NYEIS Provider Invoicing Information and Frequently Asked Questions

Background Information:

Invoices

Invoices are defined as the master document in which claims are contained for submission and payment. Within the invoice, are claims that contain details for each date a service is provided and within that claim are service lines which supply the details about the procedure(s) performed during the service delivered. Invoices are created for all authorized services, such as occupational therapy, special instruction, respite, transportation, and service coordination. Before being able to create an invoice, a provider must have an approved service authorization that has been accepted by them in order to create a claim for the service delivered. The provider of record is the provider that is assigned the service authorization. The rendering provider is the provider that provides the service to the child/family.

Provider Claim

Each Invoice can contain one or many provider claims. The provider claim is where the child, rendering provider, service authorization and date of service are captured. Provider claims are at the visit level and only one visit per provider claim is allowed. All provider claims within an invoice *must* belong to the same provider of record and Municipality. However, provider claims can be for different children, services or rendering providers.

Service Line

Procedure Codes (HCPCS, CPT, etc.) and their corresponding units are captured at the service line level of a claim. Only one visit per claim can be captured at the provider claim level.

The process for creating an invoice is similar for either a provider entering an invoice or a municipal financial user entering an invoice that was submitted by a provider into NYEIS. The one difference is the provider entering an invoice will have the provider of record defaulted to themselves.

Important Information
The unique invoice types such as Respite, Transportation and AT Device are typically provided by vendors and not providers. Some vendors may also be state-approved providers. These providers will also need to be entered into NYEIS as vendors in order to be available to select when creating a vendor invoice. Vendors who are not state-approved providers do not have access to NYEIS; therefore, the municipality must enter their invoices into NYEIS. *See* **Unit 10 Municipal Administration** in the NYEIS User Manual for further information.

Creating Invoices

Question:
Must a claim for each visit be created separately within an invoice?

Response:
Yes, a claim for each visit must be created separately within an invoice.

Question:
If a provider has not accepted a service authorization, can the service authorization be used to create a claim?

Response:
No, only service authorizations that have been accepted by the provider of record are available for claiming.

Question:
Must a separate invoice be created for each municipality that a provider bills?

Response:
Yes, a separate invoice needs to be created for each municipality that the provider intends to bill. The invoice can only include claims for services provided to children associated with the same municipality. It is *important* that the municipality entered for an invoice *match* that of the specific child's municipality.

Question:
Where is the task to accept/reject a service authorization?

Response:
The task is located in the provider of record's service authorization work queue.

Question:
Must a provider only create claims for one type of service on an invoice?

Response:
No, a provider can create claims for more than one type of service on an invoice (e.g., speech, special education, occupational therapy, etc.)

Question:
Can a provider include claims for many children on one invoice?

Response:
Yes, a provider can include claims for many children on one invoice. However, the invoice can only include claims for services provided to children associated with the same municipality.

Important Note:
If a service begins more than thirty days from the date of the IFSP meeting, a task is sent to the provider in NYEIS to record the delay reason documenting why the service began late. The task to the provider to identify a delay reason for the start of services is not generated in NYEIS until the provider claims against the service authorization for the first service delivered to the child/family. It is important that provider claims be submitted in NYEIS chronologically, so that a late start of service is not incorrectly identified by NYEIS. In the event that a provider is not a NYEIS user this task would be rerouted to the EIO/D. The reason entered by the provider for the late start of services is then stored on the service authorization in NYEIS. It is important to accurately and promptly complete this task in NYEIS to document the reason(s) for late start of services, as this data will be considered in future years as part of the municipality's local determination. Please see **Appendix D** in the NYEIS user manual for more information on late services reasons.

Waivers
A Waiver is needed if a claim is submitted and it violates a billing rule for which an upfront waiver has been denied and requires the submission of a justification from the provider. A Claim can violate one or more billing rules for which an upfront waiver has been denied and the **status** of the claim appears as **Pending**. For each claim in pending status, a task is created for the provider in their **Financials Work Queue** to provide a justification for each of the billing violations for which an upfront waiver has been denied on the claim. If the provider does not have a NYEIS user account, the task goes to the municipality's **Fiscal Staff Work Queue** to obtain the justification from the provider.
The provider can view the status of claims, either Submitted, System Approved, Pending or Denied, by viewing the **Claim Homepage.** Providers with appropriate access to a child's **IFSP Homepage** may also click the **Waivers** link off the navigation bar to view the status of any waivers for that IFSP.

Important Information
Waivers *must* be approved/rejected by an EIO/D.

Question:
If co-visits are not authorized will NYEIS allow for two providers to have an overlap in visit times?

Response:
A brief overlap (up to nine minutes) with two providers is not considered a co-visit and NYEIS will not reject billing. It is considered part of the municipality's oversight role to determine the degree of overlap time that is felt to be acceptable without the authorization of a co-visit. If co-visits are not authorized on the SA in NYEIS and an overlap of more than nine minutes occurs, the claim(s) will be denied.

ICD Codes

ICD Codes allow the provider to enter the EI Eligible ICD Code and up to three additional ICD Codes.

- To add data for **Diagnosis (ICD) Code 1** field, select the **Search** icon. **Diagnosis (ICD) Codes** if available may be one or more previously documented ICD Codes in the child's case. If applicable, select the most appropriate code for *the service delivered. Click **Select** link under **Action** column to* identify **ICD Code**. **Create Provider Claim** page displays.
- To add data for the **Diagnosis (ICD) Codes** field 2 and 3, select the **Search** icon. **Diagnosis (ICD) Codes** if available may be one or more previously documented ICD Codes in the child's case. These codes may have established or contributed to eligibility. If applicable, select the most appropriate code for the service delivered. Click **Select** link under **Action** column to identify **ICD Code**. **Create Provider Claim** page displays.
- To add data for the **Diagnosis (ICD) Code 4** field, select the **Search** icon. Type all known information in **Search Criteria** section. **Diagnosis (ICD) Code 4 is** a list of all available ICD Codes. If applicable, select the most appropriate code for the service delivered. Click **Search** button. Records matching display in **Search Results** section. *To search again, click **Reset** button.* Click **Select** link under **Action** column to identify **ICD Code**. **Create Provider Claim** page displays.

Important Information
If the EIP provider determines that there is no appropriate ICD code applicable to the service(s) being delivered in the child's record (e.g., child's health assessment or child's multidisciplinary evaluation, prescriptions, written orders, written recommendations, or referrals), the EIP provider is responsible for securing and providing accurate and appropriate diagnosis codes for Early Intervention services provided to children and families in the EIP, consistent with the scope of practice of his or her professional license, certification, or registration. Users with access rights can add these ICD codes to the child's record in NYEIS via the Health Assessments link found on the child's integrated case homepage.

CPT Codes

It is the provider's responsibility to ensure that the appropriate HCPCS/CPT codes for each procedure they perform during an early intervention service visit are reported on claims for reimbursement. Providers should select the codes that most accurately describe the service(s) provided/technique(s) used with the child and/or family during the session.

The Bureau of Early Intervention (BEI) cannot advise you as to which HCPCS/CPT codes should be used. The codes must be provided by the early intervention professionals delivering the service. The HCPCS/CPT codes reported must be appropriate for the ICD diagnoses associated with the child.

A good resource for identifying applicable HCPCS/CPT codes is the AMA website at: http://commerce.ama-assn.org/store/ which contains information regarding coding, as well as a search feature that you can use to look up both Level I and Level II HCPCS codes. At the webpage provided above, look for the option that reads RVU Search. You will be able to search by code or by keyword.

Currently in New York State, all early intervention services, including services provided by special educators, are included in the State Medicaid Plan. The EIP adheres to Medicaid standards for billing and documentation. Medicaid is enforcing a requirement for Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes to be provided on claims for all services. Providers are responsible for supplying accurate coding information and for providing the code that best describes the procedure performed during the session they are billing. Medicaid and EIP guidance require that the HCPCS/CPT code which is appropriate to describe the activity/technique being performed with the child and/or taught to the family must be submitted as part of the EIP provider's documentation to support billing to third party payors, including Medicaid and commercial insurance.

Please refer to Memorandum 2003-2 Guidance on Claiming Commercial Insurance for Early Intervention Services, specifically question 12, for additional information.

A list of CPT codes is available in a drop-down menu in NYEIS. Should you find that the most appropriate and current code identifying the service provided is not available as a choice in the menu, a feature request can be submitted to have the code added.

Submitting Invoices

A user with appropriate access rights can submit an invoice which will process using the Nightly Batch process overnight. All claims in the invoice will run through the NYEIS invoice business rules to determine for each claim whether it passes the rules and is approved, fails the rules and is denied, or is pending indicating the claim violates a billing rule for which an upfront waiver has been denied and requires the submission of a justification from the provider.

Important Information

As part of the nightly batch process, if any approved claim is determined to be the first service delivered on a service authorization and the date of service is greater than 30 days from the Authorizing IFSP, a task is generated to the providers Service Authorization Work Queue to supply a late reason. See **Appendix D** in the NYEIS User Manual for a listing of late reasons.

If the provider wants to correct a denied claim and submit it to NYEIS, the claim must first be voided and then added to a new invoice with the corrected information and submitted. It is recommended that information on the original claim to be included in the comments section of any claim that is created as a resubmission of a claim that was initially denied (e.g., claim # of the originally denied claim, nature of the error made in the initial submission, etc.)

Editing Invoices

Question:

When can invoice data be edited?

Response:

Invoice data can *only* be edited if the **Status** of the invoice is **Draft**. Draft is defined as an invoice that has not been submitted in the overnight batch process.

Voiding Claims

A claim cannot be voided if the claim has a **Status** of **Draft**. A claim can only be voided if it has been submitted. Please be aware that voiding a claim will void the claim and all service lines attached. If a correction to a claim in draft status is needed, a user can delete the claim from the invoice.