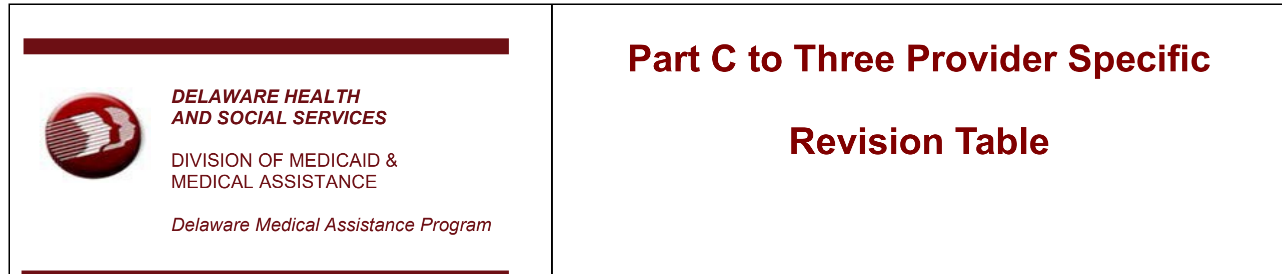
DELAWARE HEALTH AND SOCIAL SERVICES

DIVISION OF MEDICAID & MEDICAL ASSISTANCE

DELAWARE MEDICAL ASSISTANCE PROGRAM

PART C BIRTH TO THREE POLICY MANUAL



Revision Date	Sections Revised	Description
7/1/02	All	Complete manual revision to reflect changes related to the MMIS and HIPAA compliance.
5/1/03	7.3	The "TL" modifier is being removed effective for dates of service on or after 5/1/03. The modifier is not necessary in determining a program, funding source information, pricing or reporting for Part C so therefore, is not needed when billing services.
9/1/03	1.2, 2.14, 6.0, 7.1 through 7.3, 8.0	Effective 9/1/03 DMAP contracted with a broker to provide transportation services to eligible Part C clients. The manual is updated to reflect this change. Information found in Sections 1.2 (Updates) and 6.0 (Update Log) is found in the General Policy and therefore is being deleted.
11/4/03	3.0, Appendix C	Revenue center codes changed from 3-digit to a 4-digit number. Updating the definition of revenue codes in Section 3.0 as well as updating the revenue code chart in Appendix C.
1/1/04	7.1	Local codes TI10H and TV10H were mapped to the proposed code S4386. CMS didn’t approve use of this code, and in order to be in compliance with HIPAA, DMAP is changing the code to the existing HCPCS code T1023. This change is effective for dates of service on and after 1/1/04.
8/18/04	7.0, 7.1, Appendix D and Appendix E	In Appendix C (Section 7.0) the following changes are made: 1) Local codes, transportation codes and transportation information are no longer needed and are being removed. 2) The Old Code and Modifier columns are being deleted. 3) Revenue code 0551 is deleted and revenue codes 0471 and 0552 are added. Appendix D (Sections 8.0 & 8.1, the Transportation Scheduling Form and Instructions) is being removed. Appendix E-Index F (Section 9.0) is renamed Appendix D (Section 8.0)
4/16/12	1.1	Updated the policy to reflect, effective 04/01/2012 additional Medicaid populations now served through a Managed Care Organization (MCO).
5/1/14	7.0	Added reference (for dates of service through 12/31/2013) for procedure code 92506. Adding new speech evaluation code

		92523, effective 1/1/2014.
2/1/17	7.0	Adding Routine Based Interview code 96150: as part of the multidisciplinary assessment.
5/15/2019	All	Manual updated to align with the Delaware Medicaid Enterprise System (DMES) and the Delaware Medical Assistance Portal.
5/15/2019	8.0	Updated the Fiscal Agent street address and mailing address.
11/17/2023	All	Updated DXC to Fiscal Agent.
11/17/2023	1.4	Updated section to add Gainwell Technologies as the current Fiscal Agent and general responsibilities.

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Part C to Three Early Intervention System

1.0 General Information

1.1 Introduction

Those Part C services which are also covered Medicaid services are provided to the majority of Medicaid members through a Managed Care Organization (MCO). These part C services which are also covered Medicaid services are included in the MCO benefits package. All Medicaid members who are also Part C members and enrolled with an MCO must receive their Part C Medicaid services through the MCO. This manual reflects the policies as they relate to Medicaid members who are exempt from managed care coverage (see list of those exempt from managed care coverage in the Managed Care section of the General Policy).

The Part C Birth to Three program is funded by both State and Federal Part C dollars. To receive funding, the State must comply with IDEA and its regulations that are issued by the Federal Government from the Code of Federal Regulations (34CFR, Part 303, under Public Law 105-117, IDEA), Early Intervention Program for Infants and Toddlers with Disabilities.

This manual is to be used in conjunction with the General Policy Manual and the General Billing Manual which are located on the Delaware Medical Assistance Portal for providers.

1.2 Reserved

1.3 State Agency

Delaware Health and Social Services (DHSS), Division of Management Services (DMS) is the Lead Agency responsible for administering the Part C Birth to Three Program. A range of early intervention services are available to eligible members through participating providers. The State Fiscal Agent processes and pays claims for Part C allowable early intervention services.

The Part C Birth to Three program is an interagency effort consisting of the Divisions of Management Services, Public Health, Social Services, Developmental Disabilities Services, and the Division for the Visually Impaired, in Delaware Health and Social Services; the Department of Education; the Department of Services for Children, Youth and Their Families; and private agencies. While Child Development Watch within the Division of Public Health, is responsible for Part C Birth to Three program operations, the Division of Management Services is responsible for implementing the Part C mandate including service delivery, billing and contractual arrangements with providers.

1.4 Fiscal Agent

1.4.1 Gainwell Technologies is the fiscal agent for the DMAP. Gainwell Technologies is a claims processing company. General responsibilities of the fiscal agent are:

1.4.1.1 Receiving, processing, and paying claims submitted by enrolled providers of health care for services rendered to eligible members.

1.4.1.2 Maintaining the Point of Sale (POS) system, including adjudicating on-line claims and implementing the criteria established by the Drug Utilization Review (DUR) Board for prospective DUR.

1.4.1.3 Providing on-going provider relations such as receiving and responding to provider inquiries and for on-going communication and assistance to all providers.

1.4.1.4 Aiding providers in interpreting DMAP policies, procedures, and requirements.

1.4.1.5 Aiding providers in accessing current member eligibility, restrictions, and managed care enrollment through the Electronic Verification System (EVS) and through Health Care Portal-based inquiry.

1.4.1.6 Providing accounting, statistical, and costing information to the DMAP.

1.4.1.7 Advising and assisting the DMAP in carrying out the provisions of the Program.

1.4.1.8 Supplying providers with Billing Manuals.

1.4.1.9 Receive, review and support DMAP provider enrollment application processes.

1.5 Provider Contractual/Programmatic Responsibilities

A provider who signs an agreement with the Division of Management Services is responsible to meet certain conditions in order to remain on the Vendor Menu and receive payment for services rendered. The Vendor Menu lists the service, provider and other key information which is then shared with parents by their service coordinator so that parents may chose a provider for their child. The provider must abide by the policies and procedures including but not limited to:

- Submitting only claims for services that were actually rendered by the provider and properly identifying the performing provider in the case of group providers.
- Accepting final DMAP payment disposition as payment in full for services covered through Part C Birth to Three. The provider cannot charge the member for any services

reimbursable by the DMAP.

- Billing all other insurance resources or legally liable third parties and parents, where appropriate, prior to billing Medicaid.
- Making reasonable efforts to collect sliding payment fees from all non-Medicaid members receiving early intervention services. Member fees are based on either the DHSS scale included in Policy Memorandum 37 of the DHSS or the provider's member fee scale if it does not exceed the DHSS scale.
- Keeping records necessary to verify the services provided and permitting federal/state representatives access to the records.
- Verifying that the child is eligible for Part C Birth to Three services, and thus Part C funding.
- Making prompt restitution for any overpayment.
- Notifying the DMAP of any suspensions or exclusions from any program.
- Informing the member of any service that will not be covered by the Part C Birth to Three program prior to the delivery of service.
- Agree to uphold the Procedural Safeguards as required by the Part C regulations.

The Provider is responsible for the actions of its employees, and the Department will regard any negligent or fraudulent act by any such employee against the Part C program as an act of the Provider.

1.6 Covered Services

All services paid for through the Part C Birth to Three program are based on those early intervention services which are listed on a child's Individualized Family Services Plan (IFSP). If a service is not listed on the IFSP, Delaware Health and Social Services will not pay for it except where it authorizes payment under another plan (i.e., Medicaid). Services which are not necessarily Part C Birth to Three early intervention services might be listed on the IFSP so that service providers might have a better understanding of needs and that service coordinators might best attempt to address those needs. However, identifying these services in the IFSP does not impose an obligation to provide or pay for the services if they are otherwise not required to be provided under IDEA.

Under IDEA Part C regulation §303.12, Early Intervention Services are defined as services that:

- Are designed to meet the developmental needs of each

child eligible under this part and the needs of the family related to enhancing the child's development;

- Are selected in collaboration with the parents;
- Are provided:
  - Under public supervision;
  - By qualified personnel, as defined in §303.21;
  - In conformity with an individualized family service plan; and
  - At no cost, unless, subject to §303.520 (b) (3), Federal or State law provides a system of payments by families, including a schedule of sliding fees; and
- Meet the standards of the State, including the requirements of Part C.

Under Part C Birth to Three, Delaware Health and Social Services pays for the following types of services which are further defined in the Billing section of the Part C Birth to Three Provider Manual:

- Assistive technology device and services
- Audiology
- Family training and counseling
- Health services
- Medical services for evaluation purposes only
- Nursing services
- Nutrition services
- Occupational therapy
- Physical therapy
- Psychological services
- Social work services
- Developmental services
- Speech-language pathology
- Transportation

1.7 Services Not Covered by Part C and/or DMAP

Prior to rendering any service, the Provider shall inform a member of any services which the Provider will provide which are not otherwise covered by Part C and for which services the member will pay.

1.8 Reimbursement and Provider Charges

All providers must bill the Program the amount agreed on by both the Provider and the Division. This amount is included in the agreement. When a provider receives a partial payment from a member through the state's sliding payment requirement, that amount is deducted from the agreed upon reimbursement rate.

1.9 Restitution of Overpayments

The Provider shall make proper restitution to Part C for any payments received in excess of amounts due to the Provider under Division regulation or payment schedules whether such overpayment is discovered by the Provider or by the Division. The Division retains the right to offset the reimbursement to be made to the Provider subsequent to the identification of an overpayment.

1.10 Freedom of Choice

Providers have the freedom of choice to serve, or not to serve, any family or child as long as their refusal to provide a service is not on the basis of discrimination as specified in their agreement. Any such refusal to serve must be reported to Child Development Watch immediately. Families also have the right to choose their provider through the Part C Birth to Three Vendor Menu, unless where required by a managed care plan to be served by a specific provider.

1.11 Authorized Access to Information

Delaware Health and Social Services has established procedural safeguards that meet the requirements of the Individuals with Disabilities Education Act, Part C. All agencies receiving either Part C federal funds or state funds for Part C Birth to Three program services are required to abide by these safeguard policies and procedures. Any provider not abiding by these policies and procedures will lose program funding.

The use or disclosure by the Provider of any information concerning a Part C Birth to Three member for any purpose not connected with the administration of the program's or Provider's responsibilities, with respect to services provided under this agreement, is prohibited except upon written consent of the eligible child's parent.

By signing an agreement, the Provider assents to establish appropriate restrictions as a safeguard against access by unauthorized personnel to all data and records of a personal and confidential nature. Any information which is personally identifiable must be safeguarded. Personally identifiable information includes the following:

- The name of the child, the parent or other family member;
- The address of the child, the parent or other family member;
- A personal identifier, such as the social security number of

the child, parent and other family member;

- A description of personal characteristics or other information that would make it possible to identify the child, the parent or other family member with reasonable certainty.

The Division of Management Services and its authorized representatives have the right to access any information directly related to the administration of the Part C Birth to Three program. This is a contractual obligation of the provider.

When additional information is required in order to make a payment decision, it is the responsibility of the provider of the service to forward the requested documents.

1.12 Audits

All Part C Birth to Three providers are subject to routine review and/or audit by authorized representatives of the Division of Management Services or independent audit firms. Such reviews and audits are conducted to determine the accuracy and propriety of provider billings, compliance with Part C policies and procedures, quality of care and utilization of services. By agreement, providers allow DHSS authorized representatives access to all requested financial and service records as appropriate including private pay records. The DHSS authorized representatives are also permitted to reproduce records as they deem appropriate.

1.13 Provider Termination/Suspension

Agreements with providers may be terminated by the Department of Management Services upon five days written notice for documented unsatisfactory performance, as a result of loss of funding or reduction of funding for Provider services, or by either the Department or Provider with or without cause, upon 30 days written notice to the other party.

If the Provider is suspended or excluded from participation in the Medical Assistance program of this state or another state or from the Medicare program, or has been sanctioned in any way by the Centers for Medicare and Medicaid Services (CMS), the Provider will also be excluded from the Part C Birth to Three program, for the term of the Provider's suspension or exclusion. Nor may any Provider who has been so suspended or excluded receive or retain any payment from the Department either directly from the DSS or DMAP or indirectly for any service through any group practice, clinic, medical center, other facility, or individual provider.

Suspension or exclusion as described above does not mean that a provider who meets all of Part C regulations and standards but is not a DMAP provider will be disallowed as a Part C Birth to Three provider. Some providers will be Part C Birth to Three providers alone because the service they provide is either not covered by the DMAP or the DMAP system is structured in such a way that only certain provider types may enroll. For more information see the Billing Section of this manual.

If the Provider's license to practice his profession is suspended, revoked, or otherwise impaired in any jurisdiction, the Provider shall immediately notify the Division in writing and will not be authorized to perform early intervention services under the Part C Birth to Three program.

1.14 Claims Submission--Timeliness

It is a requirement that claims for Part C Birth to Three services be submitted no later than twelve (12) months from the date of service. If the claim has not been submitted within 12

months from the date of service, the claim will be denied unless one of the following circumstances is met:

- A claim for a member covered by Medicaid or other insurance which has been submitted to Medicaid or the primary carrier in a timely manner, will be considered for Part C payment up to 6 months after the provider receives notice of the disposition of the claim, even if it is received by DMAP more than twelve months after the date of service. A copy of the payment voucher or explanation of Medicaid benefits must be attached to the claim to document that the submission falls within the six-month time frame.

Claims that do not meet the above criteria that have been submitted for payment within 12 months from the date of service but have not been paid within 12 months of the date of service will be considered for payment if the initial submission can be documented. Acceptable documentation includes:

- The claim number printed on the Remittance Advice that documents that the claim was submitted within one year from the date of service. The State Fiscal Agent's Part C Analyst will research claims that suspend for review of timely filing. The provider may facilitate this process by including a copy of the Remittance Advice (RA) with the claim number circled or by including the claim number (ICN) from the RA.
- A Return-to-Provider letter (RTP) with the original State Fiscal Agent's date-stamped claims submission attached.

A claim that has been paid may be adjusted within two years of the date of payment.

NOTE: All claims submissions from enrolled providers should be acknowledged by the State Fiscal Agent within four weeks of submission in one of the following ways:

- Appear on the weekly Remittance Advice as a paid, denied or suspended claim.
- Returned to the provider with an RTP that explains the corrections needed.

If your claims submission is not acknowledged in one of these ways, it was not received by the State Fiscal Agent and should be resubmitted.

1.15 Eligibility

Eligibility is determined by a Multidisciplinary Team from Child Development Watch under the Division of Public Health. The population eligible for early intervention services in Delaware

under Part C of the Individuals with Disabilities Education Act includes infants and toddlers with established conditions (disabilities) and/or developmental delays.

The age of eligibility is from birth until the child's third birthday. In a few cases, there will be children who will remain eligible for Part C Birth to Three for up to three months after they turn three. Providers will be made aware of this extended eligibility by the child's service coordinator.

An established condition is one with a high probability of developmental delay. The presence of an established condition must be confirmed by certified professionals. A confirmation of the diagnosis is needed in order to establish service eligibility. A multidisciplinary assessment is required to develop the IFSP.

A developmental delay is a term applied to a child (from birth up to 36 months of age) who exhibits a significant delay in one or more of the following developmental domains: cognitive development; physical development (including vision and hearing); communication development; social or emotional development; or adaptive development. Verification of developmental delay is also determined by the multidisciplinary team. Eligibility criteria will be based on a substantiation of a significant difference between the age-expected level of development (based on gestational age) and current level of functioning.

A child may also become eligible for Part C services based on clinical judgement as confirmed by certified professionals through the multidisciplinary assessment.

1.16 Identifying Eligible Children

Providers will be made aware of children eligible for Part C Birth to Three in several ways:

- Each eligible child and family will receive confirmation of their eligibility which will continue until the completion of another multidisciplinary assessment or the child is no longer eligible.
- Each eligible child will have either an IFSP detailing the intensity and frequency of the needed services or an interim IFSP which is used to ensure immediate services where a full assessment has not been completed.
- Providers who are able to access the Integrated Services Information System (ISIS) will be able to view a screen which details Part C Birth to Three eligibility.
- Sometimes children who are suspected of being eligible but not yet determined to be eligible will be referred to a provider for an evaluation. These children are eligible to have their evaluation and assessment services paid for through Part C (in addition to services listed on the interim IFSP). Providers will be informed by the child's service coordinator of the eligibility of the child for assessment and early intervention services.

2.0 Part C Birth to Three Early Intervention Services

The following service descriptions for allowable Part C Birth to Three early intervention services are taken from Part C regulations.

2.1 Assistive Technology

Assistive Technology devices are any 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.

The term used to define assistive technology devices for the DMAP is Durable Medical Equipment (DME).

When billing for a Medicaid eligible child for an assistive technology device, the provider should use the appropriate code in Appendix C.

If the DMAP has not authorized the device but it is on the Part C Birth to Three eligible child's IFSP or if the child is not Medicaid eligible, the appropriate procedure code in Appendix C should be used.

The following assistive technology services can be billed under a specific provider service (i.e., speech pathology, physical therapy) or under the equipment code and are not billed as a separate service.

Assistive technology service is 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:

- The evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child's customary environment;
- Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by children with disabilities;
- Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;
- Training or technical assistance for a child with disabilities or, if appropriate, that child's family; and
- 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 children with disabilities.

2.2 Audiology

Audiology includes:

- Identification of children with auditory impairment, using at risk criteria and appropriate audiologic screening techniques;
- Determination of the range, nature, and degree of hearing loss and communication functions, by use of audiological evaluation procedures;
- Referral for medical and other services necessary for the habilitation or rehabilitation of children with auditory impairment;
- Provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training, and other services;
- Provision of services for prevention of hearing loss; and
- 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 devices.

Audiology assessment services for Part C Birth to Three eligible children will be provided by the Division of Public Health. However, children who are deaf-blind or hearing impaired and eligible through Part B of IDEA primarily receive services through the Department of Education. Accordingly, these services are funded through Part B. Providers are required to bill using the appropriate code found in Appendix C.

2.3 Mental Health Services

The Division of Child Mental Health, Department of Services for Children, Youth, and their Families is in the process of developing a managed care system which will likely include infants and toddlers eligible for Part C Birth to Three. When this process is finalized, the Division of Child Mental Health will serve as the gatekeeper for all children's mental health services and be responsible for contracting with, monitoring, and paying providers.

2.4 Psychological Services

Psychological services include:

- Administering psychological and developmental tests, and other assessment procedures;

- Interpreting assessment results;
- Obtaining, integrating, and interpreting information about child behavior, and child and family conditions related to learning, mental health, and development; and
- Planning and managing a program of psychological services, including psychological counseling for children and parents, family counseling, consultation on child development, parent training, and education programs.

The codes for psychological evaluation and individual therapy and counseling for child and family services are found in Appendix C.

Rehabilitation agencies use revenue codes to bill for their services. The appropriate revenue codes used by rehabilitation agencies are found in Appendix C.

2.5 Family Training and Family Counseling

Family training and family counseling are services provided, as appropriate, by licensed clinical social workers, psychologists, family therapists and other qualified personnel to assist the family of a Part C Birth to Three eligible child in understanding the special needs of the child and enhancing the child's development.

The appropriate code for child development oriented family training and counseling services is found in Appendix C.

An additional code for parent training for parents of Part C eligible children is also found in Appendix C. Providers of this service may be paraprofessionals with social service training and experience with an emphasis on infant and child development.

2.6 Medical Services

Medical services, which are only for diagnostic or evaluation purposes according to the Part C law, are services provided by a licensed physician to determine a child's developmental status and need for early intervention services.

The procedure code for developmental testing is found in Appendix C.

Tests that qualify as developmental testing include, but are not limited to, the Brazelton, Bayley, CAT and CLAM. For Medicaid eligible children, the Denver Developmental should continue to be billed under a well-child exam. For children who are not Medicaid eligible, however, physicians can bill Part C for administering the Denver since Part C funds do not pay for well-child services.

2.7 Health And Nursing Services

As used in Part C, health services are services necessary to enable a child to benefit from other early intervention services during the time the child is receiving the other early intervention services.

Health services include:

- Such services as clean intermittent catheterization, tracheostomy care tube feeding, the changing of dressings

or colostomy collection bags, and other health services; and

- Consultation by physicians with other service providers concerning the special health care needs of eligible children that will need to be addressed in the course of providing other early intervention services.

Health services do not include the following:

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

Nursing services include:

- The assessment of health status for the purpose of providing nursing care, including the identification of patterns of human response to actual or potential health problems;
- Provision of nursing care to prevent health problems, restore or improve functioning, and promote optimal health and development; and
- Administration of medications, treatments, and regimens prescribed by a licensed physician.

The same procedure and revenue codes found in Appendix C are used for health and nursing services.

2.8 Nutrition Services

Part C Birth to Three nutrition services are described as:

- 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;

- Developing and monitoring appropriate plans to address the nutritional needs of children eligible under this part, based on the findings of the assessments as described above; and
- Making referrals to appropriate community resources to carry out nutrition goals.

Nutrition services are not currently reimbursed by Medicaid when provided by nutritionists except when provided at a physician's office (it can be billed as part of a visit). The appropriate procedure codes for the initial nutrition consultation and nutrition counseling are found in Appendix C.

2.9 Occupational Therapy

Occupational therapy includes: services to address the functional needs of a child related to adaptive development, adaptive behavior 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:

- Identification, assessment, and intervention;
- 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,
- Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.

Home health agencies may bill for occupational therapy using the appropriate procedure code found in Appendix C.

Home health agencies, hospital outpatient facilities, and rehabilitation agencies must use the appropriate revenue code found in Appendix C.

Currently, to provide these services under Medicaid, a provider must either be a home health agency, rehabilitation agency or hospital outpatient facility. However, some providers, who are not enrolled as Medicaid providers, will be enrolled as Part C Birth to Three therapy providers. Codes are no longer specifically developed for “Part C Only” providers, so all providers will therefore be using billing codes as indicated in Appendix C.

2.10 Physical Therapy

Physical therapy under Part C consists of 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:

- Screening, evaluation, and assessment of infants and toddlers to identify movement dysfunction;
- Obtaining, interpreting, and integrating information appropriate to program planning to prevent, alleviate or compensate for movement dysfunction and related functional problems; and
- Providing individual and group services or treatment to prevent, alleviate or compensate for movement dysfunction and related functional problems.

Home health agencies may bill for physical therapy using the appropriate code found in Appendix C.

Home health agencies, hospital outpatient facilities, and rehabilitation agencies must use the appropriate revenue codes found in Appendix C for both Medicaid and Part C Birth to Three services.

Currently, to provide these services under Medicaid, a provider must either be a home health agency, rehabilitation agency or hospital outpatient facility. However, some providers, who are not enrolled as Medicaid providers, may be enrolled as Part C Birth to Three therapy providers.

2.11 Social Work

Social Work includes:

- Making home visits to evaluate a child's living conditions and patterns of parent-child interaction;
- Preparing a social or emotional developmental assessment of the child within the family context;
- Providing individual and family-group counseling with parents and other family members, and appropriate social skill building activities with the child and parents;
- Working with those problems in a 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
- Identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from early intervention services.

For the most part, these services will be provided by state agencies. However, when there is a significant need for social work, the Multidisciplinary Team might recommend that a social worker from a private agency work with the family. This service is not reimbursed by Medicaid, however, a social work procedure code is found in Appendix C to be used Part C Birth to Three only.

2.12 Developmental Services (Special Instruction)

Developmental Services, defined as Special Instruction under IDEA includes:

- The design of learning environments and activities that promote the child's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction;
- Curriculum planning, including the planned interaction of personnel, materials, and time and space, that leads to achieving the outcomes in the child's individualized family service plan;
- Providing families with information, skills, and support related to enhancing the skill development of the child: and
- Working with the child to enhance the child's development.

Developmental services are Part C Birth to Three only services. Procedure codes for these services are found in Appendix C.

2.13 Speech-Language Pathology

Speech-language pathology includes:

- Identification of children with communicative or oropharyngeal disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills;
- Referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communicative or oropharyngeal disorders and delays in development of communication skills; and
- Provision of services for the habilitation, rehabilitation, or prevention of communicative or oropharyngeal disorders and delays in development of communication skills.

Home health agencies may bill for speech-language pathology using the codes found in Appendix C.

Home health agencies, hospital outpatient facilities, and rehabilitation agencies must use the appropriate revenue codes found in Appendix C for both Medicaid and Part C Birth to Three services.

Procedure codes for comprehensive speech evaluation and speech treatment are found in Appendix C and may be used by individual speech therapists or speech therapy facilities.

2.14 Transportation

Effective September 1, 2003, DMAP contracted with a broker to manage non-emergency transportation (NET) services for Part C members. Transportation providers must enroll with the broker if they wish to provide NET services to eligible Part C members.

3.0 Billing Information

Procedure codes and revenue codes are used for all Part C Birth to Three eligible children. These codes cover Medicaid and Part C covered services.

Revenue center codes are the 4-digit UB-92 codes for inpatient, outpatient, home health and hospice claims. These codes identify accommodations and services provided for the member.

Procedure codes are based on those HCPCS codes used by Medicaid as its listing of descriptive terms and identifying codes for reporting medical services and procedures performed by practitioners.

Hospital outpatient and rehabilitation agencies use revenue center codes alone. Home health agencies use both revenue center codes and procedure codes. Other agencies, such as Part C Birth to Three only service providers, will use just the procedure codes.

Providers cannot redefine HCPCS procedure codes to meet the needs of their individual office practice.

The level of service billed must correspond to the definition of that particular code rather than the expected reimbursement amount. The documentation required to support the level of service billed must also be maintained by the provider.

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4.0 Coordination of Benefits

4.1 Medicaid and Part C Federal and State Funds

Infants and toddlers who are Medicaid eligible as well as Part C Birth to Three eligible, will continue to have medically necessary services paid for through the DMAP. Part C Birth to Three, funded by both federal Part C funds and state funds, will pay for early intervention services specified on an Individualized Family Services Plan (IFSP) for eligible children who are not eligible for Medicaid and for those services which are not reimbursable by the DMAP.

4.2 Other Coverage

Infants and toddlers eligible for Part C Birth to Three are likely to be covered by Medicaid or by other medical insurance plans. Examples of medical insurance plans are Blue Cross and Blue Shield, TRICARE/Sierra Military Health, Connecticut General, Metropolitan, Hartford, Travelers, and Health and Welfare Funds through union membership.

Medicaid, as required by Title XIX of the Social Security Act, pays for a service only after all other available insurance has been billed first. FY 2001 State Budget Epilogue Language requirements also dictate that insurers be billed first for most Part C Birth to Three early intervention services.

Assessments and evaluations are to be offered "at no cost" to the family. Funding for these services may come from Part C funds when a child has private insurance, although Medicaid can still pay for those services for Medicaid eligible children who have no other insurance coverage.

4.3 Sliding Payment Scales

Providers are also required to inform non-Medicaid families of the sliding payment scale. These fees are based on the DHSS scale developed by the Ability to Pay Committee as included in Policy Memorandum 37 of the Department or a provider may use his own scale as long as the amount paid does not exceed the payment scale of the DHSS.

The maximum fee charged to Non-Medicaid members for Program Services shall not exceed the Fee-for-Service rate paid by Medicaid for services provided to Medicaid members. The Provider is expected to make reasonable efforts to collect such fees from all non-Medicaid members receiving services. The provider will work with the service coordinator to determine the family's ability to pay. The provider should submit no more than 2 bills to the parents.

A provider cannot refuse services to any individual on the basis of such individual's inability to pay for services. When a Part C Birth to Three eligible child's family is unable to pay, the Division will use available Part C state and federal dollars to pay for those Part C Birth to Three early intervention services identified on the Individualized Family Services Plan (IFSP).

4.4 General Role of Service Providers

To the extent appropriate, service providers in each area of early intervention services are responsible for:

- Consulting with parents, other service provider, and representatives of appropriate community agencies to ensure the effective provision of services in that area;

- Training parents and others regarding the provision of those services; and
- Participating in the multidisciplinary team's assessment of a child and the child's family, and in the development of integrated goals and outcomes for the individualized family service plan.

5.0 Appendix A – Reserved for Future Use

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6.0 Appendix B – Reserved for Future Use

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7.0 Appendix C – Part C Codes

7.1 Part C Codes

When billing the DMAP, Part C providers are required to use the following codes.

Code	Description
G0154	Services of skilled nurse in home health setting, each 15 minutes
G0151	Services of a physical therapist in home health setting, each 15 minutes
G0152	Services of an occupational therapist in home health setting, each 15 minutes
G0153	Services of a speech and language pathologist in home health setting, each 15 minutes
Appropriate Level II HCPCS code	Providers must use the appropriate durable medical equipment code. These codes will require prior authorization
90801	Psychiatric diagnostic interview examination
90802	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
90805	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services
90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20-30 minutes face-to-face with the patient
90811	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20-30 minutes face-to-face with the patient; with medical evaluation and management services
90816	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20-30 minutes face-to-face with the patient
90817	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 20-30 minutes face-to-face with the patient; with medical evaluation and management services
90823	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms or non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20-30 minutes face-to-face with the patient
90824	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms or non-verbal communication, in an inpatient hospital, partial hospital or residential care setting, approximately 20-30 minutes face-to-face with the patient; with medical evaluation and

Code	Description
	management services
90845	Psychoanalysis
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); approximately 20-30 minutes
92506	Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status (For dates of service through 12/31/2013)
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
97003	Occupational therapy evaluation
97004	Occupational therapy re-evaluation
97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97001	Physical therapy evaluation
97002	Physical therapy re-evaluation
97802.	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 min.
97803	Medical nutrition therapy, re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
V5030-V5299	Hearing Services
S9127	Social work visit, in home, per diem
96150	Routine Based Interview; as part of the multidisciplinary assessment.
96154	Health and behavior intervention, each 15 min., face-to-face; family (with the patient present)
96155	Health and behavior intervention, each 15 min., face-to-face; family (without the patient present)
97532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact by the provider, ea. 15 min.
97150	Therapeutic procedure(s), group (2 or more individuals)
96111	Developmental testing; extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments, e.g., Bayley Scales of Infant Development) with interpretation and report, per hour
S4386 (Use this code for dates of service through 12/31/03).	Early intervention
T1023 (Use this code for dates of service on and after 1/1/04).	Screening to determine the appropriateness of consideration of an individual for participation in a specified program. Project or treatment protocol, per encounter.

Code	Description
S9131	Physical therapy; in the home, per diem
S9129	Occupational therapy, in the home, per diem
S9128	Speech therapy, in the home, per diem
T1023+HT mod (Use this code for dates of service on and after 1/1/04).	Screening to determine the appropriateness of consideration of an individual for participation in a specified program. Project or treatment protocol, per encounter.
S9131+mod	Physical therapy; in the home, per diem TG modifier (if applicable) Complex/High Tech Level of Care
S9129+mod	Occupational therapy, in the home, per diem TG modifier (if applicable) Complex/High Tech Level of Care
S9128+mod	Speech therapy, in the home, per diem TG modifier (if applicable) Complex/High Tech Level of Care

Revenue Center Codes

Providers will use the following revenue codes for services.

Code	Description
0420	PT, general classification
0421	PT, visit charge
0422	PT, hourly charge
0423	PT, group rate
0424	PT, evaluation or re-evaluation
0429	PT, other PT
0430	OT, general classification
0431	OT, visit charge
0432	OT, hourly charge
0433	OT, group rate
0434	OT, evaluation or re-evaluation
0439	OT, other
0440	Speech/language pathology, general classification
0441	Speech/language pathology, visit charge
0442	Speech/language pathology, hourly charge
0443	Speech/language pathology, group rate
0444	Speech/language pathology, evaluation or re-evaluation
0449	Speech/language pathology, other
0471	Audiology, diagnostic
0552	Skilled nursing, hourly charge
0910	Psychiatric/psychological treatments, general Classification (evaluation)
0914	Psychiatric/psychological treatments, individual therapy

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8.0 Appendix D – Addresses and Phone Numbers

Deputy Director's Office	Director's Office
Division of Management Services Main Building Herman M. Holloway, Sr., DHSS Campus 1901 N. DuPont Hwy. New Castle, DE 19720 Phone: (302) 577-4512	Division of Management Services Main Building Herman M. Holloway, Sr., DHSS Campus 1901 N. DuPont Hwy. New Castle, DE 19720 Phone: (302) 577-4515

Fiscal Agent	Part C Birth to Three Office (Administrative Office)
Gainwell Technologies 645 Paper Mill Road Suite 1015 Newark, DE 19711 Phone: (302) 454-7622 Fax: (302) 454-7603 Mailing Address: P.O. Box 909 Manor Branch New Castle, DE 19720-0909	Division of Management Services Main Building Herman M. Holloway, Sr., DHSS Campus 1901 N. DuPont Hwy., Room 209 New Castle, DE 19720 Phone: (302) 577-4643 Fax: (302) 577-4083

Child Development Watch Offices (Operations Offices)	
Child Development Watch 2055 Limestone Road, Suite 201 Wilmington, Delaware 19808 Phone: (302) 995-8617 Fax: (302) 995-8363	Child Development Watch 18 North Walnut Street Milford, Delaware 19963 Phone: (302) 422-1335 Fax: (302) 422-1363

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