not include personal identifiable information (PII) in the file name; i.e. client name or birth date.

Date Fields

All dates on this form provide you with option to either data enter the date or select a date from the calendar. To select a calendar date do the following:

- Click into the date field.
- Click the down arrow at the end of the field. This will open up the calendar.
- Click the date you want.
- Use the left and right arrows at the top of the calendar to move from month to month.



Completing the Waiver for Reimbursement Form

1. Open the form (double click file name in Windows Explorer).

2. The Date of Request – this date defaults to today's date. Do not update.
   Note: the date will automatically update to today's date once an update is made within the form.

3. Enter your first name and last name as the Requestor First Name and Requestor Last Name.

4. Enter the child's first name and last name
   (Note: if the client is a prenatal participant, please enter "Baby" as the child's first name and the family last name as the child's last name.)

5. Enter the child's birth date - the birth date may not be more than 3-½ years in the past or more than 6 months in the future.
   (Note: If the client is a prenatal participant, enter the estimated due date.)

6. Enter the Client ID # (5-digit number) and Referral # (1-digit number) – this number will be matched to the EIIS data at DPH. If it does not match you will be notified and requested to re-submit an updated form.

7. Choose the EI Eligibility from the drop down list
   a. Not Applicable is to be used when the request is for a non-IFSP child.
   b. If Not Applicable is chosen, proceed to step 9.

8. Enter each service currently on the child's IFSP.
   a. Service type - choose one from the drop down list or manually type in if the service you need is not listed
   b. Frequency and Duration - enter how often the child receives this service and for how long
   c. Staff Name - enter the staff member's name and credentials providing the service to the child or the name of the group the child is attending

   If you need more rows, click the [+] button.
   To remove excess rows, click the [-] button.

9. Enter the exceptional reason for making the request. Please be as descriptive as possible within the 1,000 character limit.

10. Choose the type of request from the drop down list.

11. Enter the start and end date for the timeframe being requested. The start date must be within 90 days of the date of request and the end date must occur on or after the start date.

12. Enter the **additional** amount of hours being requested *(for example, if the request is for a client to receive 2 child groups per week with one group being 2.5 hours and the other group being 1 hour then enter 1 hour. If the request is for a 4 hour home visit then enter 2 hours).*
   a. The amount of hours being requested can be 0.25 to 9.75 in quarter hour increments.
   b. If the amount is a fraction of an hour, the leading zero is required; e.g. 0.75.
   c. The following request types do not require the hours to be entered:
      07 - Extension of Clinical Judgement;
      08 - More than 3 staff;
      09 - Services by a secondary EI program
      14 - EIIS Name Refusal.

13. Choose the frequency from the drop down list.
   a. If you choose "on a single date", the requested end date will be updated to match the requested start date.
   b. The following request types do not require a frequency:
      07 - Extension of Clinical Judgement;
      08 - More than 3 staff;
      09 - Services by a secondary EI program; or
      14 - EIIS Name Refusal.

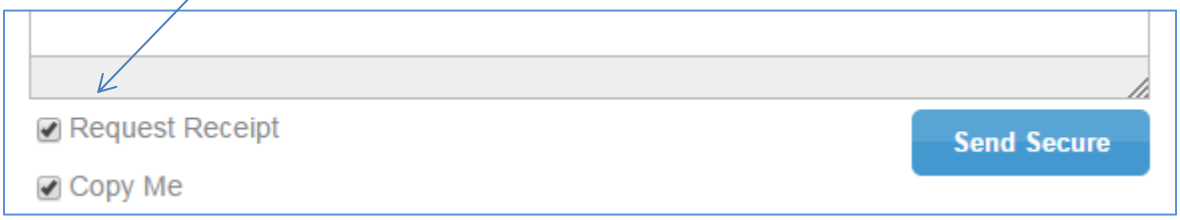
14. Check the box to indicate that the Program Director has approved this request.

15. When you have finished filling in the form, click the validate button.
    a. Any fields that are missing information will be outlined in red.
    b. Review any fields missing information.
    c. Click the validate button again; this can be repeated as often as needed.

Saving and Transmitting the Form

1. Save your form by clicking the Save button.

2. Once the validation is successful and you have saved your form, the Submit button will be activated. Click the Submit button. This will cause your internet browser to open up to the Secure Mail log in page.
    a. Remember to include the form as an attachment.
    b. Check "Request Receipt" located at the bottom of your email. This will provide you with a notification via email that Susan Grossman has received and opened up this email.



    c. Secure Mail the form to Susan Grossman at susan.grossman@eohhs-sfed.state.ma.us.

    Note: Any form transmitted to DPH by means other than Secure Mail will not be reviewed.

3. Once the form is received by DPH, it will be reviewed. A copy of your original form with any updates and a response will be Secure Mailed to the program director and clinician, if appropriate.

Waiver for Reimbursement PRINTABLE Form

A Request for Reimbursement document that can be printed and used for entering request information has been created for the EI agency/program that prefers to enter request information on paper before entering it into the new PDF form. The PRINTABLE form is NOT the official Waiver for Reimbursement form and should not be sent to DPH.

Document name: PrgXX_RequestforReimbursement_PRINTABLE.pdf

Tips and Hints

- Each form is for one request only. You cannot enter multiple request types.
- Click the Reset button at any time to clear the entire form. If the button is clicked accidentally you will not be able to retrieve your work, so remember to save your work frequently.
- Please remember this form contains personal identifiable information (PII) so please treat it with the appropriate level of security as outlined by your program.
- Any questions regarding the clinical details can be sent to Susan Grossman or your assigned Regional Specialist.
- Any technical issues with this form should be communicated to Susan Grossman.

APPENDIX 5

MA DPH Reimbursement Policy Manual for Early Intervention and Autism Services

REMITTANCE INFORMATION

Contents

Remittance Email and Files

DPH sends out a monthly remittance email at the end of PV processing for each EI program. The remittance email includes the following documents:

- ReadMe.PDF (Letter to EI agency/program of new SDR information)
- PVRpt.XLS (Payment voucher copies of all fiscal year PVs)
- ##-YYYYMMDD-HHNN.CSV (File of all accepted, pended or suspended SDR records)
    - ## is your program ID
    - CCYYMMDD translates as CCYY year, MM month, DD date
    - HHNN translates to HH hours, NN minute of day, in 24-hour clock/military time
- ##-YYYYMMDD-HHNN-Rej.CSV (File of all rejected SDR records)
    - ## is your program ID
    - CCYYMMDD translates as CCYY year, MM month, DD date
    - HHNN translates to HH hours, NN minute of day, in 24-hour clock/military time

PV File

The PVRpt.XLS file includes payment voucher summary totals for all active fiscal year for one EI program. Each future remittance email will contain both new and previous payment vouchers generated by DPH. EIPP data, if applicable, has a separate worksheet within this spreadsheet.

The PVRpt.XLS document provides you with a reporting month and year that the specific PV is associated with in accordance to when the SDR records were processed at DPH. DPH Central Accounting requires 12 months of PVs for the active accounts receivable fiscal year.

PV Amounts

DPH generates monthly payment vouchers according to all data received from a program at the time DPH processes payments. Services that have passed DPH business rules have been processed to four payment vouchers according to DPH funding sources used for these services.

The total charges on the fiscal year payment vouchers include the following:

- DPH charges approved through DPH's business rules
- Previously "PENDED" or "DENIED" DPH charges approved by DPH EI's fiscal manager
- Previously "SUSPEND" or "WPEND" services that have cleared the DPH business rules

PV Reference Number

A PV reference number consisting of a three-character vendor code, the date that the payment voucher was generated and the fiscal year is included on the payment voucher copies. The last characters of the PV reference number provide funding source information:

RFY – Insured services for the current FY
DFY – Uninsured services for the current FY
PFY – EIPP services paid for the current FY
SFY – Supplemental services for the previous FY

For example, the payment voucher reference number VEN180811R19 identifies the following:

- "VEN" – the vendor code assigned by DPH
- "180811" – the date services were processed, 8/11/2018
- "R" – insured services (both EI and autism services)
- "19" – the fiscal year of the service

The PV reference number is also found under the data field, PV, for all records in your Remit file that state "NO ERROR". Using the PV reference number, you are able to identify which DPH charges received payment on a specified check. You must sum the "Billing_DPH" (charges to DPH) column for each PV (e.g., VEN180811R18) to get this amount.

PV Reference Number on MassFinance & EFT Statement

Additional characters stating "2019" or "2018" are added to the beginning of the PV reference number on payment vouchers submitted to the comptroller for the purpose of being able to identify the appropriate fiscal year within the MMARS system. The "2019" and "2018" is NOT included as part of the PV reference number on your remittance email files. The "2019" and "2018" will be seen as part of your PV reference number within the Mass Finance web site and on your EFT statement.

PV reference number on your remittance email files: VEN180811R19
PV number under Mass Finance and on your EFT statement: 2019 VEN180811R19

Remittance Files (.CSV files)

Reading the Remittance File

The .CSV file can be uploaded to your practice management or billing system. If you do not have this option you can also import it into Excel. In order to preserve the data type (text, number, date) do the following: (1) Open Microsoft Excel; (2) Go to the *Data* tab; (3) Go to *External Data* and select *From Text*; (4) Browse and double click the file you want to open; (5) The *Text Import Wizard* screen will appear. Click *Delimited*, *Next*, *Comma*, *Next*; (6) Select *Text* or *Date* for the following data fields:

PMLineID – Text	Primary – Text
Recordno - Text	TppCode – Text
RepMonth – Text	Reason – Text
SdrDate – Date	WaiverNo - Text
PrgCode – Text	DateChange – Date
Client – Text	Claim – Text

(7) Select Finish; (8) Under the *Import Data* screen select either *Existing worksheet* or *New worksheet*. (9) Save the file.

Content of the Remittance File

The remittance file (the files with the .CSV extension) consists of the following accepted, pended, waiver for reimbursement pended, suspended or rejected claim records:

- DPH and insurance payer records newly received by DPH since the last remittance sent
- Records that have been previously sent and remain suspended, waiver for reimbursement pended or pended
- Records that have been reprocessed with a resulting change in Error Code, Claim Status or Line Status
- Rejected records based on DPH business rules (included in a separate .CSV file)

The following data fields, generated by DPH, are included on the file:

- PV: the payment voucher reference number
- FY: state fiscal year the service was rendered
- Errorcodes: one or more codes identifying a DPH business rule failure (see below: Business Rule Error Code Descriptions)
- Line_Status: status of specific line or record within a claim (see below)
- Claim_Status: status of the claim (see below)
- Billing_DPH: charge billed to DPH
- DateChange: the last time a record's error code, claim or line status was updated.
- Claim: combination of program code+client+referral #+date (YYYYMMDD)+record number
- O_Status: A text field providing additional information about a claim record (e.g., reason for approval denial).

Remittance – Other Information

Records that are Remitted Only Once

The following records are remitted to EI programs only once:

- Record with a PV reference number
- Rejected records (included in a separate .CSV file)

Full Fiscal Year Remittance

A program in need of a remit file to include all of a fiscal year's remittance records can be requested from DPH at any time.

DPH Reconciliation Records

Reconciliation of claim records involves the process where a charge is "taken back" or "reversed" by DPH. Reconciliation of previously paid claims may occur for one of the following reasons:

- Business rules are newly automated, so that previously submitted and paid claim records are found to be in error
- A claim has either been under or overpaid by DPH (this can occur at any time)
- A claim was submitted incorrectly. If a vendor has identified service delivery data that was incorrectly submitted these data records may be reconciled.

Re-Submission of SDR Records

General Guidelines follow:

1) DO NOT resubmit a claim record that has been accepted, waiver for reimbursement pended, pended or suspended.
2) Re-submissions can be done for any REJECT record included in the Reject Remit file if an Early Intervention program makes the appropriate corrections within their practice management or billing system.

APPENDIX 6

MA DPH Reimbursement Policy Manual for Early Intervention and Autism Services

DATA FIELD FILE SPECIFICATIONS, DEFINITIONS & FORMAT REQUIRMENTS

Contents

EARLY INTERVENTION SERVICE DELIVERY REPORT

General Information

Reportable Services

Service Delivery files (SDR) transmitted to DPH via the EI TVP web site include the following:

- Services billed to and paid by MassHealth or a commercial insurer
- Services directly billed to DPH
- Transfer charges billed to DPH due to a denied by MassHealth or a commercial insurer
- Credits or corrections *(reverse out of charges or services)*
- Services should NOT be bundled, regardless of how they were submitted to another payer.

Services Not Reportable to DPH

Partial transfers to secondary payers *(e.g., BC/BS denies partial charges due to a deductible. The charge is transferred to MassHealth and they deny the charge due to ineligibility. The partial charge is then transferred to DPH. The SDR files are unable to report the partial transfer between BC/BS and MassHealth. The SDR would report the BC/BS charge as the initial SDR record and then report the partial charge to DPH.)*

Deadlines

- Monthly SDR files must be submitted by the 10th of each month. If the 10th falls on a weekend or holiday then the deadline is extended through the first business day following the weekend or holiday.
- Service and payer transfer records can be reported to DPH through March of the following year following the fiscal year closing. Credits to DPH can be submitted through July of the same year.
- Support documentation must be submitted to the EI Fiscal Manager by May of the following year following the fiscal year closing.

Service Delivery Updates

- There may be updates required for SDR files from time to time based on state requirements or needs such as:
  - Rate changes
  - New services
- Although this does not affect the file specification requirements it does affect the content of the record and ability of the file to be validated through the DPH EI TVP website
- Prior to any updates DPH will contact each practice management or billing system developer to ensure that the updates can be handled and implemented in a timely manner
- DPH may need to require one or more test files an EI agency/program prior to final implementation of any significant change to SDR

File Transmission Specifications

Definition	Data Field Name	Data Type	Length	SDFORM	Decimal: dBase Files Only	Columns: Text Files Only	Format	Default	Data Required for:
Unique ID within a service	PMLINEID	Char	8	B,C,D,E	-	1 – 8			All records
Unique service #	RECORDNO	Char	7	B,C,D,E	-	9 –15			All records
SDR transaction	SDFORM	Char	1	B,C,D,E	-	16			All records
Reporting month	REPMONTH	Char	2	B,C,D,E	-	17-18			All records
Reporting year	REPYEAR	Char	4	B,C,D,E	-	19-22			All records
Service date: month	SDRMONTH	Char	2	B,C,D,E	NA	23-24			All records
Service date: day	SDRDAY	Char	2	B,C,D,E	NA	25-26			All records
Service date: year	SDRYEAR	Char	4	B,C,D,E	NA	27-30			All records
Service date	SDRDATE	Date	8	B,C,D,E	-	NA			All records
Program code	PRGCODE	Char	2	B,C,D,E	-	31-32			All records
Client ID	CLIENT	Char	7	B,C,D,E	-	33-39			All records
Client IS referral #	REFERRAL	Char	1	B,C,D,E	-	40			All records
N/A	MEDNUM	Char	10	B,C,D,E	-	41-50		NULL	N/A
Service hours	HOURS	Num	6	B,C,D	2	51-56	+/- 99.99	0.00	SDFORM is B,C,D
Professional discipline	PROFDISC	Char	2	B,C,D	-	57-58			SDFORM is B,C,D
Co-treatment code	COTRTMT	Char	1	B,C	-	59			SDFORM is BC for HV & Ctr
Primary insurer addendum info	TPPELIG	Char	1	B,C,D,E	-	60		NULL	When PRIMARY is commercial
Payer addendum info	TPPAUTH	Char	1	B,C,D,E	-	61			When TPPCODE is commercial
Service type	SERVICE	Char	1	B,C,D,E	-	62			All records
Payer type code	PAYMENT	Char	1	B,C,D	-	63			SDFORM is B,C,D
CMS/CPT code	DMACODE	Char	5	B,C,D,E	-	64-68			All records
Primary insurer code	PRIMARY	Char	2	B,C,D,E	-	69-70			All records
Insurer member ID	PRIMARY8	Char	20	B,C,D,E		71-90		NULL	When PRIMARY = 88
Payer code	TPPCODE	Char	2	B,C,D,E	-	91-92			All records
Payer code Other text	TPPCODE8	Char	20	B,C,D,E	-	93-112		NULL	When TPPCODE = 88
Reason for DPH charge	REASON	Char	3	B,C,D,E	-	113-115			when DPH is the payer
Service setting	WAIVER	Char	3	B,C,D,E	-	116-118			All records
Waiver authorization #	WAIVERNO	Char	7	B,C,D,E	-	119-125		NULL	Waived service/2ndary EIP sv
Service charge	CHARGE	Num	8	B,C,D	2	126-133	+/-9999.99	0.00	SDFORM is B,C,D
Service distinction code	DENNUM	Char	1	B,C,D,E	-	134		NULL	SERVIDE is A,I,M,N/BCBS 0359T
SSP code	INSAMT	Num	8	B,C,D,E		135-142		0.00	Autism services

File Transmission Specifications

Definition	Data Field Name	Data Type	Length	SDFORM	Decimal: dBase Files Only	Columns: Text Files Only	Format	Default	Data Required for:
N/A	PARTINS	Num	8	B,C,D,E	2	143-150	+/-9999.99	0.00	N/A
Partial charge to DPH	**PARTDPH**	Num	8	E	2	151-158	+/-9999.99	0.00	SDFORM is E
Secondary insurer	**SETTING**	Char	4	B,C,D,E	-	159-162	+/-9999.99	NULL	MH is 2ndary, primary is comm

Service Delivery Data Field Definitions & Format Requirements

Data Field	*Format Requirements*
PMLINEID: Practice Management Line ID A unique number for each record generated by the EI agency/program's billing system: • Uniquely identifies each record for an EI program within a given fiscal year • **Provides a sequencing of activity for services with transfer records** • The PMLINEID can be used by the EI agency/program to link DPH remittance information such as the PV number, reason pended/denied to a specific service or event within their billing system	*Requirements:* • Must be all numbers (alpha characters are not allowed) • Must indicate the sequencing of payer activity within a service
RECORDNO: Record Number A unique number generated by the EI agency/program's billing system for each service reported to DPH. A record number is unique per client for the duration of their stay in Early Intervention.	*Requirements:* • Must be all numbers (alpha characters are not allowed) with a length of 7 (preceding zeros if needed) • Must be the same on all record types *(data field name: SDFORM)*

Data Field	*Format Requirements*
SDFORM: Record Type Record type being reported *Values:* ORIGINAL/INITIAL Record Types: B = record with a service date (SDRDATE) same as the reporting month (REPMONTH) C = record with a service date (SDRDATE) previous to the reporting month (REPMONTH) TRANSFER Record Types: D = unit transfers E = partial payment transfers	*Requirements:* • A service MUST have one, and only one, original/initial record *(Note: A service cannot have both a "B" and "C" record)*; otherwise they will get rejected as a duplicate service • Unit transfer record (SDFORM = D): o Most unit transfers consist of two records: ▪ denial of all hours and charges by one payer ▪ payment request of all hours and charges by another payer o All insurance denials, regardless of payer transfer, must be reported to DPH. For example, if a program bills MassHealth after being denied payment by BC/BS, report both the MassHealth denial along with the charge that went to BC/BS. o If the EI agency/program needs to reverse out an original/initial service for any reason then one unit adjustment credit (negative hours & charge) is submitted. The service is then ignored at DPH. • Partial payment transfer record (SDFORM = E): o Oftentimes an insurance will pay for some but not all of the charges for a service. Partial payments charged to DPH due to this type of denial is submitted as a partial pay transfer record. o IMPORTANT: Partial charges to secondary payers are NOT reported to DPH. The partial payment transfer record is ONLY for partial DPH charges. This is the only transaction type or activity that is not reportable to DPH. For example, if a child has a MassHealth secondary insurer the denied partial charge from the primary insurer to MassHealth is not reported to DPH. o If the EI agency/program needs to reverse out the partial charge for any reason then one partial pay credit (having a negative PARTDPH) is submitted to DPH • Unit and partial pay transfer records cannot be transmitted until the original/initial record has been transmitted either previously or within the same reporting month's SDR file
REPMONTH: Month of Report The calendar month that corresponds to the DPH payment voucher reporting period.	*Note: The EI agency/program payment vouchers/invoices are processed monthly and correspond to the 12 monthly calendar reporting periods for a given fiscal year identified on the SDR file. Supplemental invoices do not need to adhere to this.*
REPYEAR: Year of Report The calendar year that corresponds to the DPH payment voucher reporting period.	*Note: The EI agency/program payment vouchers/invoices are processed monthly and correspond to the 12 monthly calendar reporting periods for a given fiscal year identified on the SDR file. Supplemental invoices do not need to adhere to this.*
SDRDATE: Date Service was Provided The date the service occurred.	*Requirements:* • Text file submissions submit the month, day and year as separate fields

Data Field	*Format Requirements*
PRGCODE: Program Code DPH assigned two-character field that identifies the program that rendered the service and submitted the SDR file. *Values:* See Program Code sheet.	

CLIENT: DPH Client ID
A seven-character data field assigned to the child by the DPH EIIS application. The first two characters are always the same as the Program Code *(data field name: PRGCODE)* with an exception *(see Secondary Services under Requirements).*
	Requirements:
	• Must match the first seven-characters of the Client ID in the EIIS Client system:
	  • First two characters are the program code
	  • Last five characters uniquely identify a child within a program *(assigned by EIIS)*
	
	Secondary Services:
	• A child is enrolled in an EI program *(primary EI programs)* receives services from another EI program *(secondary EI program)* then these services are considered secondary services. The child does NOT get entered into EIIS at the secondary EI program.
	• All services provided for this child from the secondary program must be reported to DPH using the primary EI program's client ID. Therefore, the first two characters of the client ID will refer to the primary EI program.
	• All secondary services must include a Waiver for Reimbursement authorization number (data field name: WAIVERNO) which is an approval from DPH for the child for secondary services.
	• All payments for secondary services are billed to the child's insurer

REFERRAL: Referral Number The referral number indicates whether this is a first time or subsequent referral of a child to a specific EI program. This number is automatically assigned when the EIIS *Add a Client* screen is completed and is referenced on all EIIS client forms. It is the eighth character of the DPH ID number in the EIIS client system.	*Requirements:* • The DPH Client ID and Referral numbers must correspond to the same Client ID and Referral numbers for this child registered in the EIIS Client system • If the child has had multiple referrals to the EI program then the referral number in the SDR file must match to the appropriate referral number in the EIIS system • Services under the SDR referral number must occur within the appropriate enrollment timeframe (between the EIIS Date of Referral and EIIS Last Service Date) when matched to the client and referral number entered into the EIIS system
MEDNUM This data field is no longer used by DPH	

Data Field	*Format Requirements*
HOURS: Number of Hours Service was Provided	*Requirements:* • Must be greater than 00.00 for all original/initial records (SDFORM = B or C) • Must be less than or greater than 00.00 for all unit transfer records (SDFORM = D) • Must be 00.00 for all partial pay transfer records (SDFORM = E) • Services must be billed for full fifteen-minute segments (e.g., a twenty-minute session would be billed as 0.25 hours)
PROFDISC: Professional Discipline The professional discipline providing the service. *Values:* AA = Developmental specialist *(as stated under (a), (b) or (c) of Section V, Service Providers and Roles, of the MA EI Operational Standards)* AS = Autism specialty provider *(SSP autism employees)* BB = Developmental specialist *(as stated under (d) of Section V, Service Providers and Roles, of the MA EI Operational Standards)* CS = Counselor/Psychologist LC = Lactation consultant *(EIPP service of U only)* MH = Mental Health Specialist *(EIPP services of V, P or T ONLY)* MT = Music Therapist NS = Nurse *(EI and EIPP services)* NU = Nutritionist *(EI services and EIPP service of U)* OA = Occupational Therapy Assistant OT = Occupations therapist PA = Physical Therapy Assistant PT = Physical therapist SA = Speech Language Pathology Assistant SP = Speech/language therapist SS = Specialty Provider *(EI program employees or non-autism specialty employees)* SW = Social worker *(EI and EIPP services)*	*Requirements:* • Must correspond to the code listed on the DPH provisional certification form

Data Field	*Format Requirements*
COTRTMT: Co-Treatment Session Identification flag to identify a co-treatment session *Values:* • 1 (Yes) • 0 (No)	*Requirements:* • Required for all records when service *(data field name: SERVICE)* is a home visit or center-individual service • All other SERVICEs to be *NULL* or 0 (No) for COTRTMT
TPPELIG: Insurer Addendum Information for the Primary Insurer Provides additional information about the commercial primary insurer (data field: PRIMARY) *Values:* 1 = MA Fully insured 2 = MA Self-insured/ASO 3 = Federal *(this code takes precedence over a code of "2")* 4 = HSA (Health Savings Account)/HRA/FSA (Flexible Spending Account) 5 = Union/Local/Trade Association plan *(this code takes precedence over a code of "2")* 6 = Group Insurance Commission (GIC) 7 = Out-of-state *(includes out-of-state self-insured)* 9 = Unknown	*Requirements:* • The "5" *(Union/Local/Trade)* value cannot be used when the insurer is Champus • The "6" *(GIC)* value can only be used when the primary insurer is one of the following: 20 Harvard Pilgrim Health Care *(HPHC)* 21 Tufts Associated Health Plan *(TAHP)* 22 Fallon Community Health Plan *(FCHP)* 24 Neighborhood Health Plan *(NHP)* 27 Health New England 66 Unicare 70 United Behavioral Health *(UBH)* • A *NULL* value is required when the primary insurer *(data field name: PRIMARY)* is MassHealth or the child is uninsured

Data Field	*Format Requirements*
TPPAUTH: Insurer Addendum Information for the Insurance Payer Provides additional information about the commercial payer (data field: TPPCODE) *Values:* 1 = MA Fully insured 2 = MA Self-insured/ASO 3 = Federal *(this code takes precedence over a code of "2")* 4 = HSA (Health Savings Account)/HRA/FSA (Flexible Spending Account) 5 = Union/Local/Trade Association plan *(this code takes precedence over a code of "2")* 6 = Group Insurance Commission (GIC) 7 = Out-of-state *(includes out-of-state self-insured)* 9 = Unknown	*Requirements:* • The "5" (Union/Local/Trade) value cannot be used when the insurer is Champus • The "6" (GIC) value can only be used when the primary insurer is one of the following: 20 Harvard Pilgrim Health Care *(HPHC)* 21 Tufts Associated Health Plan *(TAHP)* 22 Fallon Community Health Plan *(FCHP)* 24 Neighborhood Health Plan *(NHP)* 27 Health New England 66 Unicare 70 United Behavioral Health *(UBH)* • A *NULL* value is required when the insurance payer *(data field name: TPPCODE)* is MassHealth or the child is uninsured • Autism SSP services – if the payer *(data field name: TPPCODE)* is 70 (UBH), 71 (BCH) or 74 (ComPsych) then the TPPAUTH should be the same as the Insurer Addendum Information for the Primary Insurer (data field name: TPPELIG)

Data Field	*Format Requirements*
SERVICE: Service type *Values:* A = Home visit B = Center-based individual D = Parent group E = Comprehensive Health Assessment (CHA) G = Initial assessment: all assessment/evaluation activities completed up to the Initial IFSP signature date are defined as an initial assessment. If a child has been re-referred or transferred from another EI program and the eligibility timeframe has expired *(the child is <u>not</u> under an active IFSP)* then the assessment/evaluation is considered an initial assessment. H = Ongoing assessment: all assessment/evaluation activities for children with active IFSP's are defined as an ongoing assessment. If a child has been re-referred or transferred from another EI program and the eligibility timeframe has not expired than any assessment/evaluation activities are considered ongoing assessment. I = Initial EI service K = Autism specialty direct treatment service with supervision M = Child group: Community N = Child group: EI-only S = Autism specialty service *(submission of all autism services under this code for DPH as of 7/1/2016 and all other payers by 10/1/2016)* T = EIPP group service *(EIPP effective date: 7/1/17)* U = EIPP consult service *(EIPP effective date: 7/1/17)* P = EIPP home visit V = EIPP Initial Home visit	*Requirements:* • Must correspond to the CMS/CPT *(data field name: DMACODE)*, service setting *(data field name: WAIVER)* and service distinction *(data field name: DENNUM)* codes for the record

SERVICE	DMACODE (CMS/CPT code)	DENNUM (Service Distinction Code)	WAIVER (Service Setting)
A	H2015	1,2 or 3	H01 or H02
B	T1015	1 or 2	V01, V02 or V03
D	T1027		P01
E	T1023		S01 or S02
G	T1024		S01 or S02
H	T1024		S01 or S02
I	H2015	1	H01 or H02
J	H2019		K01, K02 or K03
K or S	H2032		K01, K02 or K03
K or S	H2012		K01, K02 or K03
K or S	0368T		K01, K02 or K03
K or S	0369T		K01, K02 or K03
M	96153	2	C02
N	96153	1	C01
S	H0031		K01, K02 or K03
S	H2012		K01, K02 or K03
S	H2019		K01, K02 or K03
S	G9012		K01, K02 or K03
S	0359T		K01, K02 or K03
S	0359T	5	K01, K02 or K03
S	0364T		K01, K02 or K03
S	0365T		K01, K02 or K03
S	0370T		K01, K02 or K03
T	T1027		P01
U	H2015		H01 or H02
P	H2015		H01 or H02
V	H2015		H01 or H02

Data Field	*Format Requirements*
PAYMENT: EI Payment Source *Values:* D = DPH M = MassHealth *(non-MCO)* X = MassHealth MCO *(Managed Care Organization for MassHealth eligible children)* H = HMO I = Commercial insurer	*Requirements:* • Must correspond to the TPPCODE code *(see Insurer code sheet)*

Data Field	*Format Requirements*
DMACODE: CMS or CPT Procedure Code *Values:* *CMS/CPT PROCEDURE CODES FOR EI SERVICES:* 96153 = Child group – EI only *(must use DENNUM = 1)* 96153 = Child group – Community *(must include DENNUM = 2)* H2015 = EI Intake, regular home visit, home visit assessment or IFSP home visit *(including EIPP services of P and V)* T1015 = Center-based individual visit T1027 = Parent-focused group session T1023 = Comprehensive Health Assessment *(CHA)* T1024 = Assessment *CMS/CPT PROCEDURE CODES FOR EI AUTISM SERVICES:* H0031 = ASSESSMENT: Assessment and case planning for home services by a licensed professional[1] *(includes preparation of assessment report).* H0032 = SUPERVISION: Supervision[2] for home services by a licensed professional. H2012 = DIRECT TREATMENT/PARENT TRAINING BY A LICENSED PROFESSIONAL: Direct instruction or parent training[3] for home services by a licensed professional[1]. H2019 = DIRECT TREATMENT BY A PARAPROFESSIONAL: Direct instruction by a paraprofessional working under the supervision of a licensed professional. [1]*Licensed professional: a BCBA or supervisor needs to have a license to be able to bill at the higher rate.* [2]*Supervision: clinical supervision that provides face-to-face instruction during a client session for the purpose of enhancing and supporting best clinical skills that will lead to improved outcomes.* [3]*Parent training: instructions to the parent or caregiver on follow-through activities, strategies, and/or techniques to be provided to the child at home.*	*Requirements:* • The CMS/CPT code for a partial payment record should include the CMS/CPT code for that service • Must correspond to the service *(data field name: SERVICE)*, service setting *(data field name: WAIVER)* and service distinction *(data field name: DENNUM)* codes for the record *Note: DPH does not require the reporting of the "UE" modifier. DPH does require the reporting of the "52" modifier for BC/BS services as "5" under DENNUM data field.* *Values (Continued):* *CMS/CPT PROCEDURE CODES FOR REPORTING BC/BS AS PAYER OF AUTISM SERVICES:* *0359T = ASSESSMENT* *0364T = DIRECT TREATMENT BY A PARAPROFESSIONAL (1st 1/2 hour)* *0365T = DIRECT TREATMENT BY A PARAPROFESSIONAL (subsequent 1/2 hours)* *0368T = SUPERVISION (1st 1/2 hour)* *0369T = SUPERVISION (subsequent 1/2 hours)* *0370T = PARENT TRAINING* *0359T-52 = RE-ASSESSMENT* *G9012 = TREATMENT PLANNING*

Data Field	*Format Requirements*
PRIMARY: Child's Primary Insurer *Values:* See Insurer code sheet.	*Requirements:* • If the child is uninsured, the primary insurer is DPH (00) • If the child is insured and the service is a charge to DPH, the primary insurer field must include the code for the primary insurer; it should not be the DPH code of 00. • If there is only one insurer *(no 2ndary insurer)* and the service is being billed to an insurance: o PRIMARY will be the same as the payer *(data field name: TPPCODE)* code o Primary insurer addendum *(data field name: TPPELIG)* code will be the same as payer addendum *(date field name: TPPAUTH)* code *Note: Unlike the payer (data field name: TPPCODE) code, there is no text field associated with the primary insurer (data field name: PRIMARY) when the primary insurer is "Other". PRIMARY8 was used for this in the past but has now taken on a different definition.*
PRIMARY8: Child's Primary Insurer Member ID	*Requirements*: • Must be completed for all children whose primary insurer is MassHealth or a commercial insurer • For MassHealth children the member ID is the child's RID number • If the child receives MassHealth as a secondary insurer then use the primary insurer member ID • Use a *NULL* value if the child is uninsured
TPPCODE: The Payer of the Service *Values:* See Insurer code sheet.	*Requirements:* • If the service is being billed to DPH this data field should be coded 00 EXCEPT for partial pay records (SDFORM = E). The TPPCODE on all E records should reflect the insurer *(exception: when using an E record to submit a credit to DPH then a code of 00 is allowed).* • TPPCODE must correspond to the payment type *(data field name: PAYMENT)* code *(see Insurer code sheet)* • If there is only one insurer *(no 2ndary insurer)* and the service is being billed to an insurance: o TPPCODE will be the same as the primary insurer *(data field name: PRIMARY)* code o Payer addendum *(data field name: TPPAUTH)* code will be the same as primary insurer addendum *(data field name: TPPELIG)* code
TPPCODE8: Insurance Payer is Other If the insurer code *(data field name: TPPCODE)* is designated as "Other" (Value of "88") the name of the organization or program must be provided in this data field.	*Requirements*: • Must not include the name of an insurer listed on the Insurer code sheet

Data Field	*Format Requirements*

REASON: Reason for Payment Request being Submitted to DPH
 	
Values: See Reason Code sheet.
	Requirements:
	• To be used for all records when DPH is the payer:
	  o *SDFORM = B, C or D and PAYMENT = D*
	  o *SDFORM = E*
	• When DPH is not the payer then the reason code:
	  o May be the same as the DPH reason code
	  o May be *NULL*
	  o May have a value of 00
	• If an 835 HIPAA remittance generated by the insurer is received then use the HIPAA adjustment reason code as the DPH reason code. If there are multiple adjustment reason codes then select the one that is most appropriate for DPH payment.
	• A non-HIPAA adjustment reason code received from an insurer is to be converted to the most appropriate DPH Adjustment Reason code.
	• If no appropriate adjustment reason code exists *(according to the DPH Reason Code sheet)*, submit the record to DPH using a reason code of D99 *(Other).*

Data Field	*Format Requirements*
WAIVER: Service setting The setting where the service is provided. *Values:* **S01** = Assessment provided at a non-community setting **S02** = Assessment provided at the home or a community setting **H01** = Home visit provided at the child's home *(including EIPP services of P and V)* **H02** = Home visit provided outside of the child's home (relative's home, babysitter, day care, playground, etc.)*(including EIPP services of P and V)* **K01** = Autism specialty service provided in the child's home **K02** = Autism specialty service provided in a natural setting outside the child's home **K03** = Autism specialty service provided in a non-community setting **V01** = Center-individual visit provided as part of a segregated child group service **V02** = Center-individual visit provided as part of a community-based child group **V03** = Center-individual visit, no child group service participation **C01** = Segregated child group service **C02** = Community-based child group service **P01** = Parent group service	*Requirements*: • Must correspond to the service *(data field name: SERVICE)*, CMS/CPT *(data field name: DMACODE)* and service distinction *(data field name: DENNUM)* codes for the record
WAIVERNO: Waiver for Reimbursement/ Authorization Number A unique number given to an EI program by DPH staff that identifies a request for reimbursement for a service.	*Requirements*: • Must be included on the original/initial record regardless of payer if a request for reimbursement is in effect for that service. • Do not include on any services other than the approved service • DO NOT include dashes *Autism:* • EI Autism Specialty services are not eligible for these types of requests from DPH

Data Field	*Format Requirements*
CHARGE: Charge to Payer Source The charge for the service based on the service rate.	*Requirements*: • Must be greater than 0.00 for all original/initial records (SDFORM = B or C) • Must be less than or greater than 0.00 for all unit transfer records (SDFORM = D) • Must be 0.00 for all partial pay transfer records (SDFORM = E) • The charge must reflect the unit rate in effect at the time the service was delivered. *Autism Requirements:* • Autism specialty service rate may vary when a commercial insurer is paying the service
DENNUM: Service Distinction Code Service distinction code *Values:* Child Group service: 1 = Service distinction code for EI-only child group 2 = Service distinction code for Community child group Home visit service: 1 = Regular home visit 2 = IFSP home visit 3 = Assessment meeting BC/BS autism re-assessment service (CPT code: 0359T-52) 5 = Use this code when: o Service (data field name: SERVICE) code of "S" is an autism re-assessment AND o Insurance code (data field name: TPPCODE) of "36" or "60" (BC/BS) AND o CPT code (data field name: DMACODE) of "0359T"	*Requirements*: • Child group service is required to have a service distinction code o Community Group – use service distinction code of 2 o EI Only Child Group – use service distinction code of 1 • Home visit is required to have a service distinction code of 1 (can be NULL, 1 is preferred) • IFSP home visit is required to have a service distinction code of 2 • Assessment home visit is required to have a service distinction code of 3 • Must correspond to the service *(data field name: SERVICE)*, CMS/CPT *(data field name: DMACODE)* and service setting *(data field name: WAIVER)* codes for the record *Autism Requirements:* • When BC/BS is the payer and the service is an autism re-assessment (CPT code of 0359T) the service distinction code of 5 is required

Data Field	*Format Requirements*
INSAMT: Autism Specialty Provider Code Specialty Provider for autism services *Values:* 201 = Amego 202 = Applied Behavioral language Services 102 = Beacon Services 203 = Behavioral Concepts 209 = Boston Behavioral Learning Center (BBLC) 103 = Building Blocks (NE Arc)Beacon Services 105 = Children Making Strides 106 = HMEA 205 = Make a Difference in Children 101 = May Center 109 = New England Center for Children 112 = Pediatric Development Center 206 = RCS Behavioral & Educational Consulting 110 = REACH (ServiceNet) 207 = Reach Educational Services	*Requirements*: • All autism services must have an SSP code • All non-autism services must have 0.00
PARTINS: Not Applicable This data field is no longer used by DPH	
PARTDPH: Cost Adjustment DPH Amount The partial pay charge to DPH when an insurance payer denies part of the charges.	*Requirements*: • Must be 0.00 for all original/initial and unit transfer records (SDFORM = B, C or D) • Must be less than or greater than 0.00 for all partial pay transfer records (SDFORM = E)

Data Field	*Format Requirements*
SETTING: MassHealth Secondary Insurer the MassHealth or MassHealth MCO secondary insurer for a commercial insurer. *Values:* 47 = MassHealth: Basic 38 = MassHealth: Children's Medical Security Plan (CMSP) 51 = MassHealth: CommCare 43 = MassHealth: CommonHealth 50 = MassHealth: Essential 44 = MassHealth: Family Assist 48 = MassHealth: HSN (Health Safety Net) 49 = MassHealth: HSN – Partial 2 = MassHealth: Standard 35 = MassHealth MCO: BMC Healthnet Plan (Boston Medical Center) 6 = MassHealth MCO: Fallon 67 = MassHealth MCO: Health New England 8 = MassHealth MCO: Neighborhood Health 34 = MassHealth MCO: Tufts Health Plan Public	*Requirements:* • Leave NULL when a child has a commercial secondary insurer

APPENDIX 7

MA DPH Reimbursement Policy Manual for Early Intervention and Autism Services

SERVICE DELIVERY REPORTING CODE SHEETS

Contents

EI Program Codes

Code (PRGCODE)	EI Program Name
14	Arc of the South Shore EIP
20	Aspire EIP
03	BAMSI EIP
02	Bay Cove EIP
67	Boston Children's Hosp EIP
06	Cape Cod & Islands Early Childhood
40	Center for Human Devmt EIP
50	Child Guidance Ctr EIP
79	Criterion-Boston EIP
73	Criterion-Heritage EIP
57	Criterion-Medford EIP
22	Criterion-Middlesex EIP
95	Criterion-Riverway EIP
48	Criterion-Stoneham EIP
25	Criterion-Valley EIP
43	Criterion-Wachusett EIP
89	Criterion-Worcester EIP
41	Dimock EIP
39	Eliot EIP
92	Eliot EIP/Cambridge-Somerville
33	Enable EIP/Norwood
16	Harbor Area EIP
23	KDC/Attleboro EIP
26	KDC/New Bedford EIP
24	KDC/Plymouth EIP
35	KDC/South Central EIP
18	Lipton EIP
64	May Center for EI
56	Meeting Street EIP
08	Minute Man Arc
05	Northeast Arc EIP-Cape Ann
47	Northeast Arc EIP-North Shore
86	Northern Berkshire EIP
91	PDC/South Berkshire

Code (PRGCODE)	EI Program Name
31	Pediatric Devmt Center
13	People, Inc EIP
58	Pernet EIP
15	Professional Center
54	Project BEAM EIP
32	REACH EIP
85	Riverside EIP/Cambr-Som EIP
29	Riverside EIP/Needham
63	South Bay EIP/Brockton
75	South Bay EIP/Fall River
93	South Bay EIP/Framingham
94	South Bay EIP/Lawrence
76	South Bay EIP/Lowell
88	South Bay EIP/Worcester
37	Step One EIP
38	Taunton Area EIP
01	Thom/Anne Sullivan EIP
44	Thom/Boston Metro EIP
82	Thom/Charles River EIP
27	Thom/Marlborough Area EIP
83	Thom/Mystic Valley EIP
84	Thom/Neponset Valley EIP
17	Thom/Pentucket Area EIP
49	Thom/Springfield EIP
21	Thom/Westfield EIP
87	Thom/Worcester Area EIP

EI Insurance Codes

Code (TPPCODE) (PRIMARY)	Description	Corresponds to Payment Code
0	DPH *(Used under PRIMARY if child is uninsured; Used under TPPCODE if DPH is payer)*	D
35	MassHealth MCO: BMC HealthNet Plan *(Boston Medical Ctr)*	X
6	MassHealth MCO: Fallon	X
67	MassHealth MCO: Health New England	X
8	MassHealth MCO: Neighborhood Health	X
34	MassHealth MCO: Tufts Health Plan Public	X
72	MassHealth: CarePlus	M
38	MassHealth: Children's Medical Security Plan	M
43	MassHealth: CommonHealth	M
44	MassHealth: Family Assist	M
48	MassHealth: HSN *(Health Safety Net)*	M
49	MassHealth: HSN-Partial	M
2	MassHealth: Standard	M
28	Aetna/US Health Care	I or H
60	Blue Cross/Blue Shield National Account/Blue Card	I or H
36	Blue Cross/Blue Shield	I or H
68	Celticare Health Plan	I or H
40	Champus/TriCARE	I or H
25	CIGNA	I or H
74	ComPsych[1]	I or H
61	Connecticare	I or H
22	Fallon Community Health Plan *(FCHP)*	I or H
62	First Network/Coventry	I or H
18	GIC plan *(state) (All)*	I or H
41	Great West Health	I or H
42	Guardian Insurance	I or H
20	Harvard Pilgrim Health Care *(HPHC)*	I or H
27	Health New England	I or H
63	Health Plans, Inc.	I or H
64	Mega Health/Mid West	I or H
73	Magellan[1]	I or H
24	Neighborhood Health Plan *(NHP)*	I or H
65	Oxford	I or H
21	Tufts Associated Health Plan *(TAHP)*	I or H
66	Unicare	I or H
70	United Behavioral Health (UBH)/Optum [1]	I or H
71	Beacon Health Strategies (BHS) [1]	I or H
26	United Health Care/Optima	I or H
88	Other commercial insurance *(complete TPPCODE8 with insurance name)*	I or H

*DPH pays all services

[1] The UBH, BHS, Magellan and ComPsych codes of 70, 71, and 74 are used only for the insurance payer (data field: TPPCODE) for autism services. The insurance addendum code should be the same as the primary insurance addendum code.

DPH EI Reason Codes

The DPH adjustment reason code used on the SDR file must be based on the adjustment reason code received on the remittance from the insurance.
BLUE = Reason codes to be used for autism services only

The following codes can be used for BOTH original and unit and cost adjustment/transfer claim records:

Code (REASON)	Description	Notes
1	Deductible Amount	
2	Coinsurance amount	
3	Co-payment amount	
50	Deemed not medically necessary by payer	
52	The rendering provider is not eligible to perform the service billed	*Use for MassHealth eligible children when directly billing DPH for professional discipline of Speech Language Pathology Assistant (SA)*
96	Non-covered benefit or charge	*DPH payment is made automatically when (1) the insurance is Champus/TriCARE, Children's Medical Security Plan (CMSP) or federal, (2) client is matched to DPH's Insurance file, or (3) client is matched to DPH's override history file.*
109	Claim is not covered by this payer	
119	Benefit maximum has been reached	
141	Claim adjustment because claim spans eligible & ineligible periods of coverage	
D01	Prior authorization for reimbursement *(e.g., excessive hours)*	
D02	Services received at a secondary EI program	
D05	Uninsured	
D06	Family refused access to insurance	
D07	Authorization is in progress-autism service	*To be used for commercially insured children where the autism specialty service was provided prior to the clinical approval consent, including children who have MassHealth as a 2ndary insurance. This reason code is not allowed for the following insurance: Aetna, Cigna and Neighborhood Health Plan (not MassHealth: NHP).*
D08	Authorization was denied-autism service	
D09	Autism service does not meet insurance requirements/No PA initiated	*To be used for MassHealth children who do not meet the MassHealth requirements for ABA services. Also to be used for commercially insured children for (1) services provided by a non-ABA specialty provider, and (2) primary insurance is TriCARE or insurance is federal.*
D11	Autism contract has not yet been established	*To be used for commercially insured children where the contract for autism services has not been established with the insurance. This reason code is not allowed for the following insurance: Aetna, BC/BS of MA, BMC (not MassHealth: BMC), Cigna, Fallon Community Health Plan, Harvard Pilgrim, Health New England, Neighborhood Health Plan (not MassHealth: NHP), Tufts Health Plan (not MassHealth: Tufts Public) or United Behavioral Health/Optum*
D25	Autism service is not a covered benefit	*To be used for commercially-insured children only where an autism benefit is not covered (do not use D09 or 096).*
D99	Other (will pend at DPH to be reviewed by DPH staff)	

The following codes can be used for BOTH original and unit and cost adjustment/transfer claim records:

Code (REASON)	Description	Notes
P10	EIPP service	

The DPH adjustment reason code used on the SDR file must be based on the adjustment reason code received on the remittance from the insurance.
BLUE = Reason codes to be used for autism services only

The following codes can ONLY be submitted on Unit & Cost Adjustment claim records:

Code (REASON)	Description	Notes
26	Expenses incurred prior to coverage	
27	Expenses incurred after coverage terminated	
28	Coverage not in effect at the time the service was provided	
32	Our records indicate dependent is not an eligible dependent as defined	
33	Claim denied. Insured has no dependent coverage	
39	Services denied at the time authorization/ pre-certification was requested	
45	Charges exceed contracted fee arrangement	
62	Payment denied for absence of pre-certification/authorization	
63	Correction to a prior claim	*DPH negative charge only*
123	Payer refund due to over payment	*DPH negative charge only*
125	Payment adjustment due to submission/billing error	*DPH negative charge only*
177	Recipient is ineligible on this date of service	
B14	Payment denied due to insurance maximum has been exceeded	*To be used for (1) Home visit services for a MassHealth child where MassHealth does not pay for more than one 4 visits per day, (2) CHA Assessment service for EIPP-referred child where MassHealth only pays for 1.0 hour (bill DPH for the extra 1/2-hour under this reason code) or (3) Autism services for a MassHealth child where services exceed 6 hours per day.*