

# **EARLY INTERVENTION SERVICE DESCRIPTIONS, BILLING CODES AND RATES**

## **EARLY INTERVENTION PROVIDER HANDBOOK**



**Illinois Department of Human Services  
Community Health and Prevention  
Bureau of Early Intervention**

**September 1, 2009**

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## Illinois Department of Human Services Early Intervention Service Descriptions, Billing Codes and Rates

### Introduction

Thank you for your interest in becoming an enrolled provider with the Illinois Early Intervention (EI) Services System to serve eligible infants and toddlers under age three and their families. Following are the Principles of Early Intervention, Important Policies and Procedures, service descriptions in alphabetical order showing billing codes, modifiers if required, and rates. In addition, please review the [DEFINITIONS](#) section of important terms used throughout the document. Additional references are in the attachments as outlined below. **Please read this document and all attachments, carefully.** If you do not fully understand this information, please contact the Bureau of Early Intervention at 217/782-1981 for technical assistance.

- Attachment 1: Early Intervention Service Report Guidelines and Format
- Attachment 2: Natural Environments Requirement And Worksheet
- Attachment 3: Developmental Justification Of Need Guidelines And Worksheet
- Attachment 4: Use Of Associate Level Providers
- Attachment 5: Requirements For Professional And Associate Level Early Intervention Credentialing And Enrollment To Bill
- Attachment 6: Procedure To Order Eyeglasses
- Attachment 7: Non-Billable Activities
- Attachment 8: Approved Assessment Instruments
- Attachment 9: Early Intervention Public And Private Insurance Use Determination Guidelines
- Attachment 10: Early Intervention Billing Guidelines
- Attachment 11: Early Intervention Assistive Technology Guidelines

**The Early Intervention program utilizes the [PRINCIPLES OF EARLY INTERVENTION](#) for service delivery.** All approaches to service delivery are based upon the unique needs of each child/family and focus on the **coordination of both developmental and therapeutic activities** to ensure that all members of the team involved in a child's intervention, including the family and/or caregiver, are working together. The following philosophy applies to Early Intervention:

- The family is viewed as the primary interventionist in a child's life and the expert in relation to the needs of the child and family.
- The family and service providers involved in a child's intervention establish a working partnership based on an open exchange of information and expertise.
- Developmental and therapeutic activities are incorporated into a child's everyday life to naturally emphasize the acquisition of functional skills.

### **If You Have Questions.....**

Below are resources you may find useful if you have questions about the Early Intervention Services System.

### **DHS -Bureau of Early Intervention**

The Department of Human Services (DHS), as the lead agency for Early Intervention in Illinois, has established the Bureau of Early Intervention to administer the statewide Early Intervention Services System. Questions concerning the system, or the service descriptions, billing codes and rates should be directed to the DHS Bureau of Early Intervention at **217/782-1981**. You should access the DHS Early Intervention website at [www.dhs.state.il.us/ei](http://www.dhs.state.il.us/ei) for current information and documents that pertain to Early Intervention Policy and Procedures.

### **Provider Connections**

Provider Connections is the credentialing/enrollment office for the Early Intervention Services System. The EI credentialing and Central Billing Office enrollment processes begin at Provider Connections. If you need credentialing/enrollment forms or have questions regarding form completion, call Provider Connections at **800/701-0995** for assistance or access their website at [www.wiu.edu/providerconnections](http://www.wiu.edu/providerconnections). You will also find current information and documents that pertain to Early Intervention Policy and Procedures on the Provider Connections website.

### **Illinois Early Intervention Training**

The Illinois Early Intervention (EI) Training Program provides training and professional development opportunities to individuals and agencies who provide services to Illinois' birth to three early intervention population. Training is provided in both workshop and video formats. The EI Training Program co-sponsors and provides EI credentialing hours for additional training events held by other training entities, develops a quarterly training newsletter and maintains a training website at [www.illinoiseittraining.org](http://www.illinoiseittraining.org) or you may contact the Illinois EI Training Program at **866/509-3867**, ext.250.

### **Illinois Early Intervention Central Billing Office**

The Early Intervention Central Billing Office (CBO) is the claims processing entity for the Early Intervention Services System. The CBO makes payment determination on claims submitted by EI providers based upon authorized services and DHS guidelines. The CBO also submits and reconciles the monthly EI Medicaid claim to the Illinois Department of Healthcare and Family Services, provides data to assist CFC's to complete an initial verification of family insurance benefits, maintains the family fee system, administers the collections process, is a source of data collection for DHS, provides technical assistance to families and providers and administers the EI Insurance Unit, which bills insurance on behalf of providers. The CBO also maintains the EI Provider data base. Upon enrollment with the CBO providers will receive a welcome letter that will provide many answers to questions that may be encountered. For more information about the CBO please visit the CBO website at [www.eicbo.info](http://www.eicbo.info).

### **Illinois Department of Human Services Central Billing Office - Cornerstone Call Center**

The Early Intervention Central Billing Office is supported by the Illinois Primary Health Care Association Cornerstone Call Center. The Call Center operates Monday through Friday from 7:30a.m. to 5:00p.m. Call Center staff, in conjunction with Central Billing Office staff, are trained to answer questions for providers and families regarding the service authorization process, billing inquiries and family fees. Providers receive a welcome letter upon CBO enrollment that will provide many of the answers to questions you might encounter. You can reach the Call Center at **800/634-8540**. For more information you can visit the CBO website at [www.eicbo.info](http://www.eicbo.info).

### **Illinois Early Intervention Clearinghouse**

The Clearinghouse provides library and information services to residents of Illinois interested in early intervention issues. The project provides access to a large lending library of books, videos and articles and is a free resource to access information on health, educational, disability and developmental concerns of infants and young children. Other Illinois libraries are available through interlibrary loan. For more information contact the Clearinghouse toll-free at **877/275-3227** or visit the interactive web site at <http://eic.crc.uiuc.edu/>.

### **Illinois Early Intervention Monitoring Program**

The purpose of the Early Intervention Monitoring Program is to ensure that state and federal regulations regarding the delivery of Illinois Early Intervention services to infants and toddlers birth to three are met. All Early Intervention Monitors have extensive knowledge of Early Intervention policy and procedure. The Monitoring offices are located in Homewood and Springfield and operate Monday through Friday from 8:00 a.m. to 5:00 p.m. Copies of all current forms utilized during the review process and frequently asked questions can be found on the Monitoring website at [www.eitam.org](http://www.eitam.org). For more information contact the Monitoring Program at **800/507-5057**.

## **PRINCIPLES OF EARLY INTERVENTION**

- 1) The primary goal of EI is to support families in promoting their child's optimal development and to facilitate the child's participation in family and community activities.
- 2) The focus of EI is to encourage the active participation of families in the therapeutic process by imbedding intervention strategies into family routines. It is the parents who provide the real early intervention by creatively adapting their child care methods to facilitate the development of their child, while balancing the needs of the rest of their family.
- 3) EI requires a collaborative relationship between families and providers, with equal participation by all those involved in the process. An on-going parent-professional dialogue is needed to develop, implement, monitor, and modify therapeutic activities.
- 4) Intervention must be linked to specific goals that are family-centered, functional, and measurable. Intervention strategies should focus on facilitating social interaction, exploration, and autonomy.
- 5) Intervention shall be integrated into a comprehensive plan that encourages transdisciplinary activities and avoids unnecessary duplication of services. The plan shall be built around family routines, with written home activity programs to encourage family participation in therapeutic activities on a daily basis.
- 6) Intervention should be monitored periodically to assure that the strategies implemented are successful in achieving outcomes.
- 7) Children and their families in the Early Intervention System deserve to have services of highest quality possible. High standards will be set for the training and credentialing of administrative and intervention staff. Training, supervision, and technology will be focused to achieve excellence.

Adopted by the Illinois Interagency Council on Early Intervention (IICEI)  
October 4, 2001

## IMPORTANT EARLY INTERVENTION POLICIES AND PROCEDURES

1. Early Intervention (EI) is Part C of the “Individuals With Disabilities Education Act” and is a developmental program serving children birth to three with developmental delays, disabilities and at-risk conditions. Services are authorized based upon functional outcomes that focus on child development and family training, education and support that address developmental needs rather than medical needs.
2. Part C requires states to provide services in “Natural Environments”. Under Section 303.18 of Part C, Natural Environments is defined as “settings that are natural or normal for the child’s age peers who have no disabilities”.
3. Early Intervention is a fee-for-service system. In a fee-for-service system the service must be provided prior to billing for the service.
4. All services are pre-authorized. **Never provide services without an authorization in hand.** Services provided without a pre-approved authorization are not guaranteed for payment. **The exception to this rule is the Individualized Family Service Plan (IFSP) meeting.** Providers will receive authorization for IFSP meetings based upon attendance. Providers must attend the entire IFSP meeting in order to receive authorization for payment.
5. Providers who attend IFSP meetings, whether in person or via a phone call, should **always** ask the Service Coordinator to give them a copy of the IFSP meeting authorization prior to leaving the meeting, **or** the IFSP meeting authorization number if the Service Coordinator is unable to print the authorization. Service Coordinators are **required** to have their laptop computers with them when facilitating an IFSP meeting. The IFSP meeting authorization number can be generated using the laptop.
6. Providers can attend the IFSP meeting in person or be present via conference call. Providers must accept responsibility for phone charges for IFSP conference calls if done for their convenience. **Providers are required to attend the entire IFSP meeting in order to receive authorization for payment, whether attending the meeting in person or participating via conference call.**
7. Evaluation and assessment services for the purpose of determining initial eligibility, participating in the development of an initial comprehensive IFSP, and adding new types of services to existing IFSPs must be provided by credentialed/enrolled evaluators only, or by an enrolled audiologist. Audiologists are not required to be credentialed.
8. One person cannot provide evaluation, assessment or direct services as two disciplines to the same child/family. This would be considered a conflict of interest.
9. A global evaluation is a general testing of the five developmental domains and is not domain specific. When determining eligibility a domain specific evaluation should always supercede the results of a general global evaluation.
10. All initial and ongoing evaluation and assessments must be submitted to the Child and Family Connections Office (CFC) in the most current DHS Evaluation and Assessment Report Format within 14 calendar days of receipt of the request to perform the evaluation or assessment. Reports not submitted in the most current format will not be accepted by the CFC. (See [ATTACHMENT 1: EARLY INTERVENTION SERVICE REPORT GUIDELINES/FORMAT](#)).
11. Early Intervention does not pay a provider to write reports other than those required by Early Intervention for initial IFSP development, annual IFSP review, the six month review, transition, discharge or others that may be required by the Service Coordinator due to additional evaluation/assessment activity required by the IFSP.

12. Providers who complete initial evaluations to determine eligibility must attend the entire IFSP meeting in order to receive payment for the initial evaluation. If the provider who completed the initial evaluation cannot attend, an equally qualified provider may attend on behalf of the provider who completed the evaluation.
13. Recommendations for goals, outcomes, and strategies for services, with frequency, intensity, duration and location **will be determined at the IFSP meeting** in collaboration with the child's family and are based on the family's identified priorities and concerns and the [PRINCIPLES OF EARLY INTERVENTION](#). **It is inappropriate for providers to approach a child's family to discuss eligibility for EI services and/or recommendations for frequency, intensity or location of services prior to the IFSP meeting.** Providers may discuss the results of evaluations and assessments only with families prior to the meeting.
14. Providers shall strive to determine the approach to service delivery for each child and family based upon the [PRINCIPLES OF EARLY INTERVENTION](#) found within this document.
15. Prior to making any changes to an IFSP such as increasing/decreasing the frequency or intensity of services that were originally identified as a need on the IFSP or changing the location from an offsite location to an onsite location, an IFSP team meeting must be convened to discuss the recommendation and justification for the change. The service coordinator must facilitate the meeting and the parent(s) must be present. Please see [ATTACHMENT 3: DEVELOPMENTAL JUSTIFICATION OF NEED GUIDELINES AND WORKSHEET](#) to request changes to existing authorizations.
16. If IFSP changes are requested within the first three months of an IFSP, the original IFSP team must reconvene and the direct service provider recommending the changes must be present to discuss the recommendation and the justification for the change. The service coordinator must facilitate the meeting and the parent(s) must be present.
17. Provisional EI services require prior approval from DHS.
18. Early Intervention does not support specific approaches to services such as NDT, ABA, Hannon Program, infant massage therapy, etc. EI pays for services as outlined in this document only. If a provider is trained in a specific approach, and it is appropriate to incorporate that approach into direct service sessions, that is allowed. A specific approach should never be written into a child's IFSP. (Please see [PRINCIPLES OF EARLY INTERVENTION](#) found within this document on guidelines for service provision).
19. All providers of EI services must obtain an EI credential and enroll with the Central Billing Office **prior** to provision of services. Exceptions to the credential requirement are deaf mentors, interpreters, audiologists, physicians, optometrists, ophthalmologists, and transportation providers. These disciplines are only required to enroll. Associate level providers must also obtain an EI credential **prior** to provision of services, but do not enroll with the Central Billing Office.
20. Providers who bill and receive payment for services that are provided by a non-credentialed/enrolled provider (if a credential is required) will be required to submit a refund for those services upon identification of this problem.
21. Early Intervention does **not** pay for therapeutic services required due to, or as part of, a medical procedure, a medical intervention or an injury. Acute rehabilitative therapy and therapy required as part of a medical procedure, medical intervention or injury, is not developmentally-based but is medically-based. Once the condition has become chronic or sub-acute, services that address on-going developmental delay can be provided by EI.



22. All providers of EI services are required under their Early Intervention Service Provider Agreement to have access to the Internet. Providers should access the EI website at [www.dhs.state.il.us/ei](http://www.dhs.state.il.us/ei) and/or the other websites identified in the Introduction section of this document regularly for current information that may affect the provision of Early Intervention services or the billing and payment of those services (i.e., current Evaluation/Assessment format, changes to EI policy).
23. Utilization of private insurance benefits is mandatory to the extent allowed by EI Program policy and/or the insurance plan/policy.
24. Providers must verify insurance company coverage of benefits and comply with insurance company requirements, including network enrollment and documentation requests as outlined in DHS policy, unless insurance use has been exempted by DHS or the service is required to be provided at public expense. (See [ATTACHMENT 9: EARLY INTERVENTION PUBLIC AND PRIVATE INSURANCE USE DETERMINATION GUIDELINES](#)).
25. Per federal and state law, services that are provided at public expense that are **not** to be billed to insurance include the following; 1) Evaluations, including Audiological evaluations and Medical Diagnostics; 2) Assessments; and 3) IFSP development. These services should only be billed to the CBO **and never** to the private insurance company of the family.
26. In addition to the services identified in number 25 above, other services **not** billable to insurance include the following: 1) Parent Liaison; 2) Interpreter, Interpreter for the Deaf and Translator; 3) Deaf Mentor; 4) Developmental Therapy; and 5) Transportation. These services should be billed to the CBO.
27. The CBO cannot generate/backdate an insurance waiver that would apply toward dates of service that have been previously provided to the child/family. Accepting waivers post service delivery is contrary to EI policy.
28. Providers should never bill the family directly for any EI service, unless the insurance payment was paid to the family versus the provider and the provider has a copy of the signed "Child and Family Connections Insurance Affidavit, Assignment and Release Form" in hand. This form is signed by the family and the CFC is responsible for making a copy of the signed form available to all providers identified on a child's IFSP. (See [ATTACHMENT 10: EARLY INTERVENTION BILLING GUIDELINES](#)).
29. Providers must accept the payment from the insurance company as **payment in full** unless the payment received is less than the EI rate. If payment from EI is required, the provider must submit a claim for payment to the CBO and attach a copy of the insurance Explanation of Benefits (EOB) to the claim. The claim and EOB must be received by the CBO within 90 days of the original date of the insurance EOB. The provider may not balance bill the family to make up the difference between the combination of the insurance and EI payments and the provider's internal rate. (See [ATTACHMENT 10: EARLY INTERVENTION BILLING GUIDELINES](#)).
30. Providers should bill for attendance at a child's Individualized Education Plan (IEP) meeting held prior to a child's third birthday using IFSP development procedure codes.
31. All providers should review the definition of IFSP Development found in the [DEFINITIONS](#) section of this document. **Do not bill for any type of service using IFSP development procedure codes unless that service is identified in this definition. A refund will be required** for all dates of service for which a provider has billed for services not identified in this definition using IFSP development procedure codes.

32. It is very rare that a provider would use exactly 15 minutes (one unit) of IFSP Development time for each date that a direct service occurs. This type of billing for IFSP Development time is a “red flag” to the EI Bureau staff and monitoring staff who complete file reviews.
33. All providers should review the definition of documentation found in the [DEFINITIONS](#) section of this document. Daily documentation is required to support the billing and payment of all EI services, including IFSP development time. In an audit or a compliance review documentation will be reviewed. **A refund will be required for all dates of service for which a provider cannot produce supporting documentation.** For EI documentation means daily record notes that summarize each date of service. **A weekly or monthly note which is one note to cover multiple dates of service, or a checklist that does not include a summary of services provided, is not considered acceptable documentation.**
34. Documentation must justify time for all services billed to and paid by the CBO, including IFSP development time.
35. In a monitoring review or audit it is the entity who submits claims and receives payments (payee) for each date of service and each procedure code billed to and paid by the CBO who is responsible for providing documentation for review. Failure to provide documentation may result in a refund. Therefore, it would be to the advantage of the payee to require all employee’s and/or contracted employee’s to submit documentation to support billing and payment prior to submitting claims to the CBO for payment. (See definition of documentation found in the [DEFINITIONS](#) section of this document).
36. Time in/time out sheets are not considered documentation, but are viewed as additional support to documentation, especially if the parent or care giver has signed this sheet.
37. All providers are required to maintain documentation for a period of at least six years from a child’s completion of EI services and permit access to those records by the entities identified in the definition of documentation found in the [DEFINITIONS](#) section of this document.
38. **Never ask a parent or care giver to sign blank case notes or time in/time out sheets for future dates of service.** This is not an acceptable practice and could result in a refund and/or the loss of a providers EI credential, CBO enrollment and notification of inappropriate practice to the Illinois Department of Financial and Professional Regulation.
39. Never submit a claim to the CBO for services that were not provided. This is considered an illegal practice and could result in the loss of a providers EI credential, CBO enrollment and notification of inappropriate practice to the Illinois Department of Financial and Professional Regulation
40. Every time the CBO makes payment to a provider, the provider receives a Claim Summary and the parent receives an EOB. The Parent EOB notifies the family of all dates of service billed and paid to each of their providers. Families are asked to review their EOB’s and to call the CBO Call Center if a provider has been paid for a date of service that their child did not receive. EI Bureau staff investigate each of these complaints. If it is determined that the provider billed for a date of service that was not actually provided or that there is no documentation to support the payment of the service, the provider will be required to submit a refund to the CBO.
41. If a provider bills for one hour of therapy, the provider must have actually delivered that therapy. **For EI, rounding up of time for billing purposes is not allowed.**
42. Once a provider accepts an authorization, the provider commits to provision of services based upon a frequency, intensity and duration that has been identified as a need on a child’s IFSP.

43. All providers are required to give a 30 day prior written notice to the child's Service Coordinator and the child's family prior to terminating services for an eligible child (see 89 Illinois Administrative Code, Part 500.115(f)).
44. All providers **must** accept evaluations and assessments that have been completed prior to the initial IFSP meeting or prior to referral when beginning direct services. Early Intervention **will not** pay for the direct service provider to duplicate evaluations and assessments completed prior to referral unless the evaluations/assessments are more than six months old.
45. The purpose of Bilingual interpreters/translators is to interpret services necessary during the rendering of other Early Intervention services in order for the direct service provider to be able to communicate with the child and family and to provide written translation of Early Intervention documents in the child/family's native language. If the interpreter is authorized to interpret service sessions for a provider/family, the interpreter may assist that provider in scheduling service appointments for that family. A provider should **never** ask an interpreter to call a child's family for any purpose other than to schedule or cancel an appointment. The responsibility of the interpreter is to simply interpret the words of the provider to the family and to interpret the family's response back to the provider. It is not the responsibility of the interpreter to discuss the provision of services with the family when not in the presence of the provider.
46. Approved Assistive Technology equipment must be delivered to the child/family as soon as possible after the vendor receives authorization.
47. All providers of Assistive Technology services are required to provide the equipment to the child/family prior to submitting a claim for services to insurance or to the CBO.
48. Make up sessions are allowed if the missed session is rescheduled within seven (7) days of the missed session. All providers should review the definition of Make Up Sessions found in the [DEFINITIONS](#) section of this document.

## **ASSISTIVE TECHNOLOGY**

**(DURABLE MEDICAL EQUIPMENT AND SUPPLIES)**

Service Description: Assistive technology device means any item, piece of equipment or product system, whether a vendor stock item, modified or customized, that is used to increase, maintain or improve the developmental capabilities of children with disabilities. Authorization to obtain assistive technology devices is based upon prior approval. The request for authorization to obtain an assistive technology device must be accompanied by: 1) a physician prescription and certification of medical/developmental necessity under the above conditions; and 2) an assistive technology evaluation by an occupational, physical, or speech therapist or audiologist indicating the child's needs, completed no earlier than six months prior to the request for the assistive technology and must be identified as a need in the family's Service Plan. It is recommended that lending libraries be utilized to meet the short-term needs of infants and toddlers eligible for this program for the purpose of acquiring/using toys and other equipment which may or may not be adapted for the child. Linking the provision of the device to an education benefit is not appropriate. Assistive technology devices are covered only if they relate to the developmental needs of the infants and toddlers served by the program. Early intervention does not cover provision of assistive technology devices to meet the medical, life sustaining, or routine daily needs of a child.

Assistive technology service means a service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device.

Assistive technology services include 1) determining the durable medical equipment and supply needs of a child with a disability; 2) purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by children with disabilities; 3) selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; 4) coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing rehabilitation plans and programs; 5) training or technical assistance for a child with disabilities or, if appropriate, that child's family; and 6) training or technical assistance for professionals (including individuals providing early intervention services) or other individuals who provide services to or are otherwise substantially involved in the major life functions of the child. Assistive technology services rendered by enrolled durable medical equipment and supplies providers are included in the cost of the device. Assistive technology evaluation services rendered by other qualified providers should be billed under the service description for their discipline.

Services must be consistent with the provider's qualifications and licensure.

**NOTE: All providers of assistive technology services are required to provide the equipment to the child/family prior to submitting a claim for services to insurance or to the CBO. Early Intervention is a fee-for-service system. In a fee-for-service system the service must be provided prior to billing for the service.**

**ASSISTIVE TECHNOLOGY - cont.**

Qualified Staff: Early Intervention System enrolled durable medical equipment and supplies providers. (See [ATTACHMENT 5: REQUIREMENTS FOR PROFESSIONAL AND ASSOCIATE LEVEL EARLY INTERVENTION CREDENTIALING AND ENROLLMENT TO BILL](#))

Billable Activities With Authorization: Purchasing, leasing, or otherwise providing the acquisition of assistive technology devices and providing related assistive technology services.

**Do not provide services without having an authorization in hand. Services provided without a pre-approved authorization are not guaranteed for payment.**

Procedure Codes	Unit of Service	Description	Customary Review Parameters	Rate
Bill using HCPCS National Level II codes for assistive technology devices at quantity and rate posted on prior approval.				

**NOTES:** 1) When a provider bills the CBO for the procedure code E1399 a description of the equipment must be included on the claim form; 2) Please see [ATTACHMENT 9: EARLY INTERVENTION PUBLIC AND PRIVATE INSURANCE USE DETERMINATION GUIDELINES](#) for information on the responsibilities of the provider to document insurance benefits verification and billing as required by EI policy; and 3) Please see [ATTACHMENT 11: EARLY INTERVENTION ASSISTIVE TECHNOLOGY GUIDELINES](#).

## AUDIOLOGY, AURAL REHABILITATION AND OTHER RELATED SERVICES

Service Description: Audiology, aural rehabilitation, and other related services include: 1) identification of children with hearing loss using appropriate audiologic screening techniques; 2) determination of the range, nature and degree of hearing loss and communication functions by use of audiological evaluation procedures; 3) referral for medical testing and other services necessary for the habilitation or rehabilitation of children with hearing loss; 4) IFSP development; 5) provision of auditory training, aural rehabilitation, speech reading and listening device orientation/training and other related services; and 6) determination of the child's need for individual amplification including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those assistive technology devices.

Family training, education, and support provided to assist the family of a child eligible for services in understanding the special needs of the child as related to audiology and aural rehabilitation services and enhancing the child's development are integral to this service. Eligible child is not required to be present but may be if appropriate. May include such services as support groups, individual support and other training or education for the family.

Services must be consistent with the provider's qualifications and licensure.

**NOTE:** Early Intervention does **not** pay for therapeutic services required for a child to recover from medical procedures such as surgery, etc., or for pre-surgery therapeutic services required by a physician to prepare a child for surgery.

Qualified Staff: Early Intervention Specialists credentialed and enrolled as 1) Licensed Speech/Language Pathologist, or 2) Developmental Therapist/Hearing or an Audiologist who is enrolled. (See [ATTACHMENT 5: REQUIREMENTS FOR PROFESSIONAL AND ASSOCIATE LEVEL EARLY INTERVENTION CREDENTIALING AND ENROLLMENT TO BILL.](#))

Billable Activities: Audiological evaluation which includes screening to determine possible hearing loss and testing to determine the range, nature and degree of hearing loss and communication functions, hearing aid assessment and aural rehabilitation.

With Authorization: (A/R) and other related services, IFSP development (see [DEFINITIONS](#) section for IFSP development definition) and direct services.

**NOTE:** Credentialed Evaluators and enrolled Audiologists bill for time required to write the assistive technology letter of developmental necessity using IFSP development codes.

**Do not provide services without having an authorization in hand. Services provided without a pre-approved authorization are not guaranteed for payment.**

**AUDIOLOGY, AURAL REHABILITATION AND OTHER RELATED SERVICES - cont.**

**AUDIOLOGY PROCEDURE CODES**

Procedure Codes	Unit of Service	Description	Rate
<b>For use by Licensed Audiologists Only</b>			
V5010	n/a	Hearing aid assessment	\$68.69
V5008	n/a	Hearing Screening	\$57.29
92551	n/a	Screen test, pure tone, air only	\$15.20
92552	n/a	Pure tone audiometry (threshold), air only	\$15.20
92553	n/a	Audiometry, air and bone	\$15.20
92555	n/a	Speech audiometry threshold	\$15.20
92556	n/a	Speech audiometry threshold; (with speech recognition)	\$15.20
92557	n/a	Comprehensive audiometry; (includes 92553 and 92556)	\$37.40
92567	n/a	Tympanometry	\$15.20
92568	n/a	Acoustic reflex testing; threshold	\$13.70
92579	n/a	Visual reinforcement audiometry (VRA)	\$22.15
92582	n/a	Conditioning play audiometry	\$22.15
92583	n/a	Select picture audiometry	\$15.15
92585	n/a	Brainstem evoked response rec. (no anesthesia)	\$53.70
92587	n/a	Evoked otoacoustic emissions: limited (single level, either transient or distortion products) (no anesthesia)	\$52.70
92588	n/a	Evoked otoacoustic emissions, comprehensive or diagnostic evaluation (Comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)	\$61.00

Audiologist should complete testing as follows:

- The audiologist will complete a hearing screening.
- If the child fails the hearing screening, the audiologist may proceed to complete additional testing to determine the range, nature and degree of hearing loss and communication function. This will ensure that all testing can be completed on the same date of service so that families will not have to schedule multiple visits.
- The audiologist will bill the CBO for the hearing screening using the procedure code V5008 (hearing screening). When additional testing is needed to determine the range, nature and degree of hearing loss and communication function, the audiologist will bill for the additional testing using the procedure codes identified above. **If you completed any of the tests identified above when completing the hearing screening (V5008), do not duplicate bill for that same test to determine range, nature and degree of hearing loss and communication function. All testing must be completed on the same date of service and must be billed to the CBO on the same claim.**

**AUDIOLOGY, AURAL REHABILITATION AND OTHER RELATED SERVICES – cont.**

- If, due to unforeseen circumstances, testing cannot be completed on the same date, the audiologist must obtain a new authorization from the child’s service coordinator prior to completing further testing.

**NOTE:** For children who have failed a hearing screening or who have a suspected hearing loss, Child and Family Connections offices will generate one authorization for audiological services. It will simply state “Audiological Evaluation”. All testing completed under this authorization must be completed on the same date of service and must be billed to the CBO on the same claim. Audiologists will choose the most appropriate test(s) for each child based upon the list of billable services identified above.

**NOTE:** Early Intervention does not pay for medical testing that requires anesthesia, sedation or medical monitoring. If these services are required, prior to scheduling such testing please refer the family back to the EI service coordinator who will explain this to the family. The family may be referred to DSCC for assistance with services that require medical testing.

**NOTE:** For children who require a **Hearing Aid Assessment** to determine the possible need for Hearing Aids, service coordinators will generate authorizations using the procedure code V5010. This procedure code will be identified on the authorization to provide a hearing aid assessment. You can only bill this code to the CBO if you have an authorization that identifies this code.

**AURAL REHABILITATION AND OTHER RELATED SERVICES PROCEDURE CODES**

Procedure Codes	Modifier	Unit of Service	Description	Rate
For use by Audiologists, Speech Therapists, and Developmental Therapists/Hearing. (must have authorization to provide Aural Rehabilitation services to bill the codes listed below.)				
92626		15 minutes	A/R assessment - onsite	\$14.53
92626		15 minutes	A/R assessment - offsite	\$18.14
99499	SC	15 minutes	A/R IFSP development	\$14.53
99499	SC	15 minutes	A/R IFSP meeting	\$18.14
92507	TL	15 minutes	A/R services - onsite	\$14.53
92507	TL	15 minutes	A/R services - offsite	\$18.14
92508	TL	15 minutes	Group A/R services (multiple families or group not to exceed 4 children)	\$ 7.88



## DEVELOPMENTAL THERAPY

**Service Description:** Developmental therapy (DT) includes global evaluation and assessment, IFSP development (see definition of IFSP development) and individual or group therapy services. Developmental Therapy may also be called Special Instruction and includes the design of learning environments and activities that promote the child's acquisition of skills in a variety of developmental areas, and provision of information and support related to enhancing the skill development of the child that enables the child to attain maximum functional level. These activities are coordinated with all other services in the plan and provide assistance with acquisition, retention or improvement in skills related to activities of daily living such as feeding and dressing, communicating with care givers, and the social and adaptive skills to enable the child to reside in his/her home or non-institutional community setting.

Family training, education, and support provided to assist the family of a child eligible for services in understanding the special needs of the child as related to developmental therapy services and enhancing the child's development are integral to this service. Eligible child is not required to be present but may be if appropriate. May include such services as support groups, individual support and other training or education for the family.

Aural Rehabilitation services for Early Intervention are defined under the service description entitled "Audiology, Aural Rehabilitation and Other Related Services". To provide and bill Aural Rehabilitation services the provider must be credentialed and enrolled as a Developmental Therapist/Hearing and have an authorization for Aural Rehabilitation services.

Vision services for Early Intervention are defined under the service description entitled "Vision". To provide and bill for Vision Services the provider must be credentialed and enrolled as a Developmental Therapist/Vision and have a authorization for Vision services.

Services must be consistent with the provider's training and qualifications.

**NOTE:** Early Intervention does **not** pay for therapeutic services required for a child to recover from medical procedures such as surgery, etc., or for pre-surgery therapeutic services required by a physician to prepare a child for surgery.

**Qualified Staff:** 1) Enrolled Specialist credentialed as a Developmental Therapist or 2) a non-enrolled Associate credentialed as a Developmental Therapy Assistant. Developmental Therapy Assistants must work under the supervision of an enrolled Developmental Therapist. (See [ATTACHMENT 5: REQUIREMENTS FOR PROFESSIONAL AND ASSOCIATE LEVEL EARLY INTERVENTION CREDENTIALING AND ENROLLMENT TO BILL.](#))

**Billable Activities Authorization** Global evaluation, assessment, IFSP development, (see [DEFINITIONS](#) section for IFSP development definition) and direct service.

**DEVELOPMENTAL THERAPY - cont.**

**Do not provide services without having an authorization in hand. Services provided without a pre-approved authorization are not guaranteed for payment.**

Procedure Codes	Modifier	Unit of Service	Description	Rate
96111		15 minutes	Evaluation/Assessment - onsite	\$11.03
96111		15 minutes	Evaluation/Assessment - offsite	\$13.91
99499	TL	15 minutes	IFSP Development	\$11.03
99499	TL	15 minutes	IFSP Meeting	\$13.91
T1027		15 minutes	Individual DT - onsite	\$11.03
T1027		15 minutes	Individual DT - offsite	\$13.91
T1027	HQ	15 minutes	Group DT (multiple families or group not to exceed 4 children)	\$ 2.76
Billing codes for Vision Services for Early Intervention are found under the service description entitled " <i>Vision</i> "				
Billing codes for Aural Rehabilitation and related services for Early Intervention are found under the service description entitled " <i>Audiology, Aural Rehabilitation and Other Related Services</i> "				

## FAMILY TRAINING AND SUPPORT

Service Description: Family training and support means family training, education and support services provided to assist the family of a child eligible for services in understanding the special needs of the child as related to the providers specific discipline and enhancing the child's development. Eligible child is not required to be present but may be if appropriate. May include such services as support groups, individual support and other training for the family.

### Parent Liaison

The role of the parent liaison as a direct service provider is to draw from his/her knowledge and personal experience to bring sensitivity, emotional support, and a peer perspective to families as they learn about the Early Intervention Program and to develop and coordinate parent-to-parent linkages. Services may be provided on an individual basis or as a leader/co-leader of a parent support group. Services are based upon the individual needs of the child/family as determined by the child's multidisciplinary team and identified on the Service Plan.

### Interpreter and Interpreter for the Deaf

Bilingual interpreter and interpreter for the deaf services necessary during the rendering of other Early Intervention services in order to communicate with the child and family. If the interpreter is authorized to interpret service sessions for a provider/family, the interpreter may assist that provider in scheduling service appointments for that family. Does not include bilingual interpreter services that would otherwise be provided at no charge to the family or bilingual interpreter services by the same person rendering the service. (See [ATTACHMENT 7: NON-BILLABLE ACTIVITIES](#))

### Translator

Written translation of Early Intervention documents into the child/family's native language are billable under this service. Does not include translation of non-EI documents.

### Deaf Mentor

Deaf Mentor Services provided by a language mentor for the deaf who interacts with the child by modeling language in the chosen communication mode, shares information about deaf culture and provides firsthand knowledge of deafness with the family and introduces the family to the local deaf community.

Parent Liaisons, Interpreters and Deaf Mentors do not provide evaluation/assessment services to determine a child's eligibility for services.

Services must be consistent with the provider's qualifications. Family Training and Support does not include services that require a license, such as counseling services that must be provided by a licensed social worker, clinical psychologist, marriage and family therapist, etc. or discussion of non-Early Intervention related activities with the family.

**FAMILY TRAINING AND SUPPORT - cont.**

Qualified Staff: Enrolled individual credentialed as a Parent Liaison, or an enrolled Interpreter, Interpreter for the Deaf, Translator or Deaf Mentor. (See [ATTACHMENT 5: REQUIREMENTS FOR PROFESSIONAL AND ASSOCIATE LEVEL EARLY INTERVENTION CREDENTIALING AND ENROLLMENT TO BILL.](#))

Billable Activities With Authorization: IFSP development (see [DEFINITIONS](#) section for IFSP development definition and family training, education and support that is not billable under other Early Intervention services.)

**Do not provide services without having an authorization in hand. Services provided without a pre-approved authorization are not guaranteed for payment.**

CODES FOR USE BY PARENT LIAISONS AND DEAF MENTORS, ONLY				
Procedure Codes	Modifiers	Unit of Service	Description	Rate
99499	HT	15 minutes	IFSP development	\$10.71
99499	HT	15 minutes	IFSP Meeting	\$13.50
T1027	TL	15 minutes	Family training and support - onsite (one family)	\$10.71
T1027	TL	15 minutes	Family training and support - offsite	\$13.50
T1027	TL, HQ	15 minutes	Group family training and support (multiple families)	\$ 2.68

CODES FOR USE BY INTERPRETERS, ONLY				
Procedure Codes	Modifiers	Unit of Service	Description	Rate
T1013		15 minutes	Family training and support –onsite	\$10.71
T1013		15 minutes	Family training and support - offsite	\$13.50
T1013	HQ	15 minutes	Group family training and support (multiple families or group with one provider and not more than four children)	\$ 2.68

**NOTE:** If there is more than one provider and four children in a group, there must be one Interpreter for each provider.

CODES FOR USE BY INTERPRETERS FOR THE DEAF, ONLY				
Procedure Codes	Modifiers	Unit of Service	Description	Rate
T1013	HT	15 minutes	Family training and support –onsite	\$10.71
T1013	HT	15 minutes	Family training and support - offsite	\$13.50
T1013	HQ & HT	15 minutes	Group family training and support (multiple families or group with one provider and not more than four children)	\$ 2.68

**NOTE:** If there is more than one provider and four children in a group, there must be one Interpreter for each provider.

**FAMILY TRAINING AND SUPPORT - cont.**

<b>CODES FOR USE BY TRANSLATORS ONLY</b>				
<b>Procedure Codes</b>	<b>Modifiers</b>	<b>Unit of Service</b>	<b>Description</b>	<b>Rate</b>
T1013	TL	15 minutes	Family training and support –onsite	\$10.71

## HEALTH CONSULTATION

**Service Description:** Health consultation is consultation by a licensed physician, as defined in the Service Plan, who has provided medical treatment to the child within the past year with members of the child's service team who are identified in the child's Service Plan or the child's family concerning the impact of special health care needs of an eligible child on the provision of services.

Consultation services must be consistent with the provider's qualifications and licensure.

**Qualified Staff:** System enrolled Physician licensed in the state where he or she provides services to Illinois children. (Physicians are not required to obtain a credential but must be enrolled to provide EI services.)

**Billable Activities With Authorization:** Physician consultation regarding impact of the child's medical status on provision of EI services.

**Do not provide services without having an authorization in hand. Services provided without a pre-approved authorization are not guaranteed for payment.**

Procedure Codes	Unit of Service	Description	Rate
99211	N/A	Office or other outpatient visit (Approximately 5 minutes)	\$35.02
99212	N/A	Office or other outpatient visit (Approximately 10 minutes)	\$35.02
99213	N/A	Office or other outpatient visit (Approximately 15 minutes)	\$35.02
99214	N/A	Office or other outpatient visit (Approximately 25 minutes)	\$35.02
99215	N/A	Office or other outpatient visit (Approximately 40 minutes)	\$35.02
99441	N/A	Telephone evaluation/management (5-10 minutes of medical discussion)	\$35.02
99442	N/A	Telephone evaluation/management (11-20 minutes of medical discussion)	\$35.02
99443	N/A	Telephone evaluation/management (21-30 minutes of medical discussion)	\$35.02

**NOTE:** Authorizations for Health Consultation services do not identify a CPT code. The authorization simply states "Health Consultation". Please use the above CPT codes and bill the most appropriate code for each Health Consultation provided.

## MEDICAL SERVICES

(DIAGNOSTIC/EVALUATION PURPOSES ONLY FOR EARLY INTERVENTION)

Service Description: Medical services only for diagnostic and evaluation purposes means services provided by a licensed physician or a multidisciplinary team (if needed) under the direction of a licensed physician to determine a child's developmental status and need for services. Medical diagnostic services may be appropriate when 1) the child's record documents that other evaluations have failed to determine the child's eligibility for services and the child is likely to be determined eligible if additional developmental diagnostic services are provided, or 2) to establish a diagnosis which would potentially meet the eligibility parameters for services. Medical referrals may be required if the need for medical testing is identified. Consultation with other medical providers, if needed, is considered a part of the diagnostic evaluation and should not be billed separately. The evaluation report must conform to the Service Report Guidelines (see [ATTACHMENT 1: EARLY INTERVENTION SERVICE REPORT GUIDELINES/FORMAT](#)) which require in part a statement of the child's eligibility, developmental status, and intervention recommendations for use in development of the Plan.

Services must be consistent with the provider's qualifications and licensure. Team members must be individually enrolled to provide Early Intervention Services under their respective disciplines and have an authorization under their discipline to provide and bill for this service. Team members should use the codes found under their respective disciplines for billing purposes.

The only other medical or health-related services which are covered by EI (other than the above diagnostic/evaluation medical services) are defined under "Nursing" and "Health Consultation". Medical and health services **do not** include the following:

- 1) services that are-
  - (i) Surgical in nature (such as cleft palate surgery, surgery for club foot, or the shunting of hydrocephalus); or
  - (ii) Purely medical in nature (such as hospitalization for management of congenital heart ailments, or the prescribing of medicine or drugs for any purpose).
- 2) Devices necessary to control or treat a medical condition.
- 3) Medical-health services (such as immunizations and regular "well-baby" care) that are routinely recommended for all children.

Qualified Staff: A system enrolled Physician licensed by the state in which he or she provides EI services to Illinois children. (See [ATTACHMENT 5: REQUIREMENTS FOR PROFESSIONAL AND ASSOCIATE LEVEL EARLY INTERVENTION CREDENTIALING AND ENROLLMENT TO BILL.](#))

Billable Activities With Authorization: Evaluation to determine the child's developmental status and need for EI services. Early Intervention will pay for one (1) medical Diagnostic Evaluation prior to the initial service plan or one (1) encounter during the initial Service Plan. Early Intervention will pay for one (1) Medical Diagnostic Evaluation prior to each annual Service Plan after the expiration of the initial Service Plan.

**Do not provide services without having an authorization in hand. Services provided without a pre-approved authorization are not guaranteed for payment.**

Procedure Codes	Unit of Service	Description	Rate
99245	N/A	Medical Diagnostic Evaluation	\$201.46



## NURSING

Service Description: Nursing services for the purposes of:

- 1) Global evaluation to determine a child's developmental status and need for early intervention services (See [DEFINITIONS](#) section for additional information);
- 2) Assessment to determine a child's health status, including the identification of patterns of human response to actual or potential health problems and the identification of the need for medical referrals;
- 3) Provision of nursing care during the time the child is receiving other early intervention services **in a clinic based setting** that may be required to allow the child to participate in EI services such as:
  - administration of medications, treatments, and regimens prescribed by a licensed physician; and
  - clean intermittent catheterization, tracheostomy care, tube feeding, the changing of dressings or colostomy collection bags, and other health services as required to allow the child to participate in EI services.
- 4) Does **not include** hospital or home health nursing care required due to surgical or medical intervention, or an injury, or medical-health services such as immunizations and regular well-baby care that are routinely recommended for all children.

Family training, education and support provided to assist the family of a child eligible for services in understanding the special needs of the child as related to nursing services and enhancing the child's development are integral to this service. Eligible child is not required to be present but may be if appropriate. May include such services as support groups, individual support and other training or education for the family.

**NOTE:** The need for nursing services does not determine eligibility for the Early Intervention program.

Services must be consistent with the provider's qualifications and licensure.

Qualified Staff: System enrolled Specialist credentialed as a Licensed Registered Nurse. (See [ATTACHMENT 5: REQUIREMENTS FOR PROFESSIONAL AND ASSOCIATE LEVEL EARLY INTERVENTION CREDENTIALING AND ENROLLMENT TO BILL.](#))

Billable Activities Authorization: Evaluation / assessment, IFSP development (see [DEFINITIONS](#) section for IFSP development definition) and direct service.

**NURSING - cont.**

**Do not provide services without having an authorization in hand. Services provided without a pre-approved authorization are not guaranteed for payment.**

Procedure Codes	Modifier	Unit of Service	Description	Rate
T1001		15 minutes	Evaluation / Assessment- onsite	\$11.39
T1001		15 minutes	Evaluation / Assessment - offsite	\$14.36
99499	TD	15 minutes	IFSP development	\$11.39
99499	TD	15 minutes	IFSP meeting	\$14.36
T1002		15 minutes	Nursing services - onsite	\$11.39
T1002		15 minutes	Nursing services - offsite	\$14.36
T1002	HQ	15 minutes	Group Nursing services (multiple families or group not to exceed 4 children)	\$ 2.85

See *"Nutrition"* for additional service activities and billing codes.

## NUTRITION

Service Description: Nutrition services for the purposes of:

- 1) Conducting individual assessments in nutritional history and dietary intake, anthropometric, biochemical and clinical variables, feeding skills and feeding problems, and food habits and food preferences;
- 2) Developing and monitoring appropriate plans to address the nutritional needs of eligible children based upon individual assessment; and
- 3) Making referrals to appropriate community resources to achieve individual planned nutrition outcomes.

Family training, education and support provided to assist the family of a child eligible for EI services in understanding the special needs of the child as related to nutritional services and enhancing the child's development are integral to this service. Eligible child is not required to be present but may be if appropriate. May include such services as support groups, individual support and other training or education for the family.

**NOTE:** The need for nutrition services does not determine eligibility for the Early Intervention program.

Services must be consistent with the provider's qualifications and licensure.

Qualified Staff: System enrolled Specialist credentialed as 1) a Licensed Dietitian Nutritionist or 2) Licensed Registered Nurse. (See [ATTACHMENT 5: REQUIREMENTS FOR PROFESSIONAL AND ASSOCIATE LEVEL EARLY INTERVENTION CREDENTIALING AND ENROLLMENT TO BILL.](#))

Billable Activities With Authorization: Assessment, IFSP development (see [DEFINITIONS](#) section for IFSP development definition) and direct service.

**Do not provide services without having an authorization in hand. Services provided without a pre-approved authorization are not guaranteed for payment.**

Procedure Codes	Modifier	Unit of Service	Description	Rate
97802		15 minutes	Assessment - onsite	\$21.29
97802		15 minutes	Assessment - offsite	\$26.27
99499	HA	15 minutes	IFSP development	\$21.29
99499	HA	15 minutes	IFSP meeting	\$26.27
97803		15 minutes	Nutrition services - onsite	\$21.29
97803		15 minutes	Nutrition services - offsite	\$26.27
97804		15 minutes	Group Nutrition services (multiple families or group not to exceed 4 children)	\$ 5.31

## OCCUPATIONAL THERAPY

Service Description: Occupational therapy includes services to address the functional needs of a child related to adaptive development; adaptive behavior, restoration, and play; and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings and include:

- 1) Evaluation, assessment, and intervention; (global evaluation not acceptable)
- 2) Adaptation of the environment and selection, design and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and
- 3) Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.

Activities also include IFSP development, assistive technology assessment if needed, and environmental consultation to ensure that appropriate adaptations and safety issues for the eligible child are incorporated.

Family training, education and support provided to assist the family of a child eligible for services in understanding the special needs of the child as related to occupational therapy services and enhancing the child's development are integral to this service. Eligible child is not required to be present but may be if appropriate. May include such services as support groups, individual support and other training or education for the family.

Services must be consistent with the provider's qualifications and licensure.

**NOTE:** Early Intervention does **not** pay for therapeutic services required due to, or as part of, a medical procedure, a medical intervention or an injury. Acute rehabilitative therapy and therapy required as part of a medical procedure, medical intervention or injury, is not developmentally-based but is medically-based. Once the condition has become chronic or sub-acute the therapy for the on-going developmental delay can be provided by EI.

Qualified Staff: 1) System enrolled Specialist credentialed as a Licensed Occupational Therapist or 2) a non-enrolled Associate credentialed as a Licensed Certified Occupational Therapy Assistant. Assistants must work under the supervision of an enrolled Licensed Occupational Therapist. (See [ATTACHMENT 4: USE OF ASSOCIATE LEVEL PROVIDERS](#) for more detail. See [ATTACHMENT 5: REQUIREMENTS FOR PROFESSIONAL AND ASSOCIATE LEVEL EARLY INTERVENTION CREDENTIALING AND ENROLLMENT TO BILL](#).)

Billable Activities With Authorization: Evaluation / assessment, IFSP development, (see [DEFINITIONS](#) section for IFSP development definition) and direct services.

**NOTE:** Bill for time required to develop assistive technology requests using IFSP development code.

**OCCUPATIONAL THERAPY - cont.**

**Do not provide services without having an authorization in hand. Services provided without a pre-approved authorization are not guaranteed for payment.**

Procedure Codes	Modifiers	Unit of Service	Description	Rate
97003		15 minutes	Evaluation/Assessment - onsite	\$14.53
97003		15 minutes	Evaluation/Assessment - offsite	\$18.14
99499	GO	15 minutes	IFSP development	\$14.53
99499	GO	15 minutes	IFSP meeting	\$18.14
97530		15 minutes	Individual therapy - onsite	\$14.53
97530		15 minutes	Individual therapy - offsite	\$18.14
97150		15 minutes	Group therapy (multiple families or group not to exceed 4 children)	\$ 7.88

## PHYSICAL THERAPY

Service Description: Physical therapy services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. These services include:

- 1) Evaluation and assessment of infants and toddlers to identify movement dysfunction; (global evaluation not acceptable)
- 2) Obtaining, interpreting, and integrating information appropriate to program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems; and
- 3) Providing individual and group services or treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems.

Activities also include IFSP development and assistive technology assessment, if needed, and environmental consultation to ensure that appropriate adaptations and safety issues for the eligible child are incorporated.

Family training, education and support provided to assist the family of a child eligible for services in understanding the special needs of the child as related to physical therapy services and enhancing the child's development are integral to this service. Eligible child is not required to be present but may be if appropriate. May include such services as support groups, individual support and other training or education for the family.

Services must be consistent with the provider's qualifications and licensure.

**NOTE:** Early Intervention does **not** pay for therapeutic services required due to, or as part of, a medical procedure, a medical intervention or an injury. Acute rehabilitative therapy and therapy required as part of a medical procedure, medical intervention or injury, is not developmentally-based but is medically-based. Once the condition has become chronic or sub-acute the therapy for the on-going developmental delay can be provided by EI.

Qualified Staff: 1) System enrolled Specialist credentialed as a Licensed Physical Therapist or 2) a non-enrolled Associate credentialed as a Licensed Physical Therapy Assistant. Assistants must work under the supervision of an enrolled Licensed Physical Therapist. (See [ATTACHMENT 4: USE OF ASSOCIATE LEVEL PROVIDERS](#) for more detail. See [ATTACHMENT 5: REQUIREMENTS FOR PROFESSIONAL AND ASSOCIATE LEVEL EARLY INTERVENTION CREDENTIALING AND ENROLLMENT TO BILL](#).)

Billable Activities With Authorization: Evaluation / assessment, IFSP development, (see [DEFINITIONS](#) section for IFSP development definition) and direct services.

**NOTE:** Bill for time required to develop assistive technology requests using IFSP development code.

**PHYSICAL THERAPY - cont.**

**Do not provide services without having an authorization in hand. Services provided without a pre-approved authorization are not guaranteed for payment.**

Procedure Codes	Modifier	Unit of Service	Description	Rate
97001		15 minutes	Evaluation / Assessment - onsite	\$14.53
97001		15 minutes	Evaluation / Assessment - offsite	\$18.14
99499	GP	15 minutes	IFSP development	\$14.53
99499	GP	15 minutes	IFSP meeting	\$18.14
97110		15 minutes	Individual therapy - onsite	\$14.53
97110		15 minutes	Individual therapy - offsite	\$18.14
97150	SE	15 minutes	Group therapy (multiple families or group not to exceed 4 children)	\$ 7.88

## PSYCHOLOGICAL AND OTHER COUNSELING SERVICES

Service Description: Psychological and other counseling services are diagnostic or active treatments as required by the child's Service Plan provided with the intent to reasonably improve the **child's** physical or mental conditions. Services include:

- 1) Global evaluation to determine a child's developmental status and need for early intervention services (See [DEFINITIONS](#) section for further information)
- 2) Administering psychological or developmental tests and other assessment procedures to determine the need for psychological or other counseling services;
- 3) Interpreting assessment results;
- 4) Obtaining, integrating and interpreting information about child behavior and child and family conditions related to learning, mental health and development;
- 5) Identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from early intervention services; and
- 6) Planning and managing a program of psychological or other counseling services, including psychological or other counseling for children and parents, family counseling required due to the developmental status of the eligible child, consultation on child development, parent training, and education programs. **NOTE: If it is identified that family members may be experiencing mental health problems that are not related to the eligible child's special needs, it is the responsibility of the provider to refer those individuals to resources other than Early Intervention for services.**

Family training, education and support provided to assist the family of a child eligible for services in understanding the special needs of the child as related to the services that the provider is licensed to provide and enhancing the child's development are integral to this service. Eligible child is not required to be present but may be if appropriate. May include such services as support groups, individual support and other training or education for the family.

**NOTE:** Counselors may only provide global evaluation services to determine eligibility for EI services. Once a child has been determined eligible, if further assessment is required to determine the need for counseling services based upon the services identified above, a Counselor Evaluator must complete an assessment that is specific to Counseling services.

**Services must be consistent with the provider's qualifications and licensure.**



**PSYCHOLOGICAL AND OTHER COUNSELING SERVICES - cont.**

Qualified Staff: 1) System enrolled Specialist credentialed as a) a Licensed Clinical Psychologist, b) Licensed Clinical Professional Counselor, c) Licensed Marriage and Family Therapist, d) Licensed Clinical Social Worker, e) Board Certified Behavior Analyst or f) School Psychologist employed by a school district, or 2) a non-enrolled Associate credentialed as a Clinical Psychology or Clinical Counseling Intern. Interns must be under the direction of their internship supervisor, who must be an enrolled Specialist in one of the above licensed fields. (See [ATTACHMENT 5: REQUIREMENTS FOR PROFESSIONAL AND ASSOCIATE LEVEL EARLY INTERVENTION CREDENTIALING AND ENROLLMENT TO BILL.](#))

Billable Activities Global evaluation, assessment, IFSP development (see [DEFINITIONS](#) section for IFSP development definition) and direct service. **NOTE:** Does not include medical case management.

**Do not provide services without having an authorization in hand. Services provided without a pre-approved authorization are not guaranteed for payment.**

Procedure Codes	Modifier	Unit of Service	Description	Rate
96150		15 minutes	Evaluation / Assessment - onsite	\$17.38
96150		15 minutes	Evaluation / Assessment - offsite	\$21.57
99499	UK	15 minutes	IFSP development	\$17.38
99499	UK	15 minutes	IFSP meeting	\$21.57
96152		15 minutes	Individual treatment - onsite	\$17.38
96152		15 minutes	Individual treatment - offsite	\$21.57
96153		15 minutes	Group treatment (multiple families or group not to exceed 4 children)	\$ 4.34

## SERVICE COORDINATION

Service Description: Service coordination services carried out by a Service Coordinator to assist and enable an eligible child and the child's family to receive the rights, procedural safeguards, and services that are authorized to be provided through the State's Early Intervention program. The responsibilities of a Service Coordinator include, but are not limited to:

- 1) Contact with the Early intervention enrolled child/family at least one time per month;
- 2) Coordinating the activities for implementation of the service plan;
- 3) Coordinating the performance of initial & annual evaluations/assessments;
- 4) Facilitating and participating in the development, review and evaluation of the Service Plan. This includes Service Plan updates, six (6) month reviews and the annual evaluation of the Service Plan;
- 5) Assisting families in identifying credentialed/enrolled/available service providers;
- 6) Coordinating and monitoring the delivery of services identified in the child's Service Plan;
- 7) Informing families of their rights and the availability of advocacy services;
- 8) Helping families to access other needed services such as WIC, housing, etc;
- 9) Coordinating with medical and health providers, including requests for medical records and other medical documentation from physicians, hospitals, nurses, etc.
- 10) Facilitating the development and implementation of a transition plan to preschool or other services, if appropriate; and
- 11) Maintenance of the child's comprehensive permanent record at the Child and Family Connections office. Maintenance includes:
  - Evaluation/Assessment and six month summary reports from all providers who participate as a member of each child's service team;
  - Notes on the progress of the child's transition plan implementation which is to begin at age two (2) years, six (6) months.
  - Service Plan updates; and
  - Any other documentation required to keep the child's permanent record updated.
- 12) Other services identified in the CFC Procedure Manual under the Section Overview of Child and Family Connections.

## SERVICE COORDINATION - cont.

Service coordinators do not provide evaluation/assessment services to determine a child's eligibility for services, but are integral members of the service team. Services must be consistent with the provider's qualifications.

Service Coordinators are required to follow written procedures that are outlined in the "Child and Family Connections Procedure Manual" and to implement policy as set forth by the DHS – Bureau of Early Intervention.

Qualified Staff: System enrolled individual credentialed as a Service Coordinator. (See [ATTACHMENT 5: REQUIREMENTS FOR PROFESSIONAL AND ASSOCIATE LEVEL EARLY INTERVENTION CREDENTIALING AND ENROLLMENT TO BILL.](#))

Effective 8/31/00: Service Coordination services are provided by service coordinators who are employed by a Child and Family Connections office. Services are funded by contracts to the Child and Family Connection offices and are not billed fee-for-service.

**NOTE:** There is no Associate level service coordination credential. The credentialed/enrolled service coordinator is responsible for personally providing services to a child/family.

## SOCIAL WORK AND OTHER COUNSELING SERVICES

Service Descriptions: Social work and other counseling services are diagnostic or active clinical treatments provided with the intent to reasonably improve the **child's** physical or mental condition or functioning. Social work and other counseling services include:

- 1) Global evaluation to determine a child's developmental status and need for early intervention services (See [DEFINITIONS](#) section for further clarification).
- 2) Making home visits to assess a child's living conditions and patterns of parent-child interaction to determine the need for social work or other counseling services;
- 3) Preparing a social or emotional developmental assessment of the child within the family context to determine the need for social work or other counseling services;
- 4) Providing individual and family-group counseling with parents and other family members, and appropriate social skill-building activities with the child and parents; **NOTE: If it is identified that family members may be experiencing mental health problems that are not related to the eligible child's special needs, it is the responsibility of the provider to refer those individuals to resources other than Early Intervention for services.**
- 5) Working with issues in the child's and family's living situation (home, community, and any center where early intervention services are provided) that affect the child's maximum utilization of early intervention services; and
- 6) Identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from early intervention services.

Family training, education and support provided to assist the family of a child eligible for services in understanding the special needs of the child as related to the services that the provider is licensed to provide and enhancing the child's development are integral to this service. Eligible child is not required to be present but may be if appropriate. May include such services as support groups, individual support and other training or education for the family.

**NOTE:** Counselors may only provide global evaluation services to determine eligibility for EI services. Once a child has been determined eligible, if further assessment is required to determine the need for counseling services based upon the services identified above, a Counselor Evaluator must complete the assessment.

**SOCIAL WORK AND OTHER COUNSELING SERVICES - cont.**

**Services must be consistent with the provider’s qualifications and licensure.**

Qualified Staff: System enrolled Specialist credentialed as a) a \*Licensed Clinical Social Worker, b) Licensed Social Worker, c) Licensed Professional Counselor d) School Social Worker employed by a school district, or 2) a non-enrolled Associate credentialed as a Social Work Intern. Interns must be under the direction of their internship supervisor, who must be an enrolled Specialist in one of the above licensed fields. (See [ATTACHMENT 4: USE OF ASSOCIATE LEVEL PROVIDERS](#) for more detail. See [ATTACHMENT 5: REQUIREMENTS FOR PROFESSIONAL AND ASSOCIATE LEVEL EARLY INTERVENTION CREDENTIALING AND ENROLLMENT TO BILL.](#))

Billable Activities: Global evaluation, assessment, IFSP development (see [DEFINITIONS](#) of With Authorization: IFSP development) and direct service as described above. **NOTE:** Does not include medical case management.

**Do not provide services without having an authorization in hand. Services provided without a pre-approved authorization are not guaranteed for payment.**

Procedure Codes	Modifier	Unit of Service	Description	Rate
*Licensed Clinical Social Workers bill using Procedure Codes and Rates for <a href="#">PSYCHOLOGICAL AND OTHER COUNSELING SERVICES</a> .				
90802		15 minutes	Evaluation / Assessment – onsite	\$11.59
90802		15 minutes	Evaluation / Assessment - offsite	\$13.95
99499	SE	15 minutes	IFSP development	\$11.59
99499	SE	15 minutes	IFSP meeting	\$13.95
H0004		15 minutes	Individual treatment - onsite	\$11.59
H0004		15 minutes	Individual treatment - offsite	\$13.95
H0004	HQ	15 minutes	Group treatment (multiple families or group not to exceed 4 children)	\$ 2.89

## **SPEECH LANGUAGE THERAPY**

**Service Description:** Speech language therapy services include: 1) evaluation / assessment activities to identify communication or swallowing disorders and delays in the development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills; 2) referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communicative or oropharyngeal disorders and delays in the development of communication skills; 3) IFSP development, and 4) treatment programs provided as a result of a medical referral by a licensed physician to improve the child's functional ability to communicate at home and in other environments. Activities for Early Intervention also include assistive technology assessment and environmental consultation to ensure that appropriate adaptations and safety issues for the eligible child are incorporated.

Family training, education and support provided to assist the family of a child eligible for services in understanding the special needs of the child as related to speech language services and enhancing the child's development are integral to this service. Eligible child is not required to be present but may be if appropriate. May include such services as support groups, individual support and other training or education for the family.

Services must be consistent with the provider's qualifications and licensure.

**NOTE:** Early Intervention does **not** pay for therapeutic services required due to, or as part of, a medical procedure, a medical intervention or an injury. Acute rehabilitative therapy and therapy required as part of a medical procedure, medical intervention or injury, is not developmentally-based but is medically-based. Once the condition has become chronic or sub-acute the therapy for the on-going developmental delay can be provided by EI.

**Qualified Staff:** 1) System enrolled Specialist credentialed as a) a Licensed Speech/Language Pathologist; or 2) a non-enrolled Associate credentialed as a Speech/Language Therapy Assistant. Assistants must be under the direction of an enrolled Speech/Language Pathologist Specialist. (See [ATTACHMENT 4: USE OF ASSOCIATE LEVEL PROVIDERS](#) for more detail. See [ATTACHMENT 5: REQUIREMENTS FOR PROFESSIONAL AND ASSOCIATE LEVEL EARLY INTERVENTION CREDENTIALING AND ENROLLMENT TO BILL.](#))

**Billable Activities With Authorization:** Evaluation / assessment, IFSP development, (See [DEFINITIONS](#) of IFSP development) and direct services.

**NOTE:** Bill for the time required to develop Assistive Technology requests using IFSP development code.

**SPEECH LANGUAGE THERAPY - cont.**

**Do not provide services without having an authorization in hand. Services provided without a pre-approved authorization are not guaranteed for payment.**

Procedure Codes	Modifiers	Unit of Service	Description	Rate
92506		15 minutes	Evaluation / Assessment - onsite	\$14.53
92506		15 minutes	Evaluation / Assessment - offsite	\$18.14
99499	GN	15 minutes	IFSP development	\$14.53
99499	GN	15 minutes	IFSP meeting	\$18.14
92507		15 minutes	Individual therapy.- onsite	\$14.53
92507		15 minutes	Individual therapy - offsite	\$18.14
92508		15 minutes	Group therapy (multiple families or group not to exceed 4 children)	\$ 7.88

See "Audiology, Aural Rehabilitation and Other Related Services" for additional service activities and billing codes for Early Intervention. MUST have authorization prior to billing those codes.

## TRANSPORTATION

**Service Description:** Transportation services as defined in the Service Plan that are necessary to enable an eligible child and a member of the child's family (if accompanying the child) to travel to and from the location where another Early Intervention service is to be provided. Transportation services include transportation by taxicab, service car or private automobile. The prior approval requirement for Medicaid eligible children, for Transportation to and from Early Intervention Services only, is satisfied by enrollment in the EI Services System and by denoting the necessity of the service in the Service Plan.

Services must be consistent with the provider's qualifications and licensure.

**Qualified Staff:** System enrolled transportation provider. Providers may include parents, guardians and other responsible adults. (See [ATTACHMENT 5: REQUIREMENTS FOR PROFESSIONAL AND ASSOCIATE LEVEL EARLY INTERVENTION CREDENTIALING AND ENROLLMENT TO BILL.](#))

**Billable Activities with Authorization:** Transportation for child and family member to and from the location where Early Intervention services are provided.

(Must be by most economical means appropriate for the child. Transportation codes can only be billed for loaded mileage. **Loaded mileage** means that the child is in the vehicle and is being transported to and from an EI Service.)

**Rate:** Established individually based on Medicaid rates.

**Do not provide services without having an authorization in hand. Services provided without a pre-approved authorization are not guaranteed for payment.**

Procedure Codes	Modifier	Unit of Service	Description
A0120		N/A	Service car, base rate
A0120		N/A	Service car, return
A0425		N/A	Service car, mileage
T2001		N/A	Non-employee attendant
A0100		N/A	Taxi, base rate
A0100		N/A	Taxi, return
A0425		N/A	Taxi, mileage
T2001		N/A	Non-employee attendant
A0090		N/A	Private auto mileage
Transportation codes can only be billed for loaded mileage. Loaded mileage means that the child is in the vehicle and is being transported to and from a EI service.			



## VISION

Service Description: Vision services include evaluation and assessment of visual functioning; diagnosis and appraisal of specific visual disorders, delays and abilities; dispensing of eyeglasses and referral for medical or other professional services necessary for the habilitation or rehabilitation of visual functioning disorders.

Vision services, also include:

- 1) services related to visual functioning,
- 2) orientation and mobility training for all environments,
- 3) communication skills training,
- 4) visual training,
- 5) independent living skills training and
- 6) additional training necessary to activate visual motor abilities.

Family training, education and support provided to assist the family of a child eligible for services in understanding the special needs of the child related to vision services and enhancing the child's development are integral to this service. Eligible child is not required to be present but may be if appropriate. May include such services as support groups, individual support and other training or education for the family.

Services must be consistent with the provider's qualifications and licensure.

**NOTE:** Early Intervention does **not** pay for therapeutic services required due to, or as part of, a medical procedure, a medical intervention or an injury. Acute rehabilitative therapy and therapy required as part of a medical procedure, medical intervention or injury, is not developmentally-based but is medically-based. Once the condition has become chronic or sub-acute the therapy for the on-going developmental delay can be provided by EI.

Qualified Staff: 1) System enrolled Licensed Registered Optometrist or licensed Ophthalmologist, and 2) System enrolled specialist credentialed as a Developmental Therapist/Vision. (See [ATTACHMENT 5: REQUIREMENTS FOR PROFESSIONAL AND ASSOCIATE LEVEL EARLY INTERVENTION CREDENTIALING AND ENROLLMENT TO BILL](#)).

Billable Activities With Authorization: Optometric examination, dispensing fee, assessment, IFSP development (see [DEFINITIONS](#) of IFSP development) and direct services.

**Do not provide services without having an authorization in hand. Services provided without a pre-approved authorization are not guaranteed for payment.**

**VISION – cont.**

Procedure Codes	Modifier	Unit of Service	Description	Rate
Procedure codes listed below are for use to determine the need for eyeglasses, to dispense eyeglasses and to make a referral to a medical doctor for medical testing, if the need is identified.				
92015		n/a	Optometric examination	\$29.27
92340		n/a	Dispensing fee	\$30.09
Procedure Codes listed below are for use by Illinois Department of Corrections only.				
V2020 V2025		n/a	Frame	varies
varies		n/a	Pair of lenses (same Rx)	varies
varies		n/a	Right lens (different Rx)	varies
varies		n/a	Left lens (different Rx)	varies

**NOTE:** Prescriptions for eyeglasses must be submitted to the CBO along with the bill for the optometric examination and the dispensing fee using “optical prescription order forms” from the Illinois Department of Corrections. The CBO will make arrangements to fill the prescription as ordered (See [ATTACHMENT 6: PROCEDURE TO ORDER EYEGLASSES](#)).

Procedure Codes	Modifier	Unit of Service	Description	Rate
Procedure Codes listed below are for Vision Services				
99199		15 minutes	Assessment - onsite	\$11.03
99199		15 minutes	Assessment - offsite	\$13.91
99499		15 minutes	IFSP development	\$11.03
99499		15 minutes	IFSP meeting	\$13.91
V2799		15 minutes	Vision services - onsite	\$11.03
V2799		15 minutes	Vision services - offsite	\$13.91
V2799	HQ	15 minutes	Group vision services (multiple families or group not to exceed 4 children)	\$2.76

## DEFINITIONS

“Authorization” Prior approval required before any service can be rendered. The exception to this rule is the initial IFSP meeting. IFSP Meeting authorizations will be based upon actual attendance at the IFSP meeting. For direct services, authorizations are generated as either Individual or Group.

Individual Authorization - An authorization to provide services to a single child/family based upon a frequency, intensity and duration. An Individual Authorization cannot be used to provide services to a child/family during the same time frame that the child/family is receiving authorized group therapy services.

Group Authorization – An authorization to provide direct services to two or more children during the same period of time based upon a frequency, intensity and duration. One provider can serve up to four (4) children or multiple families (parent groups) during a group session. See service description “Family Training and Support” for information on groups and Interpreters.

Evaluation/Assessment Authorization – An authorization to provide evaluation or assessment to determine a child’s initial eligibility, re-determination of eligibility, the need to add new types of services to an existing IFSP, and if deemed necessary, for the annual six month review.

IFSP Meeting Authorization – An authorization that is based on attendance of the IFSP meeting. This is the only authorization that is generated after the service has been provided. The amount of time allowed for billing on this authorization will be the amount of time that the provider was actually in attendance at the IFSP meeting, whether by phone or in person.

Onsite Authorization – A site where the provider of services is located during the work day that the family must travel to in order for their child to receive services. This would include agencies, hospitals, satellite sites and other similar settings. This type of setting may not be considered a natural environment.

Offsite Authorization – A site where the child typically spends his or her day which may be the child’s home, daycare center or other setting. The provider travels to the child to provide services. This is considered a natural environment.

Offsite authorizations would also include settings where both the child and provider must travel to the site of service. This type of setting would include sites such as a community swimming pool, a park or other community setting that is frequented by typically developing children.

“Child Outcomes” The changes experienced as a result of the Early Intervention services and supports provided to a child. All children in Early Intervention will have their skills compared to other children their age in three areas: positive social-emotional skills (including social relationships), acquisition and use of knowledge and skills, and taking appropriate action to meet needs. These three areas, having relationships with family and friends, being able to gain

“Child Outcomes” – cont.	new information and skills, and being able to communicate and meet needs, are believed to be important for all young children. A child’s status in the three child outcome areas is determined when the child enters the Early Intervention Services System, at his/her annual IFSP meeting, and again shortly before exiting the system. Child outcomes compares a child’s status to other children of the same age.
“Concerns”	What family members identify as needs, issues, or problems they want to address as part of the IFSP process.
“Co-treatment”	The integration of treatment by two disciplines in order to maximize therapy benefits for one individual child/family while working towards the achievement of immediate and long term goals. If it is determined at the initial IFSP meeting that co-treatment is a need, functional outcomes must be included in the IFSP that provide a clear focus and direction for the recommended co-treatment services. The outcomes must be related to a necessary skill and should state a process and a product. Co-treatment must be based upon a child’s needs and not provider logistics. Co-treatment <b>is not</b> considered group therapy. For more information see definition of “ <b>Group Therapy</b> ”.
“DHS”	Illinois Department of Human Services.
“Direct Service”	Treatment services provided directly to an eligible child or an eligible child’s family in accordance with their Service Plan. All direct services must be justified by functional outcomes that are included in a child’s IFSP. See definition of functional outcomes for more information. One person cannot provide services to the same child/family as two disciplines. Example: One person cannot provide services as a Developmental Therapist and as a Occupational Therapist.
“Documentation”	<p>You are required to maintain documentation to support each date of service and each procedure code that you bill to the CBO for a period of at least six years from the child’s completion of EI services, and permit access to these records by the local CFC and DHS, or if they are Medicaid reimbursable services the Illinois Department of Healthcare and Family Services and the Centers for Medicare/Medicaid Services (CMMS), and the United States Department of Education.</p> <p>If there are outstanding audit exceptions, records shall be retained until such exceptions are closed out to the satisfaction of DHS. If there is active or pending legal action, records shall be retained until a final written resolution is achieved. The Provider shall also make himself/herself available, as required, for mediation, impartial administrative proceedings or other legal proceedings.</p> <p>Documentation is a chronological written account kept by you of all dates of services provided to, or on behalf of, a child and family. This includes IFSP development time and the results of all diagnostic tests and procedures administered to a child. <b>All documentation, including the signature of the provider who creates the documentation, must be readable and</b></p>

“Documentation” –  
cont.

**understandable to families and to persons who will monitor or audit the Payee’s billing to the CBO.** Documentation must include:

1. Physician authorization/order.
2. Documentation of evaluation/assessment should include a record note that identifies the date of service that the evaluation or assessment was completed, time used to complete the evaluation or assessment, time used to write the report based upon the results of the evaluation or assessment, and a copy of the final report that was submitted to the CFC. The date of service is the date that the formal assessment tool was administered. For a six month review, if it is determined that a formal assessment is not required, providers may summarize their record notes to develop the required six month report. In this case documentation would consist of a record note stating that a report was created based upon the summary of record notes and a copy of the final report.
3. Daily documentation of the services provided, including date and length of time of service billed, time in and time out for direct services, or exact time used in minutes for IFSP development. Daily documentation is written and signed by the provider who actually provided the services and consists of a **complete overview** of the services provided for each procedure code and date of service billed. A check list or pages from an appointment book **are not** considered documentation or a complete overview of the services provided. **NOTE: Documentation overview and provider signature must be readable and understandable to families and to persons who will monitor or audit the Payee’s billing to the CBO.**
4. Consultations among members of the IFSP team, including the service coordinator and eligible child’s physician, can occur via **secure** email or fax, as long as the time used is documented with a begin/end time or exact time used in minutes. Email sent via the “public internet” is not considered secure. Printed copies of secure emails or faxes must be kept in each child’s file as documentation of the consultation.
5. EI does not allow a provider to round up time. So it is very important that all record notes include the exact begin/end time or exact time used in minutes for IFSP development time. In addition, **all documentation must justify the amount of time actually billed to and paid by the CBO.**
6. Progress documentation
7. Documentation of continued physician authorization
8. Documentation of discharge from treatment.
9. Supervision notes that document all contact between the supervisor who is responsible for a child’s case and the associate level provider who is actually providing the direct service to the child. Calendar pages that identify dates of supervision are not considered supervision notes or documentation.

Transportation providers’ documentation should include:

1. A travel log that documents all trips billed, including mileage, departure and destination information.

“Documentation” –  
cont.

Interpreter’s, Interpreters for the Deaf and Translators documentation should include:

1. Daily documentation of services provided, including date of service, discipline for which you have interpreted services and time in/out. Daily documentation should be signed by the provider who actually completed the services and wrote the documentation. Calendar pages are not considered documentation.
2. Type of interpretation: verbal, sign, or written translation
3. If written translation, type of document translated (ex: IFSP)
4. Copy of the document to translate and copy of the final document after translation. **NOTE:** EI does not pay for translation of non-EI documents.

In addition, providers should also keep the following:

1. Copies of all authorizations under which you have billed for services.
2. A copy of the child’s current IFSP.
3. Copies of all claims submitted to insurance and to the **CBO**,
4. Copies of all Explanation’s of Benefit received from insurance and the **CBO**,
5. Any correspondence sent or received on behalf of the child,

**PLEASE NOTE:** Providers who are not enrolled with the CBO and associate level providers who are not Early Intervention credentialed, are **NOT** considered eligible Early Intervention providers and should **NOT** provide services to eligible Early Intervention children unless approved through a provisional authorization.

**In the absence of proper and complete documentation, no payments will be made and payments previously made will be recouped by DHS or HFS.**

One case note signed by multiple providers is considered unacceptable documentation. Each provider that provides a service to a child must maintain documentation to support the actual services provided and each date of service and each procedure code billed to the CBO. This includes providers of group therapy services.

“Eligibility Criteria”

Children residing in Illinois who are under the age of three years and their families are initially eligible for Early Intervention (EI) services if written evaluation reports completed by a multidisciplinary team confirm that the child:

- a) Has a developmental delay; or
- b) Has a physical or mental condition which typically results in developmental delay; or
- c) Is at risk of having substantial developmental delays, according to informed clinical judgment.

“Eligibility Criteria ”  
– cont.

“Developmental delay” means a Illinois Department of Human Services (DHS) determined eligible level of delay in one or more of the following areas of childhood development: cognitive; physical, including vision and hearing; language, speech and communication; social-emotional; or adaptive self-help skills. The eligible level of delay must have been:

- a) Measured by a DHS-approved diagnostic instruments and standard procedures; (see [ATTACHMENT 8: APPROVED ASSESSMENT INSTRUMENTS](#)) or
- b) Confirmed through **informed clinical judgment of the multidisciplinary team if the child is unable to be appropriately and accurately tested by the standardized measures available**. Activities used to determine clinical judgment shall include observation and parent report and shall be described in the written evaluation report.

“Physical or mental condition which typically results in developmental delay” means a medical diagnosis:

- a) Approved by DHS as an eligible condition; or
- b) Confirmed by a qualified family physician, pediatrician or pediatric sub-specialist as being a condition with a relatively well-known expectancy for developmental outcomes within varying ranges of developmental disabilities. Pediatric sub-specialists included are those such as pediatric neurologists, geneticists, pediatric orthopedic surgeons and pediatricians with special interest in disabilities. If a child exhibits a medical condition not approved by DHS as being an eligible condition, the qualified multidisciplinary team may use written verification by one of the physician categories identified above that the child’s medical condition typically results in substantial developmental delay within the varying ranges of developmental disabilities.

“At risk of substantial developmental delay, according to informed clinical judgment” means the multidisciplinary team confirms that development of a DHS-determined eligible level of delay is probable if EI services are not provided because the child is experiencing either:

- a) A parent who has been medically diagnosed as having a severe mental disorder as set forth under axis I and axis II of the Diagnostic and Statistical Manual (DSM) IV or a developmental disability; or
- b) Three or more of the following risk factors:
  - 1) Current alcohol or substance abuse by the primary caregiver;
  - 2) Primary caregiver who is currently less than 15 years of age;
  - 3) Current homelessness of the child. Homelessness is defined as children who lack a fixed, regular and adequate nighttime residence, in conformity with the *McKinney Vento Homeless Assistance Act*;
  - 4) Chronic illness of the primary caregiver;
  - 5) Alcohol or substance abuse by the mother during pregnancy with the child;
  - 6) Primary caregiver with a level of education equal to or less than the 10<sup>th</sup> grade, unless that level is appropriate to the primary caregiver’s age;

“Eligibility Criteria” –  
cont.

- 7) An indicated case of abuse or neglect regarding the child and the child has not been removed from the abuse or neglect circumstances.

“Eligibility  
Determination”

Part C of the Individuals With Disabilities Education Act requires that a “comprehensive, multidisciplinary evaluation” occur in order to determine eligibility for services. Eligibility determination requires evaluations to be completed by two separate disciplines. One person cannot complete evaluations as two disciplines. In Illinois the need for nursing, nutrition or counseling services does not determine eligibility. These are services that may require further assessment to determine need once a child has been determined eligible.

Children who present with a medical diagnosis or at risk conditions that automatically make them eligible for services must still receive a minimum of two evaluations to determine a need for services and to complete a initial comprehensive multidisciplinary IFSP. Children who are auto-eligible due to a medical diagnosis or at risk conditions may be found to be developing in a typical manner and may not require services. Evaluations will determine typical versus atypical development.

“Equally Qualified  
Provider”

Providers who are equally credentialed/enrolled as the same discipline under the same provider category (ex., speech evaluator) are considered “equally qualified providers”. In order to provide services under an existing authorization as an “equally qualified provider”, the payee identified on the authorization must be an active payee on the equally qualified provider’s CBO provider file(s).

“Evaluation/  
Assessment”

Evaluation and assessment services are for the purpose of determining initial eligibility, participating in the development of an initial comprehensive multidisciplinary IFSP, annual re-determination of eligibility, adding new types of services to an existing IFSP, and if deemed necessary, to write the report for the six month review. Initial evaluation and assessment services to determine eligibility , develop an initial IFSP or to add a new service to an existing IFSP must be provided by a provider with a credential for Evaluation and Assessment. Evaluation and assessment services provided to complete a six month review or for re-determination of eligibility on an annual basis should be provided by the direct service provider, even if that provider is not credentialed as an evaluator.

Upon completion of an evaluation or assessment, **a written report of findings is required and must be submitted in the “Early Intervention Evaluation/Assessment Report Format”** to the Child and Family Connections office that is working with the child/family. Providers must complete and send the entire report within 14 calendar days of the receipt of a request, including those for initial and ongoing evaluation and assessments. Incomplete reports are not acceptable and will be returned to the provider (See [ATTACHMENT 1: EARLY INTERVENTION SERVICE REPORT GUIDELINES/FORMAT](#)).

**NOTES: 1)** In order for a provider to receive payment for an initial evaluation to determine eligibility, the provider must also attend the initial IFSP meeting



“Evaluation/  
Assessment ” – cont.

and participate in the development of the IFSP; **2)** Providers are required to attend the full IFSP meeting in order to receive an authorization for payment; **3)** When completing evaluations or assessments providers are required to use DHS approved tools. See [ATTACHMENT 8: APPROVED ASSESSMENT INSTRUMENTS](#). The attached approved tool list will be posted on the EI website(s) and all newly approved tools will be added to that list; and **4)** Providers must accept evaluations and assessments that have been completed prior to the initial IFSP meeting when beginning direct services. Early Intervention will not pay for the direct service provider to duplicate initial evaluations and assessments.

“Family Outcomes”

The changes experienced by the family as a result of Early Intervention services and supports. Family outcomes examined include information concerning a child’s strengths, abilities, and special needs and how the family helps their child develop and learn. These outcomes are measured by a survey that is sent to a portion of the families whose children receive Early Intervention services each year.

“Family Training  
Education & Support”

Time spent with the parent/caregiver **during direct service sessions only**, to assist with their understanding of the child’s special needs in relation to the providers discipline and enhancing the child’s development. The purpose of Family Training, Education and Support is to emphasize parent participation and education to maximize a child’s development. Services may consist of the following: 1) Time spent with the parent/caregiver to reflect on how the child is doing, to understand the family’s priorities and concerns (parent/caregiver report), and to problem solve together to generate new ideas about how to best work with the child in the natural environment to maximize development; 2) Time to model exercises/activities that the parent/caregiver can incorporate into the child’s daily activities/typical routines. This would require observation of the parent/caregivers existing methods. Examples of daily activities may include going to the grocery store, reading books, social play, etc. Examples of typical routines may include meal time, toileting, riding in the car, nap, etc.; and 3) Time spent with the parent/caregiver to develop written strategies to use with the child between direct service sessions to help meet the functional outcomes identified on the IFSP. If this document includes a complete overview of the services that were provided on the date of service that it was written, includes a time in/time out, is signed by the therapist and the parent/caregiver, and a copy is left with the parent, then this document can be considered documentation of services for billing and payment purposes (see definition of documentation). Time to complete documentation in the home that does not meet this definition **is not** considered “Family Training, Education and Support” time.

“Functional Outcomes”

Family centered outcomes that are written by the IFSP team and the family based upon the family’s identified priorities and concerns. Family centered functional outcomes are designed to encourage children to participate in the same types of family and community activities as other children their age. In order for this to occur the IFSP team needs to be aware of the family’s routines and the community activities that the family engages in. This will allow the team to consider daily routines and a variety of natural settings for intervention strategies to be implemented once the outcomes are developed. Family participation is the key to intervention and families are more likely to participate when the outcomes are meaningful to them and can be worked on

“Functional Outcomes”  
– cont.

throughout their everyday routines and activities. Functional Outcomes should be written to address areas of family concern rather than focusing on specific professional disciplines or therapies. The outcome must be related to a necessary skill and should state a process and a product. Functional outcomes are developed at the child’s IFSP meeting.

Family centered functional outcomes drive the decision making process to determine what Early Intervention services a child and family will receive. **Service delivery decisions are not based on a child’s medical diagnosis or percentage of delay, but rather on the child and family’s unique strengths, needs, concerns and priorities** that led to the development of each individualized family centered outcome. All outcomes must be functional and meaningful to the child and family. **Family centered functional outcomes must be written prior to the determination of service delivery decisions, which would include disciplines to provide services and frequency, intensity and duration of services identified on authorizations. All recommendations for services should be based upon the [PRINCIPLES OF EARLY INTERVENTION](#) located within this document.**

“Global Evaluation”

A global evaluation is a general testing that is based upon the mean of a child’s age equivalent peers and is used to determine a child’s status in each of the following developmental domains using standardized testing instruments approved for use by the Bureau of Early Intervention.

- 1) physical development, including vision and hearing;
- 2) cognitive development;
- 3) communication development, including language and speech;
- 4) Psychosocial or emotional development; and
- 5) adaptive development/self-help skills.

For each domain that a DHS determined eligible level of delay or more is found, further discipline specific assessment in each of those domains **must** occur prior to the IFSP meeting in order to ensure that a comprehensive, multidisciplinary IFSP can be written. Because a global evaluation is a general testing of the five domains and is not domain specific, the results of a domain specific evaluation should always supercede the results of a general global evaluation.

“Group Therapy”

Services provided by one or more disciplines to two or more children in a group setting. NOTE: Group size not to exceed more than four (4) children per provider. See service description “Family Training and Support” for information on the use of Interpreters for group services.

“IFSP Development”

All IFSP development activities identified below must be completed by the credentialed, enrolled provider, with the exception described below (see number 3 for exception.) Plan development includes attendance of the initial/annual Individualized Family Service Plan (IFSP) meeting as a member of a child/family’s service team to assist in the completion of a written document on the statewide Service Plan form detailing individualized outcomes for the child and family, services based upon the unique needs of the child and family, and transition strategies. Provider can attend the meeting in person or be present by conference call. Providers must accept

“IFSP Development” –  
cont.

responsibility for phone charges for IFSP conference calls if done for their convenience. **Providers are required to attend the entire IFSP meeting in order to receive authorization for payment.** After the initial service plan is implemented, IFSP development includes:

- 1) Periodic review of a child’s IFSP every six months or more frequently if conditions warrant, or if the family requests such a review, to determine if adjustment of the IFSP is needed. Periodic reviews must be conducted as defined in 34 CFR Parts 303.342 and 303.343. At a minimum, the child’s parent(s), other family members as requested by the child’s parent(s), an advocate or person outside of the family if requested by the parent(s) and the child/family’s service coordinator must be present at each periodic review. Meeting arrangements and written prior notice for each periodic review must be made to the family and other participants early enough before the meeting date to ensure that the participants will be able to attend. Meetings must be held in settings and at times that are convenient to the family and in the family’s native language or other mode of communication used by the family, unless it is clearly not feasible to do so.
- 2) Attendance at the transition meeting, if required.
- 3) Attendance at a child’s IEP meeting if the meeting occurs prior to the child’s third birthday. **NOTE:** EI **does not** pay for attendance at pre-IEP meetings.
- 4) The development of a direct service report required for the six-month review, or more frequently if conditions warrant a periodic review at a time other than at six months or if a review is requested by the family. This report would be a summary of a provider’s record notes.

Effective February 2004, an exception to the requirement that all IFSP Development activities be provided by the credentialed, enrolled provider was implemented. If direct services are provided by an associate level provider under the supervision of a credentialed, enrolled professional, the associate level provider may summarize his/her record notes and develop the direct service report required for the six-month review if licensing laws that govern the supervisor’s discipline allows. However, the credentialed, enrolled provider who supervises the associate must document that he/she has reviewed and agrees with the report and must sign the report as the Associate’s Supervisor.

Early Intervention has always required that all evaluations and assessments be completed by a credentialed, enrolled provider. Evaluation/ assessment reports are billed under the evaluation/ assessment procedure codes and must be completed by the credentialed, enrolled provider who actually provided that service.

The development of a discharge report by the credentialed, enrolled provider. **NOTES:** **1)** Time used to develop the report must be documented in case notes; **2)** The content of the report must justify time

“IFSP Development”  
– cont.

billed to and paid by the CBO: and **3)** Evaluation/assessment reports are billed under evaluation/assessment procedure codes.

- 5) Time for a Physical Therapist, Occupational Therapist, Audiologist, or Speech Therapist Evaluator to write a letter of developmental necessity for the CFC to submit to DHS for Assistive Technology (AT) prior approval. All requests for AT must include all required information. If a direct service provider determines a possible need for AT devices, the provider should call the child’s service coordinator to recommend that AT be added to the child’s IFSP. The service coordinator will call a meeting of the IFSP team to discuss the need to add a new service to the IFSP. If the team determines that there is a need, and the direct service provider is also a credentialed/enrolled evaluator, then the evaluator will write the letter of developmental necessity to submit to the service coordinator for AT prior approval purposes. This time is billed as IFSP development time.

If the direct service provider is not a credentialed/enrolled evaluator, then the service coordinator will generate an evaluation authorization to a credentialed/enrolled evaluator who will complete an evaluation and develop the letter of developmental necessity to submit to the service coordinator for prior approval purposes. The evaluator will bill for this time under the evaluation procedure code identified on the authorization.

- 6) Time for a provider who is requesting a change to the frequency or intensity of an existing service authorization to write the required justification of need that will be attached to the form entitled “Justification to Change Frequency/Intensity”. The written justification must be written and signed by the provider who has requested the change and the content must justify the time billed to and paid by the CBO.
- 7) Provider to provider consultation performed by the credentialed, enrolled provider among members of the child’s service team who are identified on the service plan as providers of EI services, the CFC parent liaison, the CFC social emotional consultant, the service coordinator and the child’s physician concerning the child’s developmental needs or the impact of special health care needs on services. Providers should always document this time accurately and should identify the EI provider or physician who was consulted in their documentation.

After the child/family has received a assistive technology device, consultation includes conversations held with the vendor concerning the fit and/or use of the device.

**NOTES:** **1)** IFSP Development **does not include** time to speak to a child’s parent(s) on the telephone. Time to speak to a child’s parent(s) on the telephone **is not** considered provider to provider consultation and is not billable time. Providers should speak to a child’s parent(s) during face-to-face direct service sessions. If the parent(s) cannot be present during a normally scheduled direct service session, providers should schedule an occasional direct service session at a time when the parent(s) can be present.

“IFSP Development” –  
cont.

- 8) IFSP Development **does not include** supervisory time; routine preparatory activities such as time spent packing or washing toys, file review and/or review of record notes or development of lesson plans or activity plans prior to each incident of service; time to leave a voice message; scheduling and canceling appointments, including time to speak to the interpreter who will schedule and cancel appointments for the discipline who they are interpreting for; time to write reports other than those identified in numbers four (4) and five (5) above; or family training, education and support which is an activity identified under each service description where appropriate. The activity “Family Training, Education, and Support” is built in to all services and is only billable under individual treatment and group procedure codes, not IFSP Development codes. (see [ATTACHMENT 7: NON-BILLABLE ACTIVITIES](#))
- 9) Providers are required to maintain daily documentation for all IFSP Development time based upon date of service and type of service. **For IFSP development time only**, a provider can bundle multiple dates of service together to equal a 15 minute unit. Bill using the last date added to the bundle as the date of service. All dates of service bundled into a single date of service for payment must all fall within the 90 day billing time frame.

“Make Up Session”

A provider can reschedule a missed visit based upon the guidelines stated below:

- 1) If a weekly or monthly service session cannot be rescheduled within seven (7) days from the original scheduled date, it should be considered a missed session.
- 2) If a provider knows that a service will be missed **prior** to the regular date of service due to an upcoming vacation or hospitalization, the provider may complete the service seven (7) days prior to the missed date. If more than one date of service will be missed due to vacation or hospitalization, it should be considered a missed session.
- 3) Given the frequency of illness in young children, family and provider vacations, and other unforeseen issues, missed sessions are inevitable. **However, they should not be routine occurrences.** Providers should make every effort to avoid missing service sessions.
- 4) Never provide a make up session on the same date that a regular session has been scheduled **or** as back to back sessions, as most birth to three children would be unable to tolerate an extended session.
- 5) If it is necessary for a provider to miss a number of service sessions due to an extended vacation or a prolonged illness/injury, etc., an equally qualified provider must be identified to carry out the services identified on the IFSP. The provider should contact the family and the service coordinator for each child on his/her caseload and work with the service coordinator to find a substitute for each child.

"Makeup Session" – cont.	<p>6) Always document in your case notes the date of the missed visit, the reason for the missed visit and if you reschedule based upon the above guidelines. When completing documentation after a make up session, include information in the documentation that identifies the date of service as a "make up session".</p> <p>7) Always bill for a make up session based upon the actual date of service, not the date of the missed session.</p>
"Multidisciplinary"	The involvement of two or more disciplines or professions in the provision of integrated and coordinated services, including evaluation and assessment activities and development of the IFSP.
"Natural Environment"	A setting that is natural or normal for a child's age peers who have no disability.
"Need"	A condition or situation in which something is essential, necessary or required.
"Outcome"	A statement of the benefits and changes that the multidisciplinary team expects for the family. Outcomes are discipline-free (see definition of functional outcomes).
"Priorities"	A family's choices and agenda for how Early Intervention will be involved in the family life.
"Resources"	The strengths, abilities, and formal or informal supports that can be mobilized to meet the family's concerns, needs, or outcomes.
"Strengths"	Individual characteristics that can be used as a resource.
"Want"	A preference or end result that is not essential, necessary or required.
"Written Home Activity Program"	A written home activity program is a document that is written in the home or other place of service, with the input of the parent/caregiver during a direct service session. It should identify developmental strategies to meet functional outcomes that are important to the family and that support the family in developing or refining their ability to facilitate their child's active involvement in his or her community and family. This document should be shared with all members of the IFSP service team and the parent/caregiver and is considered to be family training, education and support time and is billable as direct service time only.
"Written Developmental Justification of Need"	A written developmental justification of need should be written in narrative form and must clearly state the developmental needs that drive the recommendation for services(s) and how each recommended service is required and designed to meet the functional outcomes that have been identified in the child/family's service plan. Each child/family's unique strengths/developmental needs should be reflected in the written

“Written  
Developmental  
Justification of  
Need” – cont.

developmental justification of need. A written developmental justification of need is not a form letter and must be written based upon the Guidelines/Worksheet found in [ATTACHMENT 3: DEVELOPMENTAL JUSTIFICATION OF NEED GUIDELINES AND WORKSHEET](#) of this document.

“Under the  
supervision of”

For Associate Level Providers, work performed under the guidance and direction of a supervisor who is responsible for supervision of the work, who plans work and methods, who is available on short notice to answer questions and deal with problems that are not strictly routine, who regularly reviews the work performed and who is accountable for the results as set forth more specifically in [ATTACHMENT 4: USE OF ASSOCIATE LEVEL PROVIDERS](#) of this document. Supervisory time is non-billable time and is considered to be administrative time that is included in the rate paid for direct service.

# **EARLY INTERVENTION REQUIRED SERVICE REPORT GUIDELINES/FORMAT**

Please monitor the Provider Connections website at: [www.wiu.edu/providerconnections](http://www.wiu.edu/providerconnections)  
for policy/procedure changes.



**Illinois Department of Human Services  
Bureau of Early Intervention Required Service Report Guidelines/Format for  
Evaluation/Assessment/Direct Service Reports**

Evaluation and assessment includes initial and ongoing procedures such as tests or observation or review of existing documentation used by appropriate qualified personnel to determine a child's initial and ongoing eligibility and to assist in the development of the Individualized Family Service Plan (IFSP). Upon completion of an evaluation or assessment, a written report of findings is required and must be submitted in the "Early Intervention Evaluation/ Assessment Report Format" to the Child and Family Connections office within **14 calendar days** of receipt of the request to perform the evaluation or assessment. Providers must complete the entire report prior to submission. Incomplete reports are not acceptable and will be returned to the provider for revisions required to bring the report into compliance with the required format (See required Report Format below).

**NOTE:** Providers must accept evaluations and assessments that have been completed prior to the initial IFSP meeting or that have been completed to determine the need to add a new service to an existing IFSP when beginning direct services unless the evaluations/assessments are more than six (6) months old. Early Intervention will not pay for the direct service provider to duplicate initial evaluations and assessments.

Recommendations for goals, outcomes, and strategies for services, with frequency, intensity, duration and location **will be determined at the IFSP meeting** in collaboration with the child's family and are based on the family's identified priorities and concerns and the [PRINCIPLES OF EARLY INTERVENTION](#) found within this document. **It is inappropriate for providers to approach a child's family to discuss eligibility for EI services and/or recommendations for frequency, intensity or location of services prior to the IFSP meeting.** Eligibility is not determined by one provider alone. Eligibility is determined based upon consensus of the multidisciplinary team. Also, family centered functional outcomes that focus on child development and family training, education and support **must** be written at the IFSP meeting **prior** to the determination of service delivery (see definition of functional outcomes".) **Providers may discuss the results of evaluations and /assessments only with families prior to the meeting.**

Part C of the Individual With Disabilities Education Act (IDEA) requires that services be provided in the "Natural Environment". Part C of IDEA defines Natural Environment as "settings that are natural or normal for the child's age peers who have no disabilities" (see [ATTACHMENT 2: NATURAL ENVIRONMENTS REQUIREMENT AND WORKSHEET.](#)) If it is determined that a child will receive services in a non-natural environment, this worksheet must be completed at the IFSP meeting.

When determining **initial eligibility** a child will be determined eligible based upon one of the following reasons as stated in 89 Illinois Administrative Code 500.50(a):

Subsection (a)

An Illinois child under the age of 36 months of age and his or her family are eligible for services set forth in this Part if the child:

1. is experiencing a DHS determined eligible level of developmental delay; or
2. is experiencing a medically diagnosed physical or mental condition that typically results in developmental delay; or
3. is, according to informed clinical judgment of qualified staff based upon a multidisciplinary evaluation and assessment, at risk of substantial developmental delay. As defined in 89

Illinois Administrative Code 500.20, “at risk of substantial developmental delay, according to informed clinical judgment” means that there is consensus of qualified staff based upon multidisciplinary evaluation and assessment that development of a DHS determined eligible level of delay is probable if early intervention services are not provided, because a child is experiencing either:

- a parent who has been medically diagnosed as having a severe disorder as set forth under axis I and axis II of the Diagnostic and Statistical Manual IV (DSM IV); **or**
- three or more of the following risk factors:
  - current alcohol or substance abuse by the primary caregiver;
  - primary caregiver who is currently less than 15 years of age;
  - current homelessness of the child;
  - chronic illness of the primary caregiver;
  - alcohol or substance abuse by the mother during pregnancy with the child;
  - primary caregiver with a level of education equal to or less than the 10<sup>th</sup> grade, unless that level is appropriate to the primary caregiver’s age;
  - an indicated case of abuse or neglect regarding the child and the child has not been removed from the abuse or neglect circumstances.

On an annual basis **a re-determination of eligibility** must occur. If the child is not found eligible based upon Subsection (a) above, the child must meet the criteria as set forth in 89 Illinois Administrative Code 500.50(c) below:

Subsection (c)

Eligibility shall be determined annually. Children will continue to be eligible if they:

1. have entered the program under any of the eligibility criteria in subsection (a) but no longer meet the current eligibility criteria under this Section; **and**
2. either:
  - A. continue to have any measurable delay; **or**
  - B. have not attained a level of development in each area, including cognitive, physical (including vision and hearing), language, speech and communication, psycho-social, or self-help skills, that is at least at the mean of the child’s age equivalent peers; **and**
3. have been determined by the multidisciplinary team to require the continuation of early intervention services in order to support continuing developmental progress, pursuant to the child’s needs, and provided in an appropriate developmental manner. The type, frequency, and intensity of services will differ from the initial IFSP because of the child’s developmental progress, and may consist of only service coordination, evaluation and assessments.

If the child is re-determined eligible based upon Subsection (c) above, please mark “Annual re-determination/required for progress” under “RESULTS/IMPLICATIONS” found in the “Required Report Format” below.

**Six Month Review**

A periodic review of each child’s IFSP must occur every six months or more frequently if conditions warrant, or if the family requests such a review, to determine if adjustment of the IFSP is needed. Providers are required to submit a direct service report to each individual child’s service coordinator prior to the six month review. This report would be a summary of a provider’s record notes and must be written using the required report format. Providers are not required to address the following sections of the required report format when completing a direct service report for a six month review: 1) F; 2) Results/Implications; 3) I; or 4) J. If a formal assessment is completed for the six month review, the provider is not required to address the following: 1) Results/Implications; 2) I; or 3) J.

## REQUIRED REPORT FORMAT

Name: \_\_\_\_\_ EI #: \_\_\_\_\_

Evaluation/Assessment Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Adjusted Age: \_\_\_\_\_

Evaluation/Assessment: OT \_\_\_\_\_ PT \_\_\_\_\_ DT \_\_\_\_\_ SLP \_\_\_\_\_ SW \_\_\_\_\_ Other \_\_\_\_\_

Evaluator: \_\_\_\_\_ Service Coordinator: \_\_\_\_\_

Child is being observed in: home \_\_\_\_\_ daycare \_\_\_\_\_ clinic \_\_\_\_\_ other \_\_\_\_\_

A.) Diagnosis/Reason for Referral:

B.) Concerns expressed by parents in regard to their child's development:

C.) Medical History/Reports:

D.) Behavioral Observation: (description of child during the assessment)

E.) Clinical Observation: (should address typical/atypical observation)

F.) Tests Conducted

(standardized assessment tools)

	<u>Score</u>	<u>Age Equivalent</u>	<u>Percent of Delay</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

G.) Clinical Narrative of Developmental Domains Evaluated (should address typical/atypical development, specific areas of concern, functional skills & strengths, etc.)

H.) Further assessments recommended: (including assistive technology, family training, health consultation, diagnostic services, nursing, nutrition, psychological, and vision/hearing screening) (please state reason)

**RESULTS/IMPLICATIONS:**

Based on EI criteria, this child may be eligible for Early Intervention Services in the State of Illinois due to: (please check one)

	E01	DHS determined eligible level of delay or greater in one or more areas of development
	E02	diagnosis of qualifying medical condition/listed
	E03	Clinical Judgment that child is experiencing a Department determined eligible level of delay or greater (see I below)
	E04	Clinical Judgment - medical diagnosis unlisted
	E05	Clinical Judgment - at risk due to parent diagnosis DD (developmental disorder) under axis I and axis II of the Diagnostic and Statistical Manual IV (DSM IV)
	E06	Clinical Judgment - at risk due to parent diagnosis SMD (severe mental disorder) under axis I and axis II of the Diagnostic and Statistical Manual IV (DSM IV)
	E11	Clinical Judgment - at risk for developmental delay due to 3 or more qualifying risk factors as stated by DHS.
	E12	Annual re-determination / required for progress ( Check here if child is determined eligible based upon Subsection (c) above. Must address section J below in report).
		Further assessments/evaluations are needed in order to determine eligibility.
		This child has not met the eligibility criteria for Early Intervention services in Illinois.

I.) Justification for Clinical Judgment: (should address the following: 1) reason(s) that child was unable to be appropriately and accurately tested using a formal assessment tool to determine eligibility; **and** 2) observed atypical development that may be causing the child to experience a DHS determined eligible level of delay or greater.)

J.) Justification for Annual Re-determination / Required for Progress: (should address requirements stated in 89 Illinois Administrative Code 500.50(a) and (c).)

(For A through J use additional pages as necessary)

Recommendations for areas that intervention may be needed: (please check all that may apply)

- \_\_\_\_\_ cognitive development
- \_\_\_\_\_ physical development, including vision and hearing
- \_\_\_\_\_ language, speech and communication development
- \_\_\_\_\_ social-emotional development
- \_\_\_\_\_ adaptive self-help skills development

\_\_\_\_\_  
Evaluator Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Phone Number

**NOTES:**

- Bill for evaluation/assessment report writing time using the evaluation/assessment code identified under your credentialed/enrolled profession.
- Bill for the time to write direct service or discharge reports which require no testing procedure using the IFSP Development code identified under your credentialed / enrolled profession. See definition of IFSP development found in the [DEFINITIONS](#) section of this document to determine the types of service that are considered billable under IFSP development procedure codes.
- Early Intervention does not pay a provider to write reports other than those required by Early Intervention for the initial or annual IFSP review, the six month review, transition or discharge.

# NATURAL ENVIRONMENTS REQUIREMENT AND WORKSHEET

Please monitor the Provider Connections website at: [www.wiu.edu/providerconnections](http://www.wiu.edu/providerconnections)  
for policy/procedure changes.

## Natural Environments Requirement

Part C of the Individuals with Disabilities Education Act (IDEA) requires that Early Intervention services be provided in “Natural Environments”. Section 303.18 of Part C defines Natural Environments as **“settings that are natural or normal for the child’s age peers who have no disabilities”**. Therefore, the provision of Early Intervention in natural environments is not just a guiding principle, but is also required by Federal law.

In 2004 IDEA was amended to include changes to the following statement: “The provision of early intervention services for any infant or toddler *with a disability* occurs in a setting other than a natural environment *that is most appropriate, as determined by the parent and the individualized family service plan team*, only when early intervention cannot be achieved satisfactorily for the infant or toddler in a natural environment”. NOTE: Italicized words denote amendments to the IDEA. In addition, the Federal Office for Special Education Programs (OSEP) has had a longstanding interpretation of the IDEA that Early Intervention services must be provided in a natural environment, unless a written justification exists for providing these services in other settings (see 34 CFR 303.344(d)(ii)).

Based upon the above federal regulations, **effective July 1, 2005 all Service Coordinators and providers were required to use the “Natural Environment Justification Worksheet” at the IFSP meeting to justify all services that would not be provided in a child’s most natural learning environments**. Family centered functional outcomes **must** be written **prior** to the determination of service delivery decisions (see definition of functional outcomes). Once the functional outcomes have been written, if it is determined that the outcomes cannot be met in the child’s natural learning environment, the IFSP team must complete the Worksheet.

The Worksheet requires the IFSP team to justify why it was determined that it was not appropriate to provide the service(s) in the natural learning environment. Justification must be based on the needs of the child and the [PRINCIPLES OF EARLY INTERVENTION](#) found within this document and not on any of the following, which are considered unacceptable justification reasons:

- Administrative convenience; and/or
- Fiscal reasons; and/or
- Personnel limitations; and/or
- Parent/therapist preferences; and/or
- Medical needs rather than developmental needs.

In addition, justification must indicate why the recommended setting is necessary to achieve the identified outcome, as well as why no other natural learning environment is appropriate. An IFSP team should always maximize their efforts to support the family within the child’s natural learning environments before contemplating the need for any justification process. Justification for each outcome must include a plan to transition interventions into the natural setting.

## Natural Environments Worksheet

Child's Name:	Date:
---------------	-------

### Natural Environments Developmental Justification

Outcome # :	Service (s):
Environment in which service(s) will be provided:	
Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:	

Outcome # :	Service (s):
Environment in which service(s) will be provided:	
Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:	

Outcome # :	Service (s):
Environment in which service(s) will be provided:	
Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:	



## Natural Environments Developmental Justification Worksheet

Review area	1 (unacceptable)	3 (acceptable)	5 (best practice)
<p>A. Adequate information and evidence is provided to support the rationale that a child's needs and outcomes cannot be achieved in natural settings. <b>NOTE:</b> Outcomes should be based upon the Principals of Early Intervention and must be developmental rather than medical in nature.</p>	<p>The IFSP identifies one or more services that are not in a natural environment for the child and family</p> <p style="text-align: center;"><b>and</b></p> <p>There is no developmental justification or the justification is not based on the needs of the child but appears to be for:</p> <ul style="list-style-type: none"> <li>▪ administrative convenience, <b>and/or</b></li> <li>▪ fiscal reasons, <b>and/or</b></li> <li>▪ personnel limitations, <b>and/or</b></li> <li>▪ parent/therapist preferences and/or</li> <li>▪ medical needs rather than developmental needs.</li> </ul>	<p>The child is receiving <b>most</b> services in natural environments</p> <p style="text-align: center;"><b>and</b></p> <p>When a service is provided in a setting that is not a natural environment, a developmental justification is included in the IFSP that is based on the developmental needs of the child, justifying that the setting is necessary to achieve the outcome.</p>	<p><b>All</b> services are provided in natural environments.</p> <p style="text-align: center;"><b>OR</b></p> <p>The child is receiving <b>most</b> services in natural environments</p> <p style="text-align: center;"><b>AND</b></p> <p>When a service is provided in a setting that is not a natural environment, a developmental justification is included in the IFSP that is based on the developmental needs of the child, justifying that the setting is necessary to achieve the outcome.</p> <p style="text-align: center;"><b>AND</b></p> <p><u>For each service justified there is a written plan included in the justification to transition interventions into a natural environment setting.</u></p>

# DEVELOPMENTAL JUSTIFICATION OF NEED GUIDELINES AND WORKSHEET

Please monitor the Provider Connections website at: [www.wiu.edu/providerconnections](http://www.wiu.edu/providerconnections)  
for policy/procedure changes.

**GUIDELINES/WORKSHEET  
DEVELOPMENTAL JUSTIFICATION OF NEED TO CHANGE FREQUENCY,  
INTENSITY OR LOCATION OF AUTHORIZED SERVICES**

(Effective Date September 1, 2009)

Effective January 1, 2009, Service Coordinators and providers were notified of a new process that required all providers to submit a written justification of need to request a change to an existing IFSP, including changes made at a six month review. In order to ensure that all providers are addressing the [PRINCIPLES OF EARLY INTERVENTION](#) and other important policies, rules, regulations and guidelines that EI is required to function under, **effective September 1, 2009, all providers are required to use the following guidelines and worksheet to develop a written “Developmental Justification of Need”.**

Providers who wish to request an increase or decrease in the frequency or intensity of an authorization or a change in location to an existing authorization will submit a written “Developmental Justification of Need” to the individual child’s Service Coordinator. **Upon receipt of a written “Developmental Justification of Need” that contains all required information found in the following Worksheet, the Service Coordinator will convene an IFSP review meeting.** If changes are requested within the first three (3) months after the development of an IFSP, the original IFSP team must be reconvened and the provider who is recommending the changes must be in attendance. The team must agree that a change from the team’s original recommendation(s) is needed and is in the best interest of the child/family.

If changes are requested more than three (3) months after the development of an IFSP, the child’s current multidisciplinary service team must participate in the IFSP review meeting. The multidisciplinary service team must agree that a change from the team’s original recommendation(s) is needed and is in the best interest of the child.

The written “Developmental Justification of Need” **must** be based upon the [PRINCIPLES OF EARLY INTERVENTION](#) and the policies identified in numbers one (1) through four (4) below and **must address all information requested** in the following Worksheet. **Service Coordinator’s will return all requests to increase or decrease the frequency or intensity of an existing authorization or to change the location of an existing authorization to providers who fail to include all required information requested in the Worksheet.**

Please keep the following policies in mind when developing a written “Developmental Justification of Need”:

1. Early Intervention is Part C of the “Individuals With Disabilities Education Act” and is a **developmental program**. Services are authorized based upon the development of functional outcomes that focus on **child development and family training, education and support** and **must** address a **child’s developmental needs rather than a child’s medical needs**;
2. At the IFSP meeting, family centered functional outcomes **must** be written **prior** to the determination of service delivery decisions, which would include frequency, intensity and duration of authorizations (see definition of functional outcomes);
3. Functional outcomes **must** be based upon the [PRINCIPLES OF EARLY INTERVENTION](#) which are found within the Service Description, Billing Codes and Rates document;

4. Part C requires states to provide services in “Natural Environments”. Under Section 303.18 of Part C, Natural Environments is defined as “settings that are natural or normal for the child’s age peers who have no disabilities”. The Office of Special Education Programs (OSEP) has had a longstanding interpretation of the Individuals With Disabilities Education Act (IDEA) that early intervention services must be provided in a natural environment, unless a written justification exists for providing these services in other settings. **Effective July 1, 2005 all Service Coordinators and providers were required to use the “Natural Environment Justification Worksheet” at the IFSP meeting to justify all services that would not be provided in a child’s most natural learning environments.** (See [ATTACHMENT 2: NATURAL ENVIRONMENTS REQUIREMENT AND WORKSHEET](#) and definition of Natural Environments in [DEFINITIONS](#) section). **Service Coordinators will not authorize services in a non-natural environment without first completing the Natural Environment Justification Worksheet at the IFSP meeting.**

At the end of the IFSP review meeting, if the multidisciplinary team has agreed that a change in the originally recommended frequency/intensity/location of the existing authorization(s) is in the best interest of the child/family, the Service Coordinator will complete the following steps:

- Require that all members of the multidisciplinary team who attended the meeting sign the “Child and Family Connections Justification to Change Frequency/Intensity/Location” form. By signing this form the provider is acknowledging that he/she participated in the IFSP review meeting and agrees that a change from the originally recommended frequency, intensity and/or location is needed and that the change is in the best interest of the child.
- If a provider attends the IFSP review meeting via a phone call, the Service Coordinator will print that providers name on the form and put their (Service Coordinator’s) initials next to the provider’s name. This will verify that the provider attended the meeting via a phone call.
- If a change in location from the natural environment was made, attach the Natural Environment Worksheet that was completed at the IFSP review meeting to the “Child and Family Connections Justification to Change Frequency/Intensity/Location” form at the completion of the meeting.
- Attach the written “Developmental Justification of Need” that was submitted by the provider who requested the change to the “Child and Family Connections Justification to Change Frequency/Intensity/Location” form at the completion of the IFSP review meeting.
- Discontinue the existing authorization(s) and generate a new authorization that reflects the recommended change(s).

**EI PROVIDERS:  
 IFSP CHANGE JUSTIFICATION WORKSHEET FOR DEVELOPMENT OF THE WRITTEN DEVELOPMENTAL JUSTIFICATION OF NEED  
 TO CHANGE FREQUENCY, INTENSITY OR LOCATION OF AUTHORIZED SERVICES**

**Section 1: General Information (required for all changes)**

Name of Provider Requesting Change			Discipline of Provider Requesting Change		
Name of Child's Service Coordinator		Child's Name		EI #	

**Section 2: Current IFSP/Authorization Information (required for all changes)**

IFSP Begin Date	Authorized Frequency	Authorized Intensity	Authorized Location	# of Service Sessions Completed by Provider
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Functional Outcome That Supports Current Authorization:
Current Progress Toward That Outcome:

**Section 3: Change Requested (required for all changes)**

Increase in Frequency or Intensity	Decrease in Frequency or Intensity	Change in Location	Discharge
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**Section 4: Written Developmental Justification to Change Existing Authorization:**

Providers who are requesting an **increase in frequency or intensity or a change of location must address** all questions and provide all explanations/documentation requested in this Section. Providers who are requesting **a decrease in services or who have found the child age appropriate and are recommending that the child be discharged** from services are only required to address the last statement found under Principle #4 in the "Information Required to Justify This Principle" column.

Principles of Early Intervention & Definition of Functional Outcomes & Written Home Activity Program	Information Required to Justify This Principle	Written Justification
1) <b>Principle #1</b> - The primary goal of EI is to support families in promoting their child's optimal development and facilitate the child's participation in family and community activities.	Explain how the proposed change will increase this family's knowledge of child development and help to facilitate the child's participation in this family's daily routines and community activities?	
2) <b>Principle #2</b> - The focus of EI is to encourage the active participation of families in the therapeutic process by imbedding intervention strategies into family routines. It is the parents who provide the real Early Intervention by creatively adapting their child care methods to facilitate the development of their child, while balancing the needs of the rest of their family.	<p>What types of family training, education and support have you provided to this family to encourage their active participation in their child's services?</p> <p>What types of developmental strategies have been imbedded into this family's daily routines?</p>	
3) <b>Principle #3</b> - EI requires a collaborative relationship between families and providers, with equal participation by all those involved in the process. An on-going parent-professional dialogue is needed to develop, implement, monitor and modify therapeutic activities.	<p>Does this family (parent/caregiver) routinely participate in the therapeutic activities as an equal participant? If so, do they participate hands on, observation only, or both?</p> <p>If the family does not actively participate, document the strategies that you have used to encourage active participation. If you have not encouraged active participation in the past, document how you will proceed to work with this family (parent/caregiver) to facilitate participation in all future therapeutic activities.</p> <p>Document the type of existing on-going parent/professional dialogue that you have with this family to determine when therapeutic activities/developmental strategies that have been incorporated into this family's daily routines need to be modified.</p> <p>If you do not currently have on-going parent/professional dialogue with the family, document how you will proceed to work with this family (parent/caregiver) to develop therapeutic activities/developmental strategies to incorporate into this family's daily routines.</p>	

<b>Principles of Early Intervention &amp; Definition of Functional Outcomes &amp; Written Home Activity Program</b>	<b>Information Required to Justify This Principle</b>	<b>Written Justification</b>
<p>5) <b>Principle #5</b> - Intervention shall be integrated into a comprehensive plan that encourages transdisciplinary activities and avoids unnecessary duplication of services. The plan shall be built around family routines, with written home activity programs to encourage family participation in therapeutic activities on a daily basis.</p> <p><b>Definition of Written Home Activity Program</b> - A written home activity program is a document that <b>is written in the home or other place of service, with the input of the parent/caregiver during a direct service session.</b> It should identify developmental strategies to meet functional outcomes that are important to the family and that support the family in developing or refining their ability to facilitate their child’s active involvement in his or her community and family. This document should be shared with all members of the IFSP service team and the parent/caregiver. Time to create a written home activity program with the parent/caregiver is considered to be family training, education and support time that is billable as direct service time only.</p>	<p>Will the proposed increase in frequency or intensity or change in location be a duplication of services that the child is currently receiving?</p> <p>Is there an existing home activity program in place that you developed with the parent/caregiver?</p> <p>If so, was the existing program built around family routines and does it encourage family participation in therapeutic activities on a daily basis?</p> <p>Have the family and other members of the child’s IFSP team implemented that program?</p> <p>Would a change to the existing home activity program be more appropriate rather than an increase in frequency/intensity or change in location?</p> <p>If an increase in frequency/intensity or a change in location is still required, explain how the recommended increase or change will impact/change the existing home activity program that is currently in place.</p>	
<p>6) <b>Principle #6</b> - Intervention should be monitored periodically to assure that the strategies implemented are successful in achieving outcomes.</p>	<p>Explain how you will work with this family/caregiver to monitor and make changes to the “written home activity program” when needed. NOTE: Please refer back to Principle #3.</p>	

# USE OF ASSOCIATE LEVEL PROVIDERS

Please monitor the Provider Connections website at: [www.wiu.edu/providerconnections](http://www.wiu.edu/providerconnections) for policy/procedure changes.



## USE OF ASSOCIATE LEVEL PROVIDERS

### POLICY:

In order to enlist the widest pool of qualified service providers, Early Intervention supports the appropriate use of credentialed, non-enrolled associate level providers who function under the following guidelines and whose services are billed for by their credentialed, enrolled supervisor.

The following are the minimum requirements for Specialist supervision of Associate Level Providers for Early Intervention services. No individual is exempt from compliance with any and all pertinent professional standards governing supervision in the individual's service area. Where the individuals' professional standards require supervision beyond what is set forth below, he/she shall meet such additional standards as well.

### GUIDELINES:

Each credentialed associate level provider shall be supervised by a Specialist credentialed/enrolled in the same discipline. (Please see [ATTACHMENT 5: REQUIREMENTS FOR PROFESSIONAL AND ASSOCIATE LEVEL EARLY INTERVENTION CREDENTIALING AND ENROLLMENT TO BILL.](#))

1. The credentialed/enrolled Specialist shall:
  - a) evaluate/assess the child, develop the plan for intervention services required to accomplish Service Plan outcomes and submit evaluation/assessment report prior to Service Plan development/update/review;
  - b) instruct the associate level provider about the intervention services to be provided;
  - c) reassess the child as required by the child's Service Plan and by licensure requirements for the enrolled specialist or associate level staff at least prior to each Service Plan update/review;
  - d) revise the intervention activities as needed;
  - e) review and approve all methods and materials selected to implement the intervention plan;
  - f) conduct direct supervision during associate provided client services at a minimum of once each month for each child served. **NOTE:** Such supervision must occur **for one entire session each month** and consist of the following types of review: 1) observation of direct hands on service to the child; 2) observation of interaction between the associate level provider and the child; 3) observation of interaction between the associate level provider and the parent/caregiver; 4) review of child's progress or lack thereof; 5) discussion with parent/caregiver about family issues, priorities and concerns; 6) review of service provision plan developed by supervisor for use by associate level provider to meet functional outcomes identified in each child's IFSP to determine if the plan requires modifications; and 7) other as required by discipline specific practice acts.
  - g) submit a direct service report prior to each Service Plan update/review and more often if the child's progress/lack of progress warrants;
  - h) submit bills for services provided by the associate level provider;
  - i) participate in Service Plan development/update/review; and
  - j) follow supervision requirements as set forth in his/her licensure and/or other pertinent certification standards.

2. The credentialed associate level provider shall:
  - a) provide services only as instructed by the supervising Specialist;
  - b) record all early intervention services provided, including time in/time out;
  - c) report all changes in a child's condition to the supervising specialist;
  - d) check authorization to make sure that the associate level provider is identified in the comment field as the provider of direct service under the supervisor; and
  - e) if the associate's name does not appear in the comment field of the authorization, contact the child's service coordinator to correct the oversight.
  
3. The credentialed associate level Speech-Language Pathologist **in his/her supervised professional experience** shall:
  - a) provide services only as instructed by the supervising Specialist who is credentialed/ enrolled in the same discipline;
  - b) provide services consistent with the "Illinois Speech-Language Pathology and Audiology Practice Act" (225 ILCS 110/1 et. Seq.) that includes evaluation / assessment and service plan development; and
  - c) be exempt from the restriction in (1)(a) that does not allow the associate to provide evaluation / assessment or service plan development and be exempt from the requirement in (1)(f) that requires supervision during client services at a minimum of once each month. Otherwise the associate level provider in his/her supervised professional experience shall follow all other guidelines above.

**NOTES:**

- Number 3 above **only applies to Associate Level Providers who have a masters degree in speech-language pathology and are in their CFY year.**
- Associate Level Providers who are licensed as Speech-Language Pathology Assistants **must** follow the guidelines as listed in (1) and (2) above with **no exceptions.**
- Supervisory time is non-billable time and is considered to be administrative time.
- Bill for Evaluation/Assessment report writing time using the evaluation/assessment code identified on the authorization. Bill for time to write direct service reports, which require no testing procedure, using IFSP Development codes.

**REQUIREMENTS FOR  
PROFESSIONAL AND  
ASSOCIATE LEVEL  
EARLY INTERVENTION  
CREDENTIALING AND ENROLLMENT  
TO BILL**

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**Requirements for Professional and Associate Level  
Early Intervention (EI) Credentialing and Enrollment to Bill**

Nothing in this section shall exempt any individual from compliance with any and all State licensing requirements and/or supervisory requirements pertinent to the individual's delivery of services.

**EI SERVICE**

**QUALIFIED STAFF**

Assistive Technology

Durable medical equipment and supplies; providers may enroll to bill. No credential required.

Audiology, Aural  
Rehabilitation/Other Related  
Services

Audiologists with a current license in the state where they provide services to Illinois children may enroll to bill. Audiologists are not required to obtain a credential. (Provider is automatically enrolled under assistive technology and aural rehabilitation categories.)

Speech/Language Pathologists with a current license in the state where they provide services to Illinois children may apply for an EI Specialist: Licensed Speech/Language Pathologist credential and enroll to bill for aural rehabilitation services. (Provider is automatically enrolled under aural rehabilitation and speech therapy categories.)

Individuals with a masters in speech-language pathology who are participating in a supervised professional experience and hold a temporary license in the state where they provide services to Illinois children may apply for an EI Associate: Speech/Language Pathologist in supervised professional experience credential. Associate services are billed under the enrolled supervisor's name.

Individuals with a current Special Education degree for Deaf and Hard of Hearing may apply for an EI Specialist: Developmental Therapist/Hearing credential and enroll to bill for aural rehabilitation services. May also provide Developmental Therapy Services. (Provider is automatically enrolled under aural rehabilitation category.)

Clinical Assessment,  
Counseling, and Other  
Therapeutic Services

Clinical Psychologists with a current license in the state where they provide services to Illinois children may apply for an EI Specialist: Licensed Clinical Psychologist credential and enroll to bill.

Clinical Professional Counselors with a current license in the state where they provide services to Illinois children may apply for an EI Specialist: Licensed Clinical Professional Counselor credential and enroll to bill.

Clinical Assessment,  
Counseling, and Other  
Therapeutic Services – cont.

Marriage and Family Therapists with a current license in the state where they provide services to Illinois children may apply for an EI Specialist: Licensed Marriage and Family Therapist credential and enroll to bill.

Clinical Social Workers with a current license in the state where they provide services to Illinois children may apply for an EI Specialist: Licensed Clinical Social Worker credential and enroll to bill.

Behavior Analysts with current national certification as a Board Certified Behavior Analyst from the Behavior Analyst Certification Board may apply for an EI Specialist: Behavior Analyst credential and enroll to bill.

Unlicensed individuals employed by school districts as School Psychologists who will only be providing services through their school employment may apply for an EI Specialist: School Psychologist credential.

Graduate students in clinical psychology or clinical counseling who submit a letter from the graduate school verifying that they are providing psychological or clinical counseling services in a supervised internship setting in order to complete a comprehensive, culminating training experience prior to granting of a graduate degree in psychology may apply for an EI Associate: Psychology/Counseling Intern credential. Associate services are billed under the enrolled supervisor's name.

Developmental Therapy

Individuals with an EI Specialist Developmental Therapist credential on January 1, 2004 or who are applying for an EI Specialist Developmental Therapist credential prior to January 1, 2004 must have (1) a minimum of Teacher Endorsement in Early Childhood Education (ECE) or Special Education or bachelors degree in ECE, Early Childhood Special Education, Special Education, or human service field with one year of experience working hands on with children birth to 3 with developmental disabilities (Persons with a degree in a human service field must submit proof of training on the use of a formal assessment tool that would allow the provider to perform global evaluations/assessments.); or (2) a current license in art, music, recreation, or other type of therapy, rehabilitative or habilitative in nature, in the state where they provide services to Illinois children may apply for credential renewal or, prior to January 1, 2004, may apply for an EI Specialist Developmental Therapist credential and enroll to bill.

Developmental Therapy – cont. Individuals who do not hold an EI Specialist Developmental Therapist credential on January 1, 2004 must have a bachelors degree or higher in Early Childhood Education, Early Childhood Special Education, Special Education, Special Education: Deaf/Hard of Hearing or Blind/Partially Sighted, Child Development/Family Studies, Early Intervention, Elementary Education, Developmental Psychology, or Social Work; or with a bachelors degree or higher and a full specialist credential in the Early Intervention program; or a current license in art, music, recreation, or other type of therapy, rehabilitative or habilitative in nature, in the state where they provide services to Illinois children; and can document the completion of educational experiences as approved by the DHS that include at least 2 semester college hours or the equivalent (30 clock hours or CEU credit hours) in each of the following EI core knowledge content areas: the Development of Young Children; Typical and Atypical; Working with Families of Young Children with Disabilities; Intervention Strategies for Young Children with Special Needs; and Assessment of Young Children with Special Needs; and can submit proof of training on the use of a formal assessment tool that would allow the provider to perform global evaluations/assessments may apply for an EI Specialist: Developmental Therapist credential and enroll to bill.

An emergency waiver of educational requirements for developmental therapists may be applied for and must be accompanied by the recommendation of a regional intake entity manager documenting the need for developmental therapy services in the service area. A bachelors degree or higher is required. If approved, the resulting temporary credential will be awarded for a maximum of 18 months. A training plan toward qualification for full credential status must be submitted with the emergency waiver application.

Individuals with a Special Education degree for Deaf and Hard of Hearing may apply for an EI Specialist: Developmental Therapist/Hearing credential and enroll to bill. They may also provide aural rehabilitation services based on their qualifications and experience. (Provider is automatically enrolled under aural rehabilitation category.)

Individuals with (1) a bachelors degree or higher in Orientation and Mobility or (2) a Special Education degree for Blind and Partially Seeing may apply for an EI Specialist: Developmental Therapist/Vision credential and enroll to bill. They may provide Developmental and/or Vision Therapy services related to visual functioning based on their qualifications and experience. (Provider is automatically enrolled under the vision category.)

Developmental Therapy – cont. Individuals with an associates degree in early childhood education or child development who have an EI Associate: Developmental Therapy Assistant temporary credential on July 1, 2003 may apply for full associate credential status if additional training requirements are met. No other new temporary or full associate credentials for Developmental Therapy Assistants will be issued. Individuals who have an associate credential will be allowed to submit an application to have their credential renewed no more than two times after July 1, 2003. Associate services are billed under the enrolled supervisor's name.

Evaluation/Assessment Individuals with a current Early Intervention Specialist credential and who also meet all the following requirements may apply for an Evaluation/Assessment credential:

Documentation of a minimum of three years (full time equivalent) pediatric experience within the Early Intervention Specialist credentialed discipline is required with no less than 20% of that experience related to infants and toddlers between birth and three years of age or the equivalent, with a minimum of one year (full time equivalent) pediatric experience within the Early Intervention Specialist credentialed discipline with no less than 60% of that experience related to infants and toddlers;

Documentation of a minimum of six months pediatric post degree supervision;

Demonstration of competency in using and interpreting a variety of approved assessment tools related to his/her discipline by participating in evaluator specific training;

Demonstration of past work as a member of a service team and agreement to work with the service coordinator, other evaluators, and the family as an effective team member;

Agreement to participate in IFSP meetings as specified in this Part;

Agreement to perform evaluation/assessments and present recommendations thereon, that are consistent with DHS early intervention philosophy and best practices, and to provide adequate justification for recommendations based thereon;

Agreement to participate in routine quality assurance and/or early intervention monitoring activities conducted by the DHS or its Designee, or the U.S. Department of Education, Office of Special Education Programs;

Evaluation/Assessment – cont.	<p>Agreement to comply with all applicable federal and/or State laws, rules, regulations, policies, provider agreement and procedure and guidelines;</p> <p>Documentation of attendance at Evaluation/Assessment training as required and provided by the DHS.</p> <p>The expiration date of an Evaluation/Assessment credential will coincide with the Early Intervention Specialist discipline specific credential. Renewal of the Evaluation/Assessment credential is contingent on the successful renewal of the Early Intervention Specialist discipline specific credential.</p>
Family Training and Support	<p>Individuals with a high school diploma or equivalent who are the parent or guardian of a child with special needs and are employed by an entity such as an agency or hospital that provides early intervention services as a Parent Liaison may apply for an EI Parent Liaison credential and enroll to bill. Completion of Parent Liaison Training is required within 90 days after being issued a temporary credential for full credential status and continued enrollment.</p> <p>Individuals who are bilingual or an interpreter for the deaf may enroll to bill as an interpreter. Upon application for enrollment, the bilingual applicant must identify the languages for which he/she is applying to interpret and/or translate and document completion of Early Intervention Systems Training as defined in Section 500.60(f) and Early Intervention approved training for bilingual interpreter/translators and oral and/or written language proficiency using approved testing procedures. By September 1, 2008, all enrolled bilingual interpreters must have documented completion of Early Intervention approved training for bilingual interpreters/translators and oral and/or written language proficiency using approved testing procedures to maintain enrollment. Interpreters for the deaf must meet the requirements set forth in 225 ILCS 442 and document completion of Early Intervention Systems Training as defined in Section 500.60(f).</p> <p>Deaf adults who have been certified by Hearing and Vision Connections as a language mentor for the deaf may enroll to bill. Language mentors are not required to obtain a credential</p>
Health Consultation	<p>Physicians with a current license in the state where they provide services to Illinois children may enroll to bill. Physicians are not required to obtain a credential.</p>
<p>Medical Services (Diagnostic/Evaluation Purposes Only)</p>	<p>Physicians with a current license in the state where they provide services to Illinois children may enroll to bill. Physicians are not required to obtain a credential.</p>



Medical Services (Diagnostic/Evaluation Purposes Only) – cont.	Individuals on the physician's service team should refer to the service area appropriate to their discipline for credentialing requirements.
Nursing	Registered Nurses with a current license in the state where they provide services to Illinois children may apply for an EI Specialist: Licensed Registered Nurse credential and enroll to bill. (Provider is automatically enrolled under nutrition category.)
Nutrition	Licensed Dietitian Nutritionists with a current license in the state where they provide services to Illinois children may apply for an EI Specialist: Licensed Dietitian credential and enroll to bill.
Occupational Therapy	Registered Nurses with a current license in the state where they provide services to Illinois children may apply for an EI Specialist: Licensed Registered Nurse credential and enroll to bill.
Occupational Therapy	Occupational Therapists with a current license in the state where they provide services to Illinois children may apply for an EI Specialist: Licensed Occupational Therapist credential and enroll to bill.
Occupational Therapy	Certified Occupational Therapy Assistants with a current license in the state where they provide services to Illinois children may apply for an EI Associate: Licensed Certified Occupational Therapy Assistant credential. Associate services are billed under the enrolled supervisor's name.
Physical Therapy	Physical Therapists with a current license in the state where they provide Part C EI service to Illinois children may apply for an EI Specialist: Licensed Physical Therapist credential and enroll to bill.
Physical Therapy	Physical Therapist Assistants with a current license in the state where they provide services to Illinois children may apply for an EI Associate: Licensed Physical Therapist Assistant credential. Associate services are billed under the enrolled supervisor's name.
Service Coordination	Individuals with an EI Service Coordination credential on January 1, 2003 and: (1) an EI Specialist credential of any type, (2) a bachelors degree or higher in human services, behavioral science, social science or health related field, (3) a current license as a Registered Nurse, (4) current employment as a service coordinator in a Family

Service Coordination – cont.

Case Management Agency, or (5) an associates degree in human services, education, behavioral science, social science, or health related field plus 2 years of experience working with children birth to 5 to provide intervention services or service coordination in a community agency serving children and families, may apply for renewal of their credential.

Individuals who do not hold an EI Service Coordination credential on January 1, 2003 and with a bachelors degree or higher in human services, behavioral science, social science or health related field or a current license as a Registered Nurse may apply for an EI Service Coordination Credential and enroll as an employee of a Child and Family Connections office. Additional training is required within 90 days after being issued a temporary credential for full credential status and continued enrollment.

Social Services

Social Workers with a current license in the state where they provide services to Illinois children may apply for an EI Specialist: Licensed Social Worker credential and enroll to bill.

Professional Counselors with a current license in the state where they provide services to Illinois children may apply for an EI Specialist: Licensed Professional Counselor credential and enroll to bill.

Unlicensed individuals employed by school districts as School Social Workers who will only be providing services through their school employment may apply for an EI Specialist: School Social Worker credential and enroll to bill.

Graduate students in social work who submit a letter from their graduate school verifying that they are providing social work services in a supervised internship setting in order to complete a comprehensive, culminating training experience prior to granting of a graduate degree in social work may apply for an EI Associate: Social Work Intern credential. Associate services are billed under the enrolled supervisor's name.

Speech Therapy

Speech/Language Pathologists with a current license in the state where they provide services to Illinois children may apply for an EI Specialist: Licensed Speech/Language Pathologist credential and enroll to bill. (Provider is automatically enrolled under aural rehabilitation and speech therapy categories.)

Speech Therapy – cont.

Individuals with a masters in speech-language pathology who are participating in a supervised professional experience and hold a temporary license in the state where they provide services to Illinois children may apply for an EI Associate: Speech/Language Pathologist in supervised professional experience credential. Associate services are billed under the enrolled supervisor's name.

Speech/Language Pathology Assistants with a current license in the state where they provide services to Illinois children may apply for an EI Associate: Speech/Language Therapy Assistant credential. Associate services are billed under the enrolled supervisor's name.

Transportation

Individuals with an appropriate vehicle registration number, insurance and current driver's license may enroll to bill. Not required to obtain a credential.

Vision

Optometrists or Ophthalmologists with a current license in the state where they provide services to Illinois children may enroll to bill. Not required to obtain a credential.

Individuals with (1) a bachelors degree or higher in Orientation and Mobility or (2) a Special Education degree for Blind and Partially Seeing may apply for an EI Specialist: Developmental Therapist/Vision credential and enroll to bill. They may provide Developmental and/or Vision services related to visual functioning based on their qualification and experience.

(Source: Amended at 32 Ill. Reg. 2161, effective January 23, 2008)

# PROCEDURE TO ORDER EYEGLASSES

Please monitor the Provider Connections website at: [www.wiu.edu/providerconnections](http://www.wiu.edu/providerconnections)  
for policy/procedure changes.

## PROCEDURE TO ORDER EYEGLASSES

### Child and Family Connections

All families enter the system through one of 25 statewide intake points which are known as "Child and Family Connections" (CFCs). Upon determination of eligibility, the family will be assigned a CFC Service Coordinator for direct service. If it is determined that a child needs an Optometric examination, the referral will come to the provider from the child/family's Service Coordinator at the CFC. All services are pre-authorized. If the provider accepts the referral, the Service Coordinator will generate an authorization for vision services. The provider will receive the authorization by mail, fax or both. The authorization will allow the provider to bill the Central Billing Office (CBO) for the following:

- Optometric examination
- Dispensing fee if it was determined that a child requires eyeglasses.

### Providers

Eyeglasses for eligible children are purchased through the Illinois Department of Corrections (IDOC). Upon conformation of enrollment the provider should contact IDOC at 800/523-1487 to request the frame kit and optical prescription order forms. The provider is responsible for paying the deposit to IDOC for the frame kit. If the provider determines that a child needs eyeglasses the provider must use the following procedure to place the order.

- Show the frame kit to the family and help them choose a frame for their child.
- Complete the optical prescription order form and attach the order form to the claim form.
- Submit the claim form, along with the order form to the CBO.
- The CBO will generate the authorization for eyeglasses and fax/mail the authorization and order form to IDOC.
- IDOC will make the eyeglasses and send them directly to the provider to fit the child.
- The CBO will send a copy of the IDOC authorization and order form to the CFC to update the child's permanent record.

Early Intervention will pay for the following:

- Frames chosen from the Early Intervention frame kit
- Lenses - single vision - spheres and compounds (either plastic or glass)
- Special lenses (myodisc, lenticular nonaspheric, lenticular aspheric, and not otherwise classified)
- Bifocals - spheres and compounds
- Single vision polycarbonate lenses (medically required)
- Bifocal polycarbonate lenses (medically required)
- Photogray (medically required)

If you have questions about the process to order eyeglasses, please contact the Bureau of Early Intervention at 217/782-1981.

# NON-BILLABLE ACTIVITIES

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## NON - BILLABLE ACTIVITIES

- Unauthorized services - All early Intervention services are pre-authorized. Providers should never provide services without an authorization in hand. Services provided prior to receipt of the authorization are not guaranteed for payment. Services provided prior to the begin date and after the end date of the authorization are considered non-authorized services and will not be paid by the Early Intervention CBO.
- Weekly or daily preparatory activities for direct service sessions. This is considered to be administrative time that is built into the rate.
- Preparing claims to submit to the Central Billing Office (CBO);
- Client no shows;
- Provider no shows;
- Partial service sessions. Providers should never bill for a full service session if they did not actually provide a full service session. Only bill for the time actually spent with the child/family.
- Development of "Picture Communication Programs". A therapist can provide family training, education and support services to **teach a family how to develop a picture communication program during a direct service session only**. Early Intervention does **not** pay for therapists to develop picture communication programs for a child/family;
- Auditory Integration Training (AIT) and other Listening Programs;
- Time spent on the phone with a parent who feels the need to talk about non Early Intervention related issues (family may need to be referred to a counselor to deal with social-emotional issues);
- Services provided via the telephone. Early Intervention does not pay for therapists to provide services to a child/family via the telephone. The exception is for Counselors who are charged with "identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from early intervention services";
- Time spent helping the family to identify/access other services/resources that Early Intervention does not pay for (ex., housing, SSI). This service falls under the role/responsibility of the service coordinator and/or a Counselor. Notify the service coordinator of the family's needs;
- Services over the frequency/intensity that has been identified as a need in the child's Service Plan. If service needs require an increase in time over the authorized frequency/intensity identified on the Service Plan, adjustments must be made to the Service Plan and authorization prior to billing;
- Services that fall within the frequency/intensity identified on a child's Plan, but were never documented or provided;
- Time to attend a medical appointment with the family;
- Time to collect medical documents or other written medical information from physicians, hospitals, nurses, etc. This is the responsibility of the service coordinator.
- Time to attend an appointment with another Early Intervention provider unless you are the interpreter for the provider/family or co-treatment has been identified as a need and has been written into the child's service plan;
- Verbal interpretation for non Early Intervention services;

- Written translation of non Early Intervention documents such as SSI applications, WIC applications, Medicaid applications, car seat applications, medical records, insurance explanation of benefits, recipes, newsletters, or any other type of document that is not considered an EI document. Examples of EI documents include the IFSP, EI evaluation reports and letters to the family from the service coordinator or the provider;
- Clerical duties such as scheduling/canceling appointments and notifying the provider of such, (the exception to this rule are services provided by an interpreter) accessing voice mail, leaving voice mails messages, etc.;
- For Interpreters, time to relay information from a therapist via a phone call to a family other than scheduling information. Calls to families to discuss issues and concerns on behalf of the therapist are not allowable services. Therapists should speak to the family/caregiver about any issues or concerns they might have during direct service sessions. For service coordinators, interpreters may speak to the family about other issues if the service coordinator is present via the phone (conference call) or in person only. The responsibility of the interpreter is to simply interpret the words of the Service Coordinator to the parent/caregiver and the parent's /caregiver's words back to the Service Coordinator.
- Transporting the family to a medical service. Early Intervention pays for authorized transportation services, by enrolled transportation providers only, to and from authorized Early Intervention Services only;
- For Transportation providers: Non loaded mileage - Transportation procedure codes can only be billed for loaded mileage. Loaded mileage means that the child is in the vehicle and is being transported to or from a Early Intervention service;
- For Transportation providers: Employee attendants – EI pays for Non-employee attendants only;
- Lekotek services;
- Lunch/snack time;
- Nap time;
- Loading a child into a vehicle to transport;
- Rounding up units of service (ex., provided 50 minutes of service but billed for 60 minutes.);
- Time spent to read an article that will be discussed at an agency staff meeting;
- Attendance at an agency staff meeting - Early Intervention only pays for attendance at IFSP meetings, six month IFSP reviews or more frequent reviews called by the service coordinator if required, transition meetings, child outcome meetings as a member of a child's service team which has been identified on a child's Plan, and IEP meetings that occur prior to a child's third birthday;
- Supervisory Time;
- Provider travel time to or from an offsite location;
- Extended warranties for assistive technology equipment and devices; and
- Anything not listed as a billable service in the document entitled "Early Intervention Service Descriptions, Billing Codes and Rates.



# APPROVED ASSESSMENT INSTRUMENTS

Please monitor the Provider Connections website at: [www.wiu.edu/providerconnections](http://www.wiu.edu/providerconnections)  
for policy/procedure changes.

## APPROVED ASSESSMENT INSTRUMENTS

Developmental Area/ Test Name	Discipline(s)
<p><b><u>Global</u></b></p> <ul style="list-style-type: none"> <li>◆ Assessment Evaluation &amp; Programming System (AEPS)</li> <li>◆ Alpen-Boll Developmental Profile II</li> <li>◆ Batelle Developmental Inventory</li> <li>◆ Carolina Curriculum for Infants and Toddlers</li> <li>◆ Child Developmental Inventory (CDI)</li> <li>◆ Early Learning Accomplishment Profile (ELAP)</li> <li>◆ Infant Development Inventory (IDI)</li> <li>◆ INSITE (for visually impaired)</li> <li>◆ Hawaii Early Learning Profile (HELP)</li> <li>◆ Infant Toddler Developmental Profile (IDA)</li> <li>◆ Mullen Scales of Early Learning (MSEL)</li> <li>◆ Reynell-Zinkin Scales: Developmental Scales for Young Handicapped Children</li> <li>◆ Transdisciplinary Play Based Assessment (TPBA)</li> </ul>	<p>A professional with training and credentials and meeting the requirements specified by the particular test instrument</p>
<p><b><u>Cognitive</u></b></p> <ul style="list-style-type: none"> <li>◆ Bayley Scales of Infant Development-Mental</li> <li>◆ Functional Emotional Assessment Scales (FEAS)</li> <li>◆ Infant Toddler Sensory Profile</li> <li>◆ Pediatric Evaluation of Disability Inventory (PEDI)</li> <li>◆ Test of Sensory Functioning in Infants</li> <li>◆ Vineland Adaptive Behavior Scales (VABS)</li> </ul>	<p>A professional with training and credentials and meeting the requirements specified by the particular test instrument</p>
<p><b><u>Motor</u></b></p> <ul style="list-style-type: none"> <li>◆ Alberta Infant Motor Scale</li> <li>◆ Bayley Scales of Infant Development- Motor</li> <li>◆ Erhardt Developmental Test of Prehension</li> <li>◆ Gross Motor Functional Measures (must be used in combination with a tool that provides age equivalents or % delay)</li> <li>◆ Peabody Developmental/ Motor Test 2</li> <li>◆ Test of Infant Motor Performance (TIMP)</li> <li>◆ TIME: Miller</li> </ul>	<p>A professional with training and credentials and meeting the requirements specified by the particular test instrument</p>
<p><b><u>Adaptive</u></b></p> <ul style="list-style-type: none"> <li>◆ Early Coping Inventory</li> <li>◆ Functional Emotional Assessment Scales (FEAS)</li> <li>◆ Functional Independence Measures (WEE FIMS)</li> <li>◆ Infant Toddler Sensory Profile</li> <li>◆ Pediatric Evaluation of Disability Inventory (PEDI)</li> <li>◆ Test of Sensory Functioning in Infants</li> <li>◆ Vineland Adaptive Behavior Scales</li> </ul>	<p>A professional with training and credentials and meeting the requirements specified by the particular test instrument</p>

Developmental Area/ Test Name	Discipline(s)
<p><b><u>Communication</u></b></p> <ul style="list-style-type: none"> <li>◆ Callier-Azusa Scale</li> <li>◆ Communication &amp; Symbolic Behavior Scales (CSBS) (must use all 3 portions: Infant Toddler Checklist, Caregiver Questionnaire, &amp; Behavioral Sample)</li> <li>◆ Early Language Milestone Scales (ELM-2)</li> <li>◆ McCarthy Communicative Developmental Inventory</li> <li>◆ Non-Speech Test</li> <li>◆ Pre-School Language Scale (PLS 3 or 4)</li> <li>◆ Receptive Expressive Emergent Language Scale (REEL)</li> <li>◆ Reynell Developmental Language Scales-American Version</li> <li>◆ Rosetti Infant Toddler Language Scale</li> <li>◆ Sequenced Inventory of Communication Development (SICD)</li> <li>◆ SKI-HI Learning Development Scales (Hearing Impaired 0-3)</li> </ul> <p><b><u>Articulation</u></b> (must be used in combination with one of the approved communication tools for evaluation &amp; assessment)</p> <ul style="list-style-type: none"> <li>◆ Assessment of Phonological Processes-R (English &amp; Spanish)</li> <li>◆ Goldman-Fristoe Test of Articulation</li> <li>◆ Hodson Phonological Screening</li> <li>◆ Paden Phonological Screening</li> <li>◆ Spanish Articulation Measure (SPAM)</li> </ul>	<p>A professional with training and credentials and meeting the requirements specified by the particular test instrument</p>
<p><b><u>Social Emotional</u></b></p> <ul style="list-style-type: none"> <li>◆ Achenbach Child Behavior Checklist</li> <li>◆ Carey Temperment Scales (must be used with tool that provides age equivalents or % delay)</li> <li>◆ Early Coping Inventory</li> <li>◆ Functional Emotional Assessment Scale (FEAS)</li> <li>◆ Infant-Toddler Social and Emotional Assessment (ITSEA)</li> <li>◆ Vineland Social Emotional Early Childhood Scale</li> </ul>	<p>A professional with training and credentials and meeting the requirements specified by the particular test instrument</p>
<p><b><u>Hearing</u></b></p> <ul style="list-style-type: none"> <li>◆ Conditioned Play Audiometry (CPA)</li> <li>◆ Otoacoustic Emissions (OAE)</li> <li>◆ Speech Awareness Thresholds (SAT)</li> <li>◆ Speech Discrimination Test</li> <li>◆ Visual Reinforcement Audiometry (VRA)</li> </ul>	<p>A professional with training and credentials and meeting the requirements specified by the particular test instrument</p>
<p><b><u>Vision</u></b></p> <ul style="list-style-type: none"> <li>◆ Erhardt Developmental Test of Vision</li> <li>◆ The Oregon Project Global Assessment Tool (assessment only)</li> </ul>	<p>A professional with training and credentials and meeting the requirements specified by the particular test instrument</p>

Developmental Area/ Test Name	Discipline(s)
<u>Other</u> ♦ Autism Diagnostic Observation Scale (assessment)	A professional with training and credentials and meeting the requirements specified by the particular test instrument

**NOTE:** Providers may use tools that are not identified on this list if the tool meets all of the following criteria:

- 1) The tool is **listed** in the Mental Measurement Yearbook Series;
- 2) The tool is **nationally distributed**;
- 3) The tool is **age appropriate**;
- 4) The tool has been **formally validated**;
- 5) The tool is **individually administered**; and
- 6) The tool has **been approved for use** by the Illinois Department of Healthcare and Family Services (HFS).

It is the responsibility of the provider to present proof of the above criteria to the DHS Bureau of Early Intervention for HFS review and approval. The Mental Measurement Yearbook Series can be found at the Early Childhood Intervention Clearinghouse, many local libraries and by visiting the website at [www.unl.edu/buros](http://www.unl.edu/buros). There is a cost to access some of the materials found on this website.

The list of approved tools can also be found on the Early Intervention website(s). All new tools will be added to this list upon approval of HFS. Do not use a new tool until you receive notification from the Bureau of EI that the tool submitted for review has been approved.

# **EARLY INTERVENTION PUBLIC AND PRIVATE INSURANCE USE DETERMINATION GUIDELINES**

Please monitor the Provider Connections website at: [www.wiu.edu/providerconnections](http://www.wiu.edu/providerconnections)  
for policy/procedure changes.

## PUBLIC AND PRIVATE INSURANCE USE DETERMINATION GUIDELINES

### General:

Families whose children are enrolled under private insurance plans are required to use their benefits to assist in meeting the costs of covered Early Intervention (EI) services and Assistive Technology devices unless an insurance exemption or pre-billing waiver has been approved prior to services being rendered. **Insurance exemptions and pre-billing waivers cannot be backdated** and only cover dates of service **after** the approval date.

A provider must complete and document the results of their verification of benefits when receiving a referral. A provider must contact the insurance company to obtain a detailed verification of benefits before accepting the referral. If the provider does not meet the mandates of the insurance policy, such as enrollment, etc., the provider must give the referral back to the Child & Family Connections (CFC). If a provider feels an Exemption or Pre-billing Waiver is necessary but one has not already been requested and/or issued, the provider must contact the CFC office immediately. This contact with the CFC must occur prior to rendering services.

### Services Billable to Insurance:

- Assistive Technology (Durable Medical Equipment and Supplies)
- Aural Rehabilitation Services
- Health Services
- Nursing Services
- Nutrition Services
- Occupational Therapy
- Physical Therapy
- Psychology and Other Counseling Services
- Social Work and Other Counseling Services
- Speech Therapy Services
- Vision Services

### Responsibilities of the CFC:

The CFC will complete the following steps to document insurance coverage in the Cornerstone system for authorization and billing purposes.

- 1) Assist the family in completion of the Insurance Affidavit, Assignment and Release form.
- 2) If the child has private health insurance **ONLY**, obtain a copy of the current insurance card and enter "BILL INSURANCE FIRST".
- 3) If the child has public insurance (AllKids) **ONLY**, enter "NO PRIVATE INSURANCE".
- 4) If the child has both public and private health insurance, enter "BILL INSURANCE FIRST".
- 5) If the child does not have public and/or private health insurance, enter "NO PRIVATE INSURANCE".
- 6) If the child's insurance is provided through the Illinois Comprehensive Health Insurance Program (CHIP), enter "BILL INSURANCE FIRST".
  - a. A Family enrolled in the CHIP program automatically qualifies for an insurance exemption. However, the Service Coordinator must still submit insurance documentation to the CBO for verification.
  - b. Upon receipt of verification that the family is enrolled in the CHIP program, the CBO **will issue a pre-approved** insurance exemption to the CFC.

- 7) The CFC will forward insurance documentation to the CBO for a **limited** benefit verification in order to help the CFC determine the appropriate service provider based on insurance company restrictions and requirements. **NOTE:** Information obtained by the CBO is limited and **should not** be used by providers in place of verifying benefits for their own billing and service provision purposes.
- 8) If an Insurance Exemption Request form or Pre-Billing Insurance Waiver Request form has not previously been submitted or determined to be necessary by the CBO, upon receipt of the results of the CBO Insurance Benefit Verification form from the CBO, the CFC will review the form closely to determine whether a pre-billing waiver or exemption might apply and react accordingly.

**Responsibilities of the CBO:**

The CBO will complete the following steps to process a limited insurance benefits verification in order to assist the CFC in the process of authorizations and provider choice.

- 1) The CBO will contact the insurance company for basic benefit verification.
  - a. If the insurance plan **does not** limit provider choice, the CBO will forward a completed CBO Insurance Benefit Verification form to the CFC within five (5) business days.
  - b. If the insurance plan **does** limit provider choice, the CBO will compare a list of insurance-mandated providers with enrolled EI providers and **will forward the resulting list** and completed CBO Insurance Benefit Verification form to the CFC within five (5) working days. The list will include providers whose addresses fall within 30 miles of the family's address.
- 2) If an Insurance Exemption Request form or Pre-Billing Insurance Waiver Request form has not previously been submitted or determined to be necessary by the CBO, upon receipt of the results of the CBO Insurance Benefit Verification form from the CBO, the CFC will review the form closely to determine whether a pre-billing waiver or exemption might apply and react accordingly.

**Responsibilities of the Provider:**

The Provider will complete the following steps to document insurance benefits verification and billing as required by EI policy.

- 1) All EI providers **are required** to bill private insurance **for direct services** prior to billing the CBO **except in the following situations:**
  - a. An insurance exemption or pre-billing insurance waiver has been approved prior to rendering services;
  - b. The provider is a Developmental Therapist, Interpreter, Deaf Mentor, Transportation provider, Parent Liaison or a Physician providing Medical Diagnostic services only; or
  - c. The service is for evaluations, assessments, IFSP development or any thing else that is not considered a direct service to the child/family. **The family and the service provider in cooperation with the insurance company will determine insurance benefits for direct service provision purposes.**
- 2) The EI provider **must** verify that services identified on the IFSP are a covered benefit under the insurance plan. There may be multiple plans. For example, vision or speech related services might be covered in a separate policy. **NOTE: The Insurance Benefit Verification form issued by the CBO is not to replace the more detailed insurance benefit verification that must be completed by providers.** It is the responsibility of the provider to verify benefits with the insurance company. Failure to verify benefits may result in the provider's inability to receive payment from the insurance company and/or the CBO.
- 3) **Providers must always check** with the family to determine if a child's private or public (AllKids) insurance coverage has changed and **must notify the child's Service Coordinator**

**immediately** if there has been a change. Failure by the provider or family to inform the Service Coordinator of the insurance change may result in the provider's inability to receive payment from the insurance company and/or the CBO.

- 4) Upon receipt of new or conflicting information, **the provider must immediately** contact the CFC and/or the CBO to determine future steps or risk non-payment of services rendered during the resolution of the new or conflicting information.

#### **Determining the Need for Insurance Exemptions:**

- 1) Families may request exemption from private insurance use for one or more services if such use would put the family at material risk of losing their coverage. Other exemption reasons are listed below. The CFC will submit a request for exemption if one or more of the following criteria apply.
  - a. The individual insurance plan/policy covering the child was purchased individually and the child is not eligible for group medical insurance.
  - b. The child's private insurance plan/policy has a **lifetime** cap (annual cap does not apply) for one or more types of early intervention services, which could be exhausted during the IFSP period based on the estimated cost of the EI services.
  - c. The child is enrolled in CHIP, which automatically qualifies for an insurance exemption.
  - d. The Child is covered under an insurance plan that is supplemented by an automatically withdrawing tax savings plan such as a Health Reimbursement Account or Health Savings Account.
  - e. If an insurance exemption is approved, all providers serving the child should bill the CBO only. The family's private insurance should never be billed for EI services when an exemption is in place.
- 2) These steps must be taken by the CFC to ensure an Exemption is requested and approved appropriately by the CBO prior to the service provider rendering services.
  - a. The CFC will forward all required documentation to the CBO along with the appropriate Exemption Request form.
  - b. The CBO will provide determination of the Exemption request to the CFC within 10 business days of receipt of the request.
  - c. The CFC will forward a copy of the approved/denied Insurance Exemption Request form to all applicable providers.
  - d. Eligibility for Insurance Exemption **must** be re-determined and re-issued at the time of the annual IFSP meeting **or** earlier if the family reports a change to one or more of the insurance exemption criteria. **NOTE:** It is not necessary to reissue an Insurance Exemption Request to cover the time period created by extending an IFSP end date. The CFC will notify the CBO of the extension via e-mail (secure WebMail) or by fax.
  - e. If an insurance exemption is approved, all providers serving the child should bill the CBO only. The family's private insurance should never be billed for EI services when an exemption is in place.

#### **Determining the Need for a Pre-Billing Waiver:**

- 1) A pre-billing waiver may be requested and issued for one or more services if any of the following criteria apply.
  - a. An insurance mandated provider is not available to receive the referral and begin services immediately (within 15 business days). This reason will be used if the insurance mandated provider is unable to perform the services as written in the IFSP.



- b. When services are to be rendered in a center or office location and the family would have to travel more than an additional 15 miles or an additional 30 minutes to the insurance provider as compared to travel to a different enrolled provider.
  - c. The required Primary Care Physician referral is unobtainable.
  - d. If an insurance waiver is approved, the provider is still allowed to bill the family's private insurance. If the private insurance pays for the services billed, the provider must continue to bill the insurance company as the primary payer and then bill the CBO as the secondary payer. A new claim containing the EI procedure code identified on the EI authorization and a copy of the insurance company Explanation of Benefits is required to post information to the child's authorization or pay the claim.
- 2) In **limited situations, a pre-approved** pre-billing waiver may be automatically generated by the CBO to allow authorizations for direct service provision to be made by any available enrolled EI provider. The situations in which a pre-approved pre-billing waiver may be generated include the following:
- a. There are no insurance mandated providers that are also credentialed/enrolled as providers in the EI Services System.
  - b. The required Primary Care Physician referral is unobtainable.
  - c. If during the benefit verification process it is determined that the service is not covered.
- 3) Eligibility for a Pre-Billing Waiver **must** be re-determined and re-issued at the time of the annual IFSP meeting or earlier if the family reports a change to one or more of the pre-billing waiver criteria. **NOTE:** It **is not** necessary to reissue a Pre-Billing Insurance Waiver to cover the time period created by extending an IFSP end date. The CFC must notify the CBO of the extension via e-mail (secure WebMail) or fax.

### **Granting Post-Billing Waivers:**

- 1) Post billing waivers are automatically issued by the CBO when an insurance explanation of benefits, received with a claim at the CBO, indicates benefits for a particular service are not covered and/or benefit maximums have been met on covered services.
- 2) Once the post-billing waiver has been entered into the CBO billing system, the provider can continue to submit claims to the CBO directly without billing the insurance company first for the remainder of the benefit year of the policy. **NOTE:** The provider will receive notification of the post-billing waiver on their Provider Claim Summary.
- 3) Once the benefit year expires, the provider will need to submit claims to the insurance company for the service rendered to determine if the insurance company can generate payment.

### **Types of Plans and Provider Restrictions:**

**No provider choice/payment restrictions apply** in the following situation:

- 1) The insurance company does not limit which providers the family may choose for direct service provision. Under this situation, the CFC may refer the child to any EI enrolled provider that a family chooses for direct service provision.
  - a. When making the referral to the provider, the CFC will explain that the initial benefit verification indicated that the plan does not limit which provider may provide direct services. However, **it is still the responsibility of the provider to verify with the insurance company** that the services they will be providing, as outlined by the IFSP, are consistent with the provisions of the plan and to determine if any special considerations must be made prior to providing services.

**Provider payment restrictions do apply** in the following situations:

- 1) The insurance company requires providers to enroll in order to receive payment from the insurance company directly. If the provider does not enroll, payments are rendered directly to the insurance policy holder (family).
  - a. The insurance company has indicated that providers must enroll before payment can be made directly to the provider.
  - b. Providers may be able to provide services without enrolling however, payment and Explanation of Benefits will be sent directly to the insurance policy holder (family). The provider would then be responsible for working with the family in order to obtain the insurance payment and copies of the insurance EOBs. **NOTE:** In this situation, it is critical for the provider to obtain copies of the insurance EOBs in case the provider is required to seek additional payment from the CBO, as DHS policy requires that such claims be accompanied by an insurance EOBs.
- 2) Providers should also obtain copies of insurance EOBs for their records in the event that an insurance company performs a review and determines the need for a refund. If the provider has received the insurance payment from the family, the provider is **responsible** for working with the family to make the required refund. Then, with the appropriate documentation from the insurance company, the provider can submit claims to the CBO for payment by EI.
- 3) The family is responsible for supplying any insurance EOBs or payments made directly to the policyholder to the rendering provider as outlined in the Insurance Affidavit, Assignment & Release form signed by the family. The provider is responsible for obtaining a copy of the Insurance Affidavit, Assignment and Release form from the CFC and for ensuring that the policyholder reimburses them in the event the payment goes directly to the policyholder.
- 4) The provider is also responsible for submitting claims to the CBO even in the event the provider receives reimbursement from insurance.
  - a. By signing the Early Intervention Service Provider Agreement providers agree to the following: "The EOB and a completed claim shall be submitted to the CBO for all EI children even if the entire claim was paid by private insurance."
  - b. The purpose of this requirement is to ensure that the services identified on a child's IFSP are being provided and that providers are being reimbursed. This allows EI to unencumber dollars for services for which insurance is providing payment. These dollars can then be used to pay for other services that insurance is not paying for.

**Provider choice/payment restrictions do apply** in the following situations:

- 1) Preferred Providers Only (Preferred Provider Organization).
  - a. The insurance company has indicated that providers must apply and become a preferred provider or claims will be denied.
  - b. The CFC is only allowed to make direct service referrals to providers included in the insurance company's network.
  - c. If none of the insurance company mandated providers are able to see the child for one of the Pre-Billing Waiver reasons, the CFC will request a Pre-Billing waiver from the CBO in order to make a referral to a non-insurance required EI credentialed/enrolled provider.
  - d. If a pre-billing waiver is requested, the CFC will not make a referral for direct service provision until the approval/denial for the insurance waiver has been received from the CBO. **NOTE:** No provider should render any service prior to receipt of notification of waiver approval from the CFC. See number 26 under "Important Early Intervention Policies and Procedures".
- 2) Primary Care Physician (PCP) Referral Required.
  - a. The insurance company will provide payment to non-enrolled or preferred providers as long

- as the child's PCP has referred the child to the provider prior to beginning services
- b. The family should assist the provider in obtaining the PCP referral if necessary.
  - c. If a PCP's referral is required for the family to see providers other than those mandated by the insurance company, but one is unable to be obtained, the family will be required to utilize the insurance mandated provider unless a Pre-Billing Waiver Request is applicable and approved prior to service provision.
- 3) If during the CBO's limited Benefits Verification it is determined that no insurance mandated providers are EI credentialed/enrolled, CBO will automatically provide a pre-billing insurance waiver to the CFC. The CFC may choose any EI credentialed/enrolled provider.

### **Determining the Provider:**

- 1) Based upon the type of insurance, insurance restrictions, waivers or exemptions, the Service Coordinator will assist the family to choose a provider by giving the family a list of enrolled EI providers in the geographical area.
  - a. IF THE INSURANCE COMPANY will not approve payment to an out-of-network provider, the family will be required to accept services from an in-network provider in accordance with all applicable EI rules and statutes.
- 2) The Service Coordinator will print and attach the following information to the full IFSP and distribute the information to the IFSP team members and the family:
  - a. Front and back of family's insurance card, if applicable;
  - b. Insurance Affidavit, Assignment and Release form;
  - c. Insurance Use Exemption Request form, if applicable; and
  - d. Approved Pre-Billing Waiver Request form, if applicable.

### **Updating Insurance Information:**

- 1) When a family's insurance coverage changes/updates or insurance coverage is obtained for the first time on an active child who is already receiving EI services, the provider is given a 45-day exception period **from the date that the CBO receives the new insurance information** in order to determine what, if any, provider restrictions and/or pre-authorization requirements the new insurance carrier/plan has. The provider **may** bill the CBO for dates of service that fall within that 45-day exception period or the provider **may** proceed with verifying insurance benefits and billing the new insurance plan if they meet all the necessary criteria of the updated coverage.
  - a. When the CFC receives notification from the family or service provider that insurance coverage has changed or been updated, the CFC will **immediately** begin the necessary steps to update and re-verify the insurance through the CBO. The 45-day exception period will begin on the date that the CBO receives the new insurance plan information from the CFC.
  - b. During this 45-day exception period, providers may bill the CBO for services. No insurance EOB will be required during this period unless all conditions and requirements of the new insurance plan have been identified or until the expiration of the 45-day exception period. **NOTE:** At the end of the 45-day exception period providers will no longer receive payment from the CBO unless an insurance exemption or pre-billing waiver has been determined or the provider meets all other insurance-required billing policies and procedures with the individual insurance company/plan. The family may be required to change service providers to meet the insurance billing requirements of EI.

## DEFINITIONS

### **Enrolled Provider**

A provider that is credentialed and/or enrolled in the EI Services System to provide direct service to children.

### **Approved Provider**

A provider that is authorized to provide services and bill an insurance company as part of their network of providers.

## **Private Plans**

### **Health Maintenance Organization – HMO**

An HMO relies heavily on their network of providers and will typically require documentation and a standardized process to cover providers outside the network.

### **Preferred Provider Organization – PPO**

PPO contract with a network of preferred providers but will reimburse at a lower rate for out-of-network providers.

### **Point-Of-Service – POS**

A POS plan combines an HMO and PPO. A provider may subscribe to one or both plans. Because of the PPO component, out-of-network providers may be used. When requesting a list of network providers make certain both HMO and PPO providers are being included.

### Private Insurance – Group (may also be HMO, PPO or POS)

Group Insurance is usually offered through an employer. The employer may purchase a policy from an insurance company or may administer its own (self-insured) plan. Group health insurance may also be offered through other organizations or special-interest groups. Coverage varies with each plan.

### Private Insurance – Individual (may also be HMO, PPO or POS)

Health insurance is purchased out-of-pocket directly from an insurance company to cover one or more members of a family. Coverage varies widely with each plan. This type of plan is eligible for an Insurance Exemption.

### **Government-Sponsored Health Plans**

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and Civilian Health and Medical Program of the Veterans Administrations (CHAMPVA)

These are federal programs to cover health expenses of the dependents of military personnel and veterans. They are secondary to commercial health plans. Military medical-care providers are to be used if available. Prior authorization may be required for use of civilian providers. Administered by TRICARE.

### **Illinois Comprehensive Health Insurance Plan – ICHIP**

CHIP is a state-subsidized program for Illinois residents who cannot otherwise purchase major medical insurance due to a pre-existing condition or disability. It is administered by Blue Cross/Blue Shield of Illinois.

## **Public – Sponsored Health Plans**

### **AllKids**

AllKids is a comprehensive health insurance program that is available to uninsured children in the State of Illinois. It is administered by the Illinois Department of Healthcare and Family Services and includes the following:

- Medicaid/AllKids Assist – Medicaid is a federally assisted program to help with the medical expenses of eligible low-income families. It is administered through the Illinois Department of Healthcare and Family Services.
- AllKids Share, Premium or Rebate – Children whose families are not eligible for Medicaid (AllKids Assist) due to income may be eligible for these low-income programs:
- AllKids Share and Premium require a co-pay for services.
- AllKids Premium also requires a payment monthly to meet a “premium”.
- AllKids Rebate reimburses the policyholder for the cost of other health insurance.

# EARLY INTERVENTION BILLING GUIDELINES

Please monitor the Provider Connections website at: [www.wiu.edu/providerconnections](http://www.wiu.edu/providerconnections)  
for policy/procedure changes.

## EARLY INTERVENTION BILLING GUIDELINES

Providers participating in the Early Intervention program are required to bill the Central Billing Office (CBO) for reimbursement for services provided. Listed below is a brief outline of billing procedures. A more-detailed document entitled “Billing Information for Providers” can be found on the CBO website at [www.eicbo.info](http://www.eicbo.info)

### Billing Guidelines and Forms

Providers should bill the CBO at their usual and customary rate. The amount billed to the CBO must duplicate the amount billed to the insurance company, if applicable. By signing the EI Provider Agreement, a provider accepting Early Intervention authorizations also agrees to:

- Not bill the family directly for authorized direct services unless the insurance payment was paid to the family versus the provider and you have a copy of the signed “Child and Family Connections Insurance Affidavit, Assignment and Release” form in hand.
- Accept the insurance payment in full unless the payment is less than the EI rate. If the insurance payment is less than the EI rate, bill the CBO the same rate that was billed to the insurance company and the CBO will process payment for the difference in the insurance paid rate versus the EI rate.
- Not bill the family directly or their insurance for screening, evaluation and assessment services or IFSP development. These are services that must be provided at no cost to the family per Federal law (Part C of the Individuals With Disabilities Education Act).
- Maintain accurate records, including daily documentation of services for each date of service billed, including IFSP time, for a period of at least six years from the child’s completion of EI services (please see documentation definition found in the [DEFINITIONS](#) section of this document). **NOTE:** In a monitoring review or audit it is the entity who submits claims and receives payments (payee) for each date of service and each procedure code billed to and paid by the CBO who is responsible for providing documentation for review. Failure to provide documentation will result in a refund. Therefore it would be to the advantage of the payee to require all employee’s or contracted employee’s to submit documentation to support billing and payment prior to submitting claims to the CBO for payment.

Electronic Billing - Electronic billing is the preferred method of claim delivery to the CBO. Claims may be submitted directly to the CBO using the software of the provider’s choice or by sending claims through the Qclaims billing software provided at no cost to the provider. Information on how to sign up for Qclaims is available on the CBO website at [www.eicbo.info](http://www.eicbo.info). **NOTE:** Electronically billed claims may not be received at the CBO the same day they are transmitted by the provider. Due to the 90 day filing limit, please allow ample time for claims to be received at the CBO.

The CBO will also accept paper claims submitted on the CMS-1500 and UB-04 claim forms only. Refer to the service description for your discipline found in the front of this handbook for the EI payment rates.

Transportation Billing Form - Providers and parents who bill for transportation services must use the DHS Transportation Billing Form when submitting claims to the CBO. Insurance is not required to be billed for this service nor is an ICD-9 code required on claim submissions.

Interpreter/Translator Billing – Interpreters must indicate the type of service provided in Box 23 of the CMS-1500 form when submitting claims to the CBO. Insurance is not required to be billed for this service nor is an ICD-9 code required on Interpreter/Translator claim submissions. See the document entitled “Billing Information for Providers” found on the CBO website at [www.eicbo.info](http://www.eicbo.info) for more detailed information on Interpreter/Translator billing requirements.

### **Private Insurance Use in Early Intervention**

Private insurance use is mandatory in the EI program **unless** a waiver or exemption has been approved before the start of services. If a child's family has a primary insurance, it must be billed before seeking further reimbursement from the CBO. **When billing a child's primary insurance all payee's should bill based upon the providers treating ICD-9 and treating CPT/HCPCS codes. They should not bill based upon information found on the EI IFSP, EI authorizations or from the physician's medical diagnosis.** The primary insurance EOB must accompany all claims submitted to the CBO for further reimbursement and for claims paid in full by the primary insurance.

### **Time to Bill**

Claims must be received by the CBO no later than ninety (90) days following the date of service delivery. For claims where primary insurance is involved, the claim must be submitted along with a copy of the insurance EOB from the primary insurance, no later than ninety (90) days from the date identified on the insurance EOB. **The CBO will not use a fax date or computer print out date to determine timely filing.** If the primary insurance pays the charges in full, a claim, along with a copy of the insurance EOB, must be submitted to the CBO to ensure posting to the child's authorization.

### **Provider Claim Summary**

Once a claim has been processed by the CBO, the provider will receive a "Claim Summary" and the family will receive a "Explanation of Benefits" that details all charges billed, paid and denied. Questions with regard to this summary should be directed to the CBO Call Center at 800/634-8540.

### **Insurance Billing Services**

The Early Intervention program provides insurance billing services for providers participating in the program. This insurance billing service is specifically designed to bill primary insurance companies on behalf of the provider for new client referrals only.

Providers will register one time with the CBO insurance billing unit and will submit enrollment and encounter forms for children they wish to obtain the billing services for. **The purpose of the encounter forms is to provide treating documentation that will allow CBO staff to correctly code insurance claim(s) using treating level ICD-9 and CPT/HCPCS codes. Therefore, it is extremely important to submit thorough and accurate documentation on all encounter forms.** The CBO will bill the primary insurance company on behalf of the provider and the provider, in turn, will receive insurance payment/CBO payment for the claims submitted.

More detailed information regarding this service can be found on the CBO website at [www.eicbo.info](http://www.eicbo.info).



# EARLY INTERVENTION ASSISTIVE TECHNOLOGY GUIDELINES

Please monitor the Provider Connections website at: [www.wiu.edu/providerconnections](http://www.wiu.edu/providerconnections)  
for policy/procedure changes.

## EARLY INTERVENTION ASSISTIVE TECHNOLOGY GUIDELINES

**NOTE:** All providers of assistive technology services are required to provide the equipment to the child/family prior to submitting a claim for services to insurance or to the CBO. Early Intervention is a fee-for-service system. In a fee-for-service system **the service must be provided prior to billing for the service.**

### DEFINITION OF ASSISTIVE TECHNOLOGY

The definition of Assistive Technology (AT) includes both AT devices and AT services. An AT device is any durable item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of children with disabilities.

An AT service means any service that directly assists a child with a disability in the selection, acquisition, or use of an AT device. The term includes:

- a. The evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child's natural environment;
- b. Purchasing, leasing, or otherwise providing for the acquisition of AT devices by children with disabilities;
- c. Selecting, designing, fitting, customizing, adapting, applying, retaining, repairing, or replacing AT devices;
- d. Coordinating and using other therapies, interventions, or services with AT devices, such as those associated with existing education and rehabilitation plans and programs;
- e. Training or technical assistance for a child with a disability or, if appropriate, that child's family; and
- f. Training or technical assistance for professionals who provide services to children with disabilities through the Early Intervention program.

### ASSISTIVE TECHNOLOGY DEVICES

Assistive technology devices range from low technology to high technology items. Low technology devices are devices that rely on mechanical principles and can be purchased or made using simple hand tools and easy to find materials, such as homemade or modified items already used in the home. High technology devices include sophisticated equipment and may involve electronics.

Consideration of the types of AT devices and services available through this system is continually monitored. Determination of what equipment and services falls within these guidelines will be updated periodically as these considerations are reviewed. Eligible devices and services refer to items and services for which payment can be made. A written recommendation (order), signed and dated by the child's physician (often a prescription form) is required for all items requested.

Early Intervention deals only with AT that is directly relevant to the developmental needs of the child and specifically excludes devices and services that are necessary to treat or control a medical condition or assist a parent of caregiver with a disability. Equipment/devices must be developmentally and age appropriate to be considered eligible for Early Intervention funding.

The following sections address those items currently eligible for Early Intervention funding and those items that are not considered eligible under the definition of AT.

Information contained in this document supercedes any previous decisions regarding approval of specific AT equipment or services.

## **Eligible Services**

As the term AT covers so many different types of devices, it is often useful to divide the devices into functional categories. The following are examples of the types of AT devices that may be provided to eligible children and their families under this program. The AT available to young children is changing and expanding at a rapid pace, and it should be noted that this list is not an exhaustive list of AT devices, but is intended to provide guidance. There may be other items not listed that would appropriately meet the needs of children in this program.

Available assistive technology include:

- **Aids for Daily Living.** Self-help aids are designed for use in activities such as bathing, eating, dressing, and personal hygiene. Ex.: Bath chairs, adaptive utensils.
- **Assistive Listening.** Assistive listening devices to help with auditory processing. Ex.: hearing aids.
- **Assistive Toys and Switches.** Because “play” is the work of infants and toddlers, assistive devices such as switch-operated toys serve a vital role in the development of young children with disabilities. Playing with switch-operated toys helps build important cause and effect and choice-making skills that prepare a child for communication aids and computer use. Ex.: Single-use switches, switch battery adapters, switch adapted toy items.
- **Augmentative Communication.** Augmentative communication devices are devices that should be used across all the natural settings so that the child learns how to communicate with a variety of different people in different circumstances. The inclusion of a variety of different augmentative communication strategies is particularly important for young children and may include a program that uses signing, device, gestures, and communication pictures and boards. Ex.: Symbol systems, picture or object communication boards, electronic communication devices, and communication enhancement software.
- **Computer Access.** There are a wide variety of technologies that provide access to the computer. Once an access method has been determined, then decisions can be made about input devices and selection techniques. Input devices can include switches, touch windows, head pointers, etc. In some cases, access to keyboards can be improved by simple modifications such as slant boards, keyguards or keyboard overlays. Output devices include any adaptation that may be needed to access the screen display. Computer technology can help very young children acquire important developmental skills and work toward their individual goals. A variety of software programs have been developed for this population. These programs help infants and toddlers learn and practice cause and effect, early choice making, and build fine motor and visual motor skills.
- **Mobility.** Mobility devices include braces, certain types of orthotics, self-propelled walkers and crawling assist devices.
- **Positioning.** Proper positioning is important so that a child can interact effectively in their environment and to aid in promotion of the child’s physical development. Proper positioning is typically achieved by using padding, structured chairs, straps, supports, or restraints to hold the child’s body in a stable and comfortable position. Also considered is a child’s position in relation to family or peers. Often, it is necessary to design positioning systems for a variety of setting so the child can participate in multiple activities in their natural environment. Ex.: Stenders, walkers, floor sitters, chair inserts, trays, side-lyers, straps, rolls, weighted vests and garments, etc.
- **Visual aids.** General methods for assisting with vision needs include increasing contrast, enlarging images, and making use of tactile and auditory materials. Devices that assist with vision may include optical or electronic magnifying devices, low vision aids such as hand-held or spectacle mounted magnifiers, and vision stimulation devices such as light boxes.

- **Repair and Maintenance.** Repair, alteration and maintenance of necessary equipment. The provider is responsible for the fulfillment of all warranty service and warranty repair.

It is important to realize that within each of these categories, there is a continuum of device choices from simple to complex that should be considered when trying to find the AT to use with a particular child for different tasks and in different settings.

When an infant or toddler's needs are being assessed for the possible use of AT, there are usually a number of options that can and should be explored. The selection of devices should always start with simpler, low or mid tech tools to meet the child's needs. If a low-tech device, such as a laminated picture for making a choice, meets the child's needs, then that should be the device provided. Different devices from across the continuum should also be carefully matched to the different environments in which the devices will be used, appreciating that while a device may be useful in one setting, it may not be appropriate or effective in other settings.

When choosing a device, it is important to note that trials with a variety of different devices can actually help determine the child's needs, preferences and learning styles.

### **Limitations**

- EI reserves the right to limit items of the same or similar nature such as switches, adapted switch toys, adapted utensils and tableware, computer software, therapy balls, rolls, bolsters, wedges, sensory items, etc.

Certain equipment/services are not covered in the scope of AT and payment will not be made for their provision. The following are examples of devices or services that are **not** considered AT under this program.

- Equipment/services that are prescribed by a physician, primarily medical in nature and not directly related to a child's developmental needs. Examples include but are not limited to helmets, oxygen, feeding pumps, heart monitors, apnea monitors, intravenous supplies, electrical stimulation units, beds, etc.;
- Devices requested for children 2 years, 9 months of age and over, as equipment requested during this time would not be available long enough to achieve identified outcomes. Request must be on the IFSP prior to 2 years, 9 months and received for review prior to 2 years, 10 months;
- Equipment/services for which developmental necessity is not clearly established;
- Equipment/services covered by another agency;
- Equipment/services where prior approval (when applicable) has not been obtained;
- Typical equipment, materials, and supplies related to infants and toddlers utilized by all children and which require no special adaptation. Examples include clothing, diapers, cribs, mattresses, high chairs, car seats, infant swings, typical baby/toddler bottles and holders, cups, utensils, dishes, infant monitors, mats, disposable items, etc. Toys that are not adapted, used by all children and are not specifically designed to increase, maintain, or improve the functional capabilities of children with disabilities include such examples as building blocks, dolls, puzzles, balls, ball pits, tents, tunnels and other common play materials;
- Standard equipment used by service providers in the provision of early intervention services (regardless of service delivery setting), such as therapy mats, tables, desks, etc;
- Seating and mobility devices such as car seats, strollers, wheelchairs or any part thereof;
- Equipment/services which are considered duplicative in nature, generally promoting the same goal and/or objective with current or previously approved equipment/services;
- Equipment/service if a less expensive item or service is available and appropriate to meet the child's need;
- FM systems;

- Replacement equipment if original item has not been returned to vendor or if payment for equipment has not been returned to the CBO by the supplying vendor;
- Sales tax, shipping and handling charges.

## **EVALUATION**

Assistive technology evaluations can be requested when there is reason to believe that a child may benefit from the use of AT. AT evaluations are to be completed by a credentialed evaluator as in most situations the AT request is for a new AT item or service. The need for AT devices/services may be identified:

1. As part of the initial multidisciplinary evaluation, where the credentialed evaluator determines a need that can be addressed when eligibility is determined;
2. As part of a supplemental evaluation included in the child's IFSP based on an anticipated or emerging need and as agreed upon by the team;
3. Through the ongoing assessment process conducted by the child's provider(s) if they are a credentialed evaluator.

**NOTE:** Reimbursement for evaluations is done through the evaluation code for the specific provider type.

Assistive technology evaluations differ somewhat from "typical" evaluations conducted as part of eligibility or review of a child's needs and strengths. There are virtually no standardized tests to "find out" what kind of technology a child needs to use. Instead, a good assistive technology evaluation looks at the results of all recent evaluations, along with the current IFSP goals and objectives. The evaluator should talk with the child's parents, interview people who work with the child, and interact directly with the child and the devices. The environment should be carefully examined, especially when the device has to work in a variety of settings.

The actual evaluation process consists of considerable observation coupled with trials with a full range or continuum of possible devices from low to high technology. Data is gathered from these trials about the effectiveness of various technologies to meet the child's needs. Information is collected concerning the child's ability and accuracy when using various technologies, including the positioning and settings that work best. The child's and family's feelings about the actual devices tried should be considered, as even very young children can show what they like and dislike by how they interact with different devices.

As the number of devices and the complexity of those technologies have grown exponentially in the past few years, many people who work extensively in this area have found the need to specialize in different areas of assistive technology. Typically, these people have expertise in areas like assistive computer technology, augmentative communication, mobility and positioning and so forth. Other assistive technology experts specialize in age or disability-specific technologies, such as visual and hearing impairment devices.

### **Components of an Assistive Technology Evaluation**

The four principles to consider when evaluating the potential for AT solutions should include:

1. Use of the multidisciplinary team.
2. Family members are a crucial member of the team
3. Focus on function – "What is it that the child needs to do that he/she currently cannot do?"
4. Strive for simplicity.

Team members should have a basic understanding of the kinds of AT that exists and how it can be used to help a child achieve more independence and control of his/her environment. The team assessing AT needs should address the following:

- 1. Current developmental needs and functioning of the child.** Consideration should be given to the recommendation of the most appropriate device for the child's *current* development. Because technology devices and the needs of a child and family change, devices should be used to enhance the child's *current* development and functioning, addressing *immediate* needs and the appropriateness of the equipment in attaining outcomes that address the development and functioning of the child.
- 2. Cognitive and emotional resources.** This should include assessing the child's ability to understand language, respond to prompts and trials, ability to make choices and the ability for social interaction. The child's response to stimuli and reinforcers, distractibility and attention span need also be considered.
- 3. Health and development.** Statements regarding child's current health status, vision, hearing, and motor status should be included.
- 4. Needs of the child and family.** Consideration should be given to devices that can fit easily into the family's lifestyle and will have the optimum functional and developmental impact on the child.
- 5. Equipment and device options.** Consideration should be given to whether outcomes can be accomplished through the creative use of existing resources (e.g. household items, toys, etc. currently available in the home), loan programs or low-technology devices and other less intrusive option, prior to progressing to high technology equipment.
- 6. Use of equipment.** Consideration should be given to devices that are needed to help achieve a specific functional outcome and are not therapeutically "nice to have." Equipment should be used to achieve a functional goal that will improve a child's development. Utilization of current equipment in the home should be documented as well.
- 7. Proper recommendation for the device.** Consideration should be given to using a team which includes the parent, Service Coordinator, other early intervention service providers and the AT specialist to ensure a common understanding of the recommendation for a particular device or characteristic of the type of AT device.
- 8. Use of loan equipment.** Checking out equipment from available local lending libraries or accessing local Lekotek programs is strongly recommended to ensure the appropriateness of the device prior to purchase. The Illinois Assistive Technology Project (IATP) can answer questions regarding specific AT needs and a comprehensive directory available to assist in locating equipment and funding. IATP can be reached at 800-852-5110 or on the web at [www.iltech.org](http://www.iltech.org). If equipment is needed for short-term use, utilizing equipment in this manner rather than purchase is strongly recommended.

The AT evaluation report should include information listed above and any other pertinent information regarding the reasons for evaluation, background of the child, observations of the child in the natural environment(s), observations of the child using currently available technologies, and observations of the child using a variety of possible AT options.

If the report recommends AT, it should include a full range of options or minimum specifications for equipment and a detailed justification if one device is recommended over all other choices. Equipment choices should consider current equipment, as well as high and low-tech options. Funding options must also be included as well as information about vendors and possible repair and maintenance providers.

## **Other Considerations**

There are a number of questions that the IFSP team including the family should answer when deciding about the inclusion of AT in a child's IFSP based on the conclusions included in the evaluation report.

- What are the parent's goals for their child? Is any AT necessary to meet the parent's current goals?
- What are the skills, needs, and likes of the child?
- What problem will the AT device solve?
- Will the proposed solution enable the child to function more independently and/or more successfully?
- What is the ability of the child to independently and successfully learn and use the device?
- Are there implications for the child's health status (e.g. effects of required positioning on respiratory or cardiac status)?
- What are the limitations of the device?
- Are there a number of equal device options for consideration?
- Why is this technology more appropriate than other low-tech or no-tech alternatives?
- How flexible is the device? Can it grow with the child's needs and abilities?
- Is there a way a currently available piece of technology can be modified to meet the need?
- How useful will the technology be with the other devices the child currently uses?
- Does the family (or child) like or have other feelings about the device?
- Are the size and weight of the device important issues?
- If the device is carried between home and other settings, what precautions need to be made?
- Have all the functional environments of the child's use been considered? What are the child's home and family activities?
- Is the device safe and/or sturdy?
- Is the technology current enough to provide service and part options for the immediate future? How easy is it to obtain repairs?
- Has the device been on the market long enough to establish itself and for problems to have been worked out?
- Has there been or is there a possibility for an adequate trial period?
- Is the device available?
- What is the expected lifetime and duration of use for the device?
- Can the device be used for a number of different tasks?

Parents play a vital role in the choice, implementation, and use of AT. They should be involved with choosing, adapting, routine maintenance, training, and on-going assessment associated with the child's use of the devices. They are also vital in sharing their dreams and visions for their family and the child so that the team can better determine what kind of technologies would best suit their child.

## **ASSISTIVE TECHNOLOGY AND THE IFSP**

All children with disabilities who are eligible for early intervention services must be provided with AT, if appropriate, as part of the Individualized Family Service Plan (IFSP). AT devices should be considered if interventions are required to aid in the developmental tasks such as interaction with the environment, communication, and cognition. These AT devices and services are required, however, only when they relate to the developmental needs of infants and toddlers and their families.

Inclusion of AT in the IFSP must occur on an individual basis and must be based on the child's needs, the family's concerns and intervention priorities and goals. Assistive technology devices/services must be included in the IFSP as agreed upon by the parent and other team members. At minimum, the IFSP should have the following information:

1. The outcomes that will be achieved for the child and family, including the way in which the AT device is expected to increase, maintain, or enhance a child's functional capabilities.
2. A description of the specific AT device(s) needed by the child, the projected dates for acquisition of the device, and the method of acquisition.
3. The methods and strategies for use of the AT device to increase, maintain, or improve the child's functional capabilities, the individuals (including parents, other caregivers and family members, and qualified personnel) who will be assisting the child in using the device, and the settings in which the device is to be used.
4. The qualified personnel who will be providing the AT services and the frequency, intensity and method of delivery recommended.

## **FUNDING**

Early Intervention will pay for AT items at rates comparable with the Illinois Healthcare and Family Services (HFS) rate structure. For those items requiring individualized pricing, Early Intervention will reimburse at the rate of vendor wholesale cost plus 50% up to the manufacturer's suggested retail price (MSRP). For items in which there is no wholesale discount to vendors (such as equipment marketed direct to consumer/catalog companies), rate may be adjusted by 25% if no alternative is available pending approval by the AT coordinator. All rates submitted are subject to the approval of the AT coordinator.

Pricing information submitted by vendors must include manufacturer's pricing information either by providing with the quote copies of the catalog page depicting the item with printed price easily readable or a copy of the separate pricing sheet along with picture and description of the item. For items that are marketed direct to consumer, the vendor price quote must explain any variance between manufacture or catalog pricing submitted.

## **OBTAINING ASSISTIVE TECHNOLOGY**

Any assistive technology requested for a child must be submitted to DHS for prior approval and is required for the provision of all equipment/services with the exception of hearing aid earmolds (no more than two per authorization) and hearing aid batteries (no more than 16 every 60 days) (see 4.a. below).

The prior approval process reviews requests to look for developmental necessity, equipment/services as described in the section addressing "limitations," pricing requests, quantity and duplication.

Requests are processed through the DHS Bureau of Early Intervention for prior approval consideration. Requests must be submitted by mail to:

DHS - Bureau of Early Intervention - Assistive Technology  
222 South College, 2<sup>nd</sup> Floor  
Springfield, IL 62704



## Procedure

1. The therapist identifies an AT need through evaluation or ongoing assessment, contacts the service coordinator to schedule an IFSP meeting and brings the information to the IFSP team for consideration.
2. If the IFSP team agrees with a need, an outcome page relating to the AT need is completed by the service coordinator.
3. The service coordinator compiles all the necessary documentation:
  - a. A separate letter of developmental necessity from a credentialed evaluator is required. The letter must be dated within the recent six-month time frame and include information on the child's developmental need and current functioning level. Goals and objectives must be identified in the most current IFSP with regards to the utilization of the recommended equipment/service. **NOTE: Do not include AT justification in the initial evaluations or assessments. A recommendation to complete an evaluation to determine the need for AT must be made by the IFSP team prior to the development of a letter of developmental necessity;**
4. When the service coordinator receives an approval memo for the AT equipment, the service coordinator enters an authorization(s) for any **approved** items indicated in the DHS notification and sends the approved authorization to the vendor.
5. Approved Assistive Technology equipment must be delivered to the child/family as soon as possible after the vendor receives authorization.
6. If the AT request is denied, no authorization is entered and the service coordinator notifies the vendor and family.
7. The service coordinator notifies the family, reprints the IFSP and sends the revised IFSP to all team members, sending only the approved authorization to the supplying vendor.

Any requests received without the above information may experience delays in processing. As with any other EI service, AT services must be related to one or more outcomes in the IFSP and be utilized by the child and family while enrolled in the Early Intervention Program. Early Intervention does maintain the right to request the substitution of a less expensive item of comparable function if a substitution is deemed appropriate. **Note: Requests for children 2 years, 9 months and older may be denied as equipment requested during this time would not allow the child to achieve substantial benefit while in the EI program.**

Typically, insurance, Medicaid, and DSCC funds pay for equipment and devices that fall under the category of "Durable Medical Equipment." This includes equipment such as daily living aids, standers, positioning systems, wheelchairs, prosthetics/orthotics, augmentative communication devices and hearing aids. Seldom does it include learning tools like switch-operated toys, assistive play equipment, sensory items and computer equipment.

## IMPLEMENTATION OF ASSISTIVE TECHNOLOGY

There are several things to consider when the use of AT is to be implemented. The best device in the world will not work if the child does not use it. One reason for this is that it may be the wrong technology for the child. The device might be one of many other assistive items for the child and may be overwhelming for the family. The family may not have the physical space in their home to accommodate the utilization of the specific technology. Another reason is that parents or other

caregivers may not be adequately trained on how to use the technology. Parents who understand how a device works and believe that it plays an important role in their child's development will provide more and better opportunities for the child to learn about and use the devices. Parents' preferences and feelings about particular devices often determine whether implementation and use of devices will be successful.

In many cases, successful choice and use of a device often requires an extended "trial period" with the device via rental, lease, or loan programs giving the child an adequate chance to learn and use the technology and then evaluate its usefulness. In situations where a variety of different technologies, both low and high tech, serve the same needs, the child should also be provided, when appropriate, with reasonable access to several of these technologies for a trial period to make decisions about when and where to use each device. While it would be helpful if AT companies would allow free trial periods or offer loaners at no cost, this rarely happens. Some companies do, however, allow for equipment rental or have return policies.