ARKANSAS REGISTER

Transmittal Sheet

Use only for **FINAL** and **EMERGENCY RULES**

Secretary of State
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For Office Use Only:

Effective Date _____ Code Number _____

Name of Agency Department of Human Services

Department Division of Developmental Disabilities Services

Contact Elizabeth Pitman E-mail elizabeth.pitman@dhs.arkansas.gov Phone 501-682-4936

Statutory Authority for Promulgating Rules Arkansas Code Annotated 20-48-101

Rule Title: Early Intervention Day Treatment (EIDT) New-18, State Plan Amendment #2018-004, etc.

Intended Effective Date (Check One)		Date
☐ Emergency (ACA 25-15-204)	Legal Notice Published	04/09/2018
☐ 10 Days After Filing (ACA 25-15-204)	Final Date for Public Comment	05/08/2018
☑ Other July 1, 2018 (Must be more than 10 days after filing date.)	Reviewed by Legislative Council	06/15/2018
	Adopted by State Agency	07/01/2018

Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Becky Murphy (Contact Person) becky.murphy@dhs.arkansas.gov (E-mail Address) _____ (Date)

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Melissa Stone
Signature

(501) 682-8682 (Phone Number) melissa.stone@dhs.arkansas.gov (E-mail Address)

Director
Title

6/18/18
Date

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY

DEPARTMENT Arkansas Department of Human Services

DIVISION Division of Developmental Disabilities Services

PERSON COMPLETING THIS STATEMENT Elizabeth Pitman

TELEPHONE 501-682-4936 **FAX** 501-682-8380 **EMAIL:** Elizabeth.pitman@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the following Financial Impact Statement and file two copies with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Early Intervention Day Treatment-New-18; State Plan Amendment #2018-004; and DDS Standards for Certification and Monitoring for Center-based Community Services

1. Does this proposed, amended, or repealed rule have a financial impact? Yes ☒ No ☐

2. Is the rule based on the best reasonably obtainable scientific, technical, economic, or other evidence and information available concerning the need for, consequences of, and alternatives to the rule? Yes ☒ No ☐

3. In consideration of the alternatives to this rule, was this rule determined by the agency to be the least costly rule considered? Yes ☒ No ☐

   If an agency is proposing a more costly rule, please state the following:

   (a) How the additional benefits of the more costly rule justify its additional cost;

   (b) The reason for adoption of the more costly rule;

   (c) Whether the more costly rule is based on the interests of public health, safety, or welfare, and if so, please explain; and;

   (d) Whether the reason is within the scope of the agency's statutory authority; and if so, please explain.

4. If the purpose of this rule is to implement a federal rule or regulation, please state the following:

   (a) What is the cost to implement the federal rule or regulation?

Current Fiscal Year		**Next Fiscal Year**	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other (Identify)		Other (Identify)	

Total _____ Total _____

(b) What is the additional cost of the state rule?

Current Fiscal Year		Next Fiscal Year	
General Revenue	($3,909,964.71) savings	General Revenue	($11,000,715.72) savings
Federal Funds	($9,389,235.00) savings	Federal Funds	($29,064,910.78) savings
Cash Funds	0	Cash Funds	0
Special Revenue	0	Special Revenue	0
Other (Identify)	0	Other (Identify)	0
Total	($13,299,199.71) savings	Total	($40,065,626.50) savings

5. What is the total estimated cost by fiscal year to any private individual, entity and business subject to the proposed, amended, or repealed rule? Identify the entity(ies) subject to the proposed rule and explain how they are affected.

Current Fiscal Year
$ 0

Next Fiscal Year
$ 0

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6. What is the total estimated cost by fiscal year to state, county, and municipal government to implement this rule? Is this the cost of the program or grant? Please explain how the government is affected.

Current Fiscal Year
$ 0

Next Fiscal Year
$ 0

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7. With respect to the agency's answers to Questions #5 and #6 above, is there a new or increased cost or obligation of at least one hundred thousand dollars ($100,000) per year to a private individual, private entity, private business, state government, county government, municipal government, or to two (2) or more of those entities combined?

Yes ☐ No ☐

If YES, the agency is required by Ark. Code Ann. § 25-15-204(e)(4) to file written findings at the time of filing the financial impact statement. The written findings shall be filed simultaneously with the financial impact statement and shall include, without limitation, the following:

(1) a statement of the rule's basis and purpose;

(2) the problem the agency seeks to address with the proposed rule, including a statement of whether a rule is required by statute;

(3) a description of the factual evidence that:
(a) justifies the agency's need for the proposed rule; and
(b) describes how the benefits of the rule meet the relevant statutory objectives and justify the rule's costs;

(4) a list of less costly alternatives to the proposed rule and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(5) a list of alternatives to the proposed rule that were suggested as a result of public comment and the reasons why the alternatives do not adequately address the problem to be solved by the proposed rule;

(6) a statement of whether existing rules have created or contributed to the problem the agency seeks to address with the proposed rule and, if existing rules have created or contributed to the problem, an explanation of why amendment or repeal of the rule creating or contributing to the problem is not a sufficient response; and

(7) an agency plan for review of the rule no less than every ten (10) years to determine whether, based upon the evidence, there remains a need for the rule including, without limitation, whether:
   (a) the rule is achieving the statutory objectives;
   (b) the benefits of the rule continue to justify its costs; and
   (c) the rule can be amended or repealed to reduce costs while continuing to achieve the statutory objectives.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
TDD/TTY: 501-682-6789

TO: Arkansas Medicaid Health Care Providers – Early Intervention Day Treatment

EFFECTIVE DATE: July 1, 2018

SUBJECT: Provider Manual Update Transmittal EIDT-New-18

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
—	—	ALL	7-1-18

Explanation of Updates

A new Early Intervention Day Treatment (EIDT) policy manual is available for all EIDT providers. This program is replacing the Child Health Management Services program effective July 1, 2018.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: https://medicaid.mmis.arkansas.gov/.

Thank you for your participation in the Arkansas Medicaid Program.

Rose M. Naff
Director

TOC required

200.000 GENERAL INFORMATION

201.000 Introduction to Early Intervention Day Treatment (EIDT) 7-1-18

Arkansas Code Annotated §§ 20-48-1101—1108, authorizes the use of a successor program for early intervention day treatment for children. The Department of Human Services, Division of Developmental Disabilities Services ("DDS") is responsible for the implementation, general administration, and oversight of the successor program for early intervention day treatment for children. Division of Provider Services and Quality Assurance (DPSQA) is responsible for certification and licensure criteria as the regulatory entity governing this successor program.

Child Health Management Services (CHMS) means an array of clinic services for children intended to provide full medical multidiscipline diagnosis, evaluation, and treatment of developmental delays in Medicaid recipients who meet eligibility criteria and for whom the treatment has been deemed medically necessary.

Developmental Day Treatment Clinic Services (DDTCS) for children means early intervention day treatment provided to children by a nonprofit community program that is licensed to provide center-based community services by the Division of Developmental Disabilities.

For both CHMS and DDTCS for children, early intervention day treatment means services provided by a pediatric day treatment program run by early childhood specialists, overseen by a physician and serving children with developmental disabilities, developmental delays, and a medical condition.

For both CHMS and DDTCS for children, early intervention day treatment includes without limitation diagnostic, screening, evaluation, preventive, therapeutic, palliative, rehabilitative and habilitative services, including speech, occupational, and physical therapies and any medical or remedial services recommended by a physician for the maximum reduction of physical or mental disability and restoration of the child to the best possible functional level. Early Intervention day treatment is available year-round to children aged 0-6; and in the summer months for children aged 6-21.

CHMS, DDTCS for children or the successor programs constitute the State's early intervention day treatment program.

Successor program means a program that provides early intervention day treatment to children that is created to replace in whole the CHMS and DDTCS for children programs. For profit and nonprofit providers from CHMS and DDTCS programs may participate, conditioned on program compliance.

Early Intervention Day Treatment (EIDT) is the successor program under Ark. Code Ann. §§ 20-48-1101—1108.

Determination of underserved status for expansion of services

An expansion of early intervention day treatment services in a county is necessary when the Division of Developmental Disabilities Services determines that a county is underserved with regard to:

A. Early intervention day treatment services as defined above; or

B. A specific category of early intervention day treatment services currently offered to children with developmental disabilities or delays.

201.100 Licensing Requirements 7-1-18

EIDT providers must meet the provider participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

A. Each provider of EIDT must be licensed as an Early Intervention Day Treatment provider by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance (DPSQA).

B. Each provider of EIDT must meet all child care licensing rules, as well as all health and safety requirements, as applicable under local, state, and federal laws, rules and regulations, unless otherwise specified in this manual.

C. A copy of all relevant current licenses and certifications must accompany the provider application and the Medicaid contract.

EIDT providers may furnish and claim reimbursement for covered services in the Arkansas Medicaid Program subject to all requirements and restrictions set forth and referenced in this manual. Claims must be filed according to the specifications in this manual. Covered services must be medically necessary and prescribed by the child's primary care physician (PCP). When referring to or prescribing EIDT services, the PCP shall not make any self-referrals in violation of state or federal law.

201.200 Providers in Arkansas and Bordering States 7-1-18

Providers in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) within fifty (50) miles of the state line may be enrolled as EIDT providers if they meet all Arkansas Medicaid participation requirements.

201.300 Academic Medical Center Program Specializing in Development Pediatrics 7-1-18

An academic medical center program specializing in developmental pediatrics is eligible for reimbursement as an EIDT provider if it is certified as an Academic Medical Center by DPSQA. An Academic Medical Center must meet the following requirements:

A. Is located in the state of Arkansas;

B. Provides multi-disciplinary diagnosic and evaluation services to children throughout the state of Arkansas;

C. Specializes in developmental pediatrics;

D. Serves as a large, multi-referral program, as well as a referral source for other, non-academic EIDT programs within the state;

E. Is staffed to provide training of pediatric residents and other professionals in the multi-disciplinary diagnostics and evaluation of children with developmental disabilities and other special health care needs; and

F. Does not provide treatment services to children.

Only an EIDT that is certified as an Academic Medical Center Program may bill the following codes, in addition to those listed in Section 232.100:

90791, U9	96101, U1, UA	99202	99215, U1	99173
90791, U1, U9	96105	99203	92551	T1016
90887	96111	99204	92567	T1025

96101 UA	96118	99205	92587	
96101, UA, UB	99201	99205, U1	95961	

202.000 Documentation Requirements for All Medicaid Providers **7-1-18**

Documentation and provider participation requirements are detailed within Section 140.000, Provider Participation, of this Manual.

202.100 EIDT Record Requirements **7-1-18**

A. Providers must establish and maintain medical records for each beneficiary that include documentation of medical necessity for all services billed.

B. Each beneficiary's record must include the results of the developmental screen performed by the Department of Human Services' Third Party Vendor, or an approved waiver of that screen in accordance with the Provider Manual Governing Independent Assessments and Developmental Screens.

C. Sufficient, contemporaneous written documentation for each beneficiary must be present and must support the necessity of all services provided. This requirement applies to core services and optional services. Refer to Section 210.000 of this manual for description of services and documentation required.

D. Service documentation for each beneficiary must, at a minimum, include the following items:

1. The specific services furnished daily;
2. The date and beginning and ending time the services were performed daily;
3. Name(s) and credential(s) of the person(s) providing the service(s), daily;
4. The relationship of the daily services to the goals and objectives described in the beneficiary's individual treatment plan (ITP); and
5. At a minimum, weekly progress notes describing each beneficiary's status with respect to his or her goals and objectives that are signed or initialed by the person(s) providing the service(s),

202.200 Electronic Signatures **7-1-18**

Medicaid will accept electronic signatures if the electronic signatures comply with Arkansas Code Ann. §§ 25-31-103 et seq.

203.000 Referral to First Connections program, pursuant to Part C of Individuals with Disabilities Education Act (IDEA) **7-1-18**

DDS is the lead agency responsible for the general administration and supervision of the programs and activities utilized to carry out the provisions of Part C of the IDEA. First Connections is the DDS program in Arkansas that administers, monitors, and carries out all Part C of IDEA activities and responsibilities for the state. The First Connections program ensures that appropriate early intervention services are available to all infants and toddlers from birth to thirty-six (36) months of age (and their families) that are suspected of having a developmental delay.

Federal regulations under Part C of the IDEA require "primary referral sources" to refer any child suspected of having a developmental delay or disability for early intervention services. An EIDT is considered a primary referral source under Part C of IDEA regulations.

Each EIDT must, within two (2) working days of first contact, refer all infants and toddlers from birth to thirty-six (36) months of age for whom there is a diagnosis or suspicion of a developmental delay or disability. The referral must be made to the DDS First Connections Central Intake Unit, which serves as the State of Arkansas' single point of entry to minimize duplication and expedite service delivery. Each EIDT is responsible for maintaining documentation evidencing that a proper and timely referral to First Connections has been made.

204.000 Election to Provide Special Education Services in Accordance with Part B of the Individuals with Disabilities Education Act (IDEA) 7-1-18

Local Education Agencies ("LEA") have the responsibility to ensure that children ages three (3) until entry into Kindergarten who have or are suspected of having a disability under Part B of IDEA ("Part B") receive a Free Appropriate Public Education. The Arkansas Department of Education provides each EIDT with the option of participating in Part B as an LEA. Participation as an LEA requires an EIDT to provide special education and related services in accordance with Part B ("Special Education Services") to all children with disabilities it is serving aged three (3) until entry into Kindergarten. A participating EIDT is also eligible to receive a portion of the federal grant funds made available to LEAs under Part B in any given fiscal year.

Each EIDT must therefore make an affirmative election to either provide or not provide Special Education Services to all children with disabilities it is serving aged three (3) until entry into Kindergarten.

For further clarification related to Special Education Services refer to the DPSQA EIDT Licensure Manual.

View or print the Arkansas Department of Education Special Education contact information.

205.000 EIDT Providing Occupational, Physical, or Speech Therapy 7-1-18

Services available through EIDT include occupational, physical and speech therapy and evaluation as an essential component of the individual treatment plan (ITP) for an individual accepted for developmental disabilities services.

An EIDT facility may contract with or employ qualified therapy practitioners. The individual therapy practitioner who actually performs a service on behalf of the EIDT facility must be identified on the claim as the performing provider when the EIDT facility bills for that service. This action is taken in compliance with the federal Improper Payments Information Act of 2002 (IPIA), Public Law 107-300 and the resulting Payment Error Rate Measurement (PERM) program initiated by the Centers for Medicare and Medicaid Services (CMS).

If the facility contracts with a qualified therapy practitioner, the criteria for group providers of therapy services apply (See Section 201.100 of the Occupational, Physical, Speech Therapy Services manual). The qualified therapy practitioner who contracts with the facility must be enrolled with Arkansas Medicaid. The contract practitioner who performs a service must be listed as the performing provider on the claim when the facility bills for that service.

If the facility employs a qualified therapy practitioner, that practitioner has the option of either enrolling with Arkansas Medicaid or requesting a Practitioner Identification Number (**View or print form DMS-7708**). The employed practitioner who performs a service must be listed as the performing provider on the claim when the facility bills for that service.

210.000 PROGRAM COVERAGE

211.000 Introduction 7-1-18

Medicaid assists eligible individuals to obtain medical care in accordance with the guidelines specified in Section I of this Manual. Reimbursement may be made for medically necessary, covered Early Intervention Day Treatment Services provided to Medicaid beneficiaries, aged 0-21, at qualified provider facilities. Services may be provided year-round to beneficiaries aged 0-6, and during the summer months for beneficiaries aged 6-21.

212.000 Establishing Eligibility 7-1-18

Reimbursement for covered services will be approved only when the beneficiary's physician has determined that EIDT services are medically necessary:

A. The physician must identify the individual's medical needs that EIDT services can address;

B. To initiate EIDT services, the physician must issue a written prescription. The prescription for EIDT services is valid for one (1) year, unless a shorter period is specified. The prescription must be renewed at least once a year for EIDT services to continue;

C. Each prescription must be dated and signed by the physician with his or her original signature to be considered valid; and .

D. For all beneficiaries who are enrolling in habilitative services for children (0-6), the prescription must be based on the results of an age appropriate developmental screen performed by DHS' Third Party Assessor that indicates the beneficiary has been referred for further evaluation, as well as the results of the full evaluation.

If the child has been diagnosed with one of the following diagnoses or has been deemed to meet the institutional level of care (as shown on a DMS-703), , the physician or EIDT provider may send all relevant documentation to DHS' Third Party Vendor for review in lieu of referring the patient for a developmental screen:

1. Intellectual Disability
2. Spina bifida
3. Cerebral palsy
4. Autism spectrum disorder
5. Epilepsy/seizure disorder
6. Down syndrome

A clinician will review the submitted documentation to determine if a developmental screen is needed.

212.100 Eligibility Criteria 7-1-18

To receive EIDT day habilitation services, the beneficiary must have a documented developmental disability or delay, as shown on the results of an annual comprehensive developmental evaluation. The comprehensive annual developmental evaluation must include a norm referenced (standardized) evaluation and a criterion referenced evaluation. The norm referenced evaluation must be the most current addition of the Battelle Developmental Inventory (BDI). The Criterion referenced evaluation must be the most current edition of one of the following and appropriate for the child's age:

A. Hawaii Early Learning Profile (HELP)

B. Learning Accomplishment Profile (LAP)

C. Early Learning Accomplishment Profile (E-LAP)

D. Brigance Inventory of Early Development (IED)

The evaluator must document that the test protocols for each instrument used were followed, and that the evaluator met the qualification to administer the instrument. The length of the service may not exceed one unit per date of service. The billable unit includes time spent administering the test, time spent scoring the test and/or time spent writing a test report. Services are covered once each calendar year if the service is deemed necessary.

A. Evaluation that shows:

1. For ages 0-36 months, a score of 25% or greater delay in at least two of five domains: motor, social, cognitive, self-help/adaptive, or communication on both the BDI and the criterion referenced;
2. For ages 3-6, a score of at least two standard deviations below the mean in at least two of the five domains: motor, social, cognitive, self-help/adaptive, or communication on the BDI and 25% or greater delay on the criterion referenced test;
3. The same two areas of delay on both the BDI and the criterion referenced test.

B. In addition to having a documented developmental disability or delay, the beneficiary must have a documented need for at least one of the following, as shown on a full evaluation for that service:

1. Physical therapy,
2. Occupational therapy,
3. Speech therapy, or
4. Nursing services

Physical, Occupational and Speech Therapy evaluations must meet qualifying scores as written in the Medicaid Occupational, Physical and Speech Therapy Provider manual.

For children who have a documented delay in the areas of social emotional and adaptive only, a referral must be made to an appropriate head start, home visiting, or Early Interventions or Part B program. This referral must be documented and placed in the child's evaluation record.

C. It is presumed that no more than eight (8) hours of EIDT core and optional services combined per day is medically necessary.

D. EIDT day habilitation prescription is valid for one (1) year.

E. Children who are enrolled in a DDTCS or CHMS as of July 1, 2018, and meet the eligibility criteria promulgated on October 1, 2017, for either the DDTCS children's program or the CHMS program, will be allowed enrollment in EIDT until June 30, 2019, as long as they meet the former criteria on July 1, 2018, and continue to meet the former criteria until June 30, 2019.

213.000 Core Services **7-1-18**

EIDT core services are provided in certified clinics and include the following core services when (a) prescribed by the beneficiary's physician; (b) medically necessary; (c) provided on an outpatient basis; and (d) provided in accordance with a written Individual Treatment Plan (ITP) and this Manual:

A. Year-round Day Habilitative services and evaluation for beneficiaries aged 0-6, up to five (5) hours per day without an approved extension of benefits;

B. Speech evaluation and speech therapy up to ninety (90) minutes per week without prior approval/extension of benefits;

C. Physical evaluation and physical therapy up to ninety (90) minutes per week without prior approval/extension of benefits;

D. Occupational evaluation and occupational therapy up to ninety (90) minutes per week without prior approval/extension of benefits; and

E. Day Habilitative Services in the summer for beneficiaries aged 6-21.

213.100 Nursing Services 7-1-18

EIDT nursing services are available for beneficiaries who are medically fragile, have complex health needs, or both, if prescribed by the beneficiary's PCP in accordance with this manual.

213.200 Non-covered Services 7-1-18

Nothing other than the services listed in Sections 213.100 and 213.200 are covered as an EIDT services, including educational services, supervised living services, and inpatient services.

214.000 Description of EIDT Core Services

214.100 Evaluation 7-1-18

The evaluation service is a component of the process of determining a person's eligibility for habilitative services and habilitative services in the summer. Evaluation services are covered separately from habilitative services.

Evaluation services are covered once per calendar year, if the service is deemed medically necessary by a physician. For children age 18 or less who are enrolling (including those who have been discharged and are re-enrolling) in the habilitative services program (ages 0-6), medical necessity of evaluation services is determined by an age appropriate developmental screen conducted in accordance with the Manual Governing Independent Assessments and Developmental Screens. Children who are only enrolled in the summer habilitation services do not have to undergo a developmental screen.

If the physician or EIDT provider believes that the beneficiary has a significant, documented developmental diagnosis, disability or delay such that he or she does not need a developmental screen, the physician or EIDT provider may send relevant documentation for review by a clinician. The clinician will determine the necessity of a developmental screen.

Evaluation services are reimbursed on a per unit basis, with one unit equal to 15 minutes. There is a maximum of four (4) units per year. The billable unit includes time spent administering the test, scoring the test, and/or writing a test report.

214.200 Habilitative Services for Ages 0-6 7-1-18

A. Habilitative Services are instruction in areas of cognition, communication, social/emotional, motor, and adaptive skills; or to reinforce skills learned and practiced in occupational, physical or speech therapy. Habilitation activities must be designed to teach habilitation goals and objectives specified in the client's Individual Treatment Plan (ITP). (Refer to Section 216.000 of this manual.)

Habilitative Services may be provided to a child before they reach school age, including children who are aged 5-6, if the kindergarten year has been waived.

B. Habilitative services must be overseen by an Early Childhood Development Specialist (ECDS) who:

1. Is a licensed Speech Therapist, Occupational Therapist, Physical Therapist, or Developmental Therapist; or
2. Has a Bachelor's Degree, plus one of the following:
   (a) Current Arkansas state certification in Early Childhood or Early Childhood Special Education;
   (b) A current Child Development Associate Certificate;
   (c) A current Birth to pre-K credential; or
   (d Documented experience working with children with special needs and twelve (12) hours of completed college courses in any of the following areas:
      (i) Early Childhood;
      (ii) Child Development;
      (iii) Special Education/Elementary Education; or
      (iv) Child and Family Studies.

There must be one (1) ECDS for every forty (40) beneficiaries enrolled at an EIDT site.

C. The following staff to beneficiary ratio must be observed:

Age Group	Ratio
0-18 months	1:4
18-36 months	1:5
3-4 years	1:7
4-6 years	1:8

1. During naptime:
   a. A minimum of 50% of the staff shall remain with children 3 years of age and older.
   b. Staff ratios must be maintained at 100% for children under the age of 3.
2. Additional staff must be provided for children with significant medical or behavior needs that require more individual attention.

D. One unit of habilitative services equals one hour. No more than five (5) units of habilitative services may be billed per day without an extension of benefits. This includes naptime.

214.300 Occupational, Physical, and Speech Therapy Services 7-1-18

Occupational, physical, and speech therapy services must be medically necessary to the treatment of the beneficiary's developmental disability or delay, in accordance with the Medicaid Provider Manual for Occupational, Physical, and Speech Therapy Services, Section II. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy.

214.500 Habilitative Services in the Summer for Ages 6-21 7-1-18

Beneficiaries aged 6-21 may receive day habilitative services during the months of May, June, July, and August, when school is not in session if they

A. Have one of the following diagnoses (as defined in DDS Policy 1035):

1. Intellectual Disability
2. Spina Bifida
3. Cerebral Palsy
4. Autism Spectrum Disorder
5. Epilepsy/Seizure Disorder
6. Down Syndrome
7. A condition found to be closely related to intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to those persons with intellectual disability or requires treatment and services similar to those required for such persons. This determination must be based on the results of a team evaluation including at least a licensed Physician and a licensed Psychologist.

AND

B. Receive at least one of the following services:

1. Occupational Therapy
2. Speech Therapy
3. Physical Therapy
4. Nursing

The purpose of these services is to continue habilitation instruction to prevent regression during the summer months while school is not in session. Habilitation activities in the summer must be based on the goals and objectives of the beneficiary's Individual Treatment Plan (ITP).

A. One hour of habilitative services is equal to one unit. No more than five (5) units of habilitative services may be billed per day without an extension of benefits.

B. There must be a staff to beneficiary ratio of one (1) staff to every ten (10) beneficiaries.

215.100 Nursing Services 7-1-18

Nursing services that are needed by a beneficiary and that can only be performed by a licensed nurse may be performed and billed by an EIDT. For the purposes of this Manual, nursing services are defined as the following, or similar, activities:

A. Assisting ventilator-dependent beneficiaries;

B. Tracheostomy: suctioning and care

C. Feeding tube: feeding, care and maintenance

D. Catheterizations

E. Breathing treatments

F. Monitoring of vital statistics, including diabetes sugar checks, insulin, blood draws, and pulse ox

G. Administration of medication

Reimbursable nursing services do not include the taking of temperature or provision of standard first aid.

Administration of medication alone is not enough to qualify a child to receive nursing services.

Nursing services must be performed by a licensed Registered Nurse or Licensed Practical Nurse, and must be within the nurse's scope of practice as set forth by the Arkansas State Board of Nursing.

To establish medical necessity for nursing services the beneficiary must have a medical diagnosis and a comprehensive nursing evaluation approved by a PCP that designates the need for nursing services. The evaluation must specify what the needed nursing services are. Based on the nursing evaluation, the PCP must authorize the number of nursing units per day.

Medicaid will reimburse up to 4 units of nursing per day without authorization. Additional nursing units will require an extension of benefits.

216.000 Annual Individual Treatment Plan (ITP) 7-1-18

For each beneficiary receiving services at an EIDT, an annual Individual Treatment Plan (ITP) must be developed. The ITP consists of a written, individualized plan to improve the beneficiary's condition. The ITP must contain:

A. A written description of the beneficiary's treatment objectives;

B. The beneficiary's treatment regimen, which includes the specific medical and remedial services, therapies and activities that will be used to achieve the beneficiary's treatment objectives and how those services, therapies, and activities are designed to achieve the treatment objectives;

C. Any evaluations or documentation that supports the medical necessity of the services, therapies or activities specified in the treatment regimen;

D. A schedule of service delivery that includes the frequency and duration of each type of service, therapy or activity session or encounter;

E. The job title or credential of the personnel that will furnish each service, therapy or activity; and

F. The schedule for completing re-evaluations of the beneficiary's condition and updating the ITP.

The annual ITP must be developed by the Early Childhood Development Specialist assigned to the child.

220.000 REIMBURSEMENT AND RECOUPMENT

221.000 Method of Reimbursement 7-1-18

The reimbursement methodology for Early Intervention Clinic-based Day Treatment (EIDT) is a "fee schedule" methodology. Under the fee schedule methodology, reimbursement is based on the lesser of the billed amount or the Title XIX (Medicaid) maximum allowed for each procedure. The maximum allowable fee for a procedure is the same for all EIDT providers.

221.100 Fee Schedules 7-1-18

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at **https://medicaid.mmis.arkansas.gov/** under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

222.000 Retrospective Reviews 7-1-18

Arkansas Medicaid conducts retrospective review of the core EIDT services:

The purpose of retrospective review is to promote effective, efficient and economical delivery of health care services.

The Quality Improvement Organization (QIO), under contract to the Arkansas Medicaid Program, performs retrospective reviews of medical records to determine if services delivered and reimbursed by Medicaid meet medical necessity requirements as outlined in the Medicaid Provider Manual and any applicable Certification Standards. **View or print QIO contact information.**

223.000 Recoupment 7-1-18

The Division of Medical Services (DMS), Utilization Review Section (UR) is required to initiate the recoupment process for all services denied by the contracted QIO, for not meeting the medical necessity requirements. Based on QIO findings during retrospective reviews, recoupment will be initiated, as appropriate.

DMS, or its QIO, will send the provider an Explanation of Recoupment Notice that will include the claim date of service, Medicaid beneficiary name and ID number, service provided, amount paid by Medicaid, amount to be recouped, and the reason the claim has been denied.

224.000 Administrative Reconsideration 7-1-18

When a provider or beneficiary wishes to ask for administrative reconsideration of a DHS decision, he or she must follow the procedure laid out in the Medicaid Provider Manual, Section 161.200.

224.100 Appeal Process 7-1-18

When the Division of Medical Services (DMS) denies coverage of services, the beneficiary or the provider may request a fair hearing to appeal the denial of services from the Department of Health and Human Services. To do so, the beneficiary or provider must follow the procedures laid out in the Medicaid Provider Manual, Sections 160.000 and 190.000.

230.000 BILLING PROCEDURES

231.000 Introduction to Billing 7-1-18

EIDT providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to Medicaid beneficiaries. Each claim may contain charges for only one beneficiary.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claims submission.

232.000 CMS-1500 Billing Procedures

232.100 Early Intervention Day Treatment Services Procedure Codes 7-1-18

EIDT core services are reimbursable on a per unit basis. Partial units are not reimbursable. Service time less than a full unit of service may not be rounded up to a full unit of service and may not be carried over to the next service date. Must use the Type of Service (TOS) code M.

Procedure Code	Required Modifier	Description
T1015	U6, UB	Habilitative Services Aged 0-6 (1unit equals 1 hour, maximum of 5 units per day)
T1015	U6, UC	Habilitative Services in the Summer Aged 6-21 (1 unit equals 1 hour, maximum of five units per day)
T1002	U6	Nursing Services (1 unit equals 15 minutes of service; maximum of 4 units per day)
T1023	U6, UC	Comprehensive Annual Developmental Evaluation (not to be billed for therapy evaluations) (1 unit equals 1 hour; maximum of 1 unit)
99367	UA	Treatment Plan developed by EIDT professionals and the client's caregiver(s). Plan must include short and long term goals and objectives and include appropriate activities to meet those goals and objectives (1 unit equals 15 minutes, limit of 4 units annually)

Occupational Therapy Procedure Codes

Procedure Code	Required Modifier(s)	Description
97003	—	Evaluation for occupational therapy (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30)
97150	U1, UB	Group occupational therapy by occupational therapy assistant (15-minute unit; maximum of 6 units per week, maximum of 4 clients per group)
97150	U2	Group occupational therapy by Occupational Therapist (15-minute unit; maximum of 6 units per week, maximum of 4 clients per group)
97530	—	Individual occupational therapy by Occupational Therapist (15-minute unit; maximum of 6 units per week)
97530	UB	Individual occupational therapy by occupational therapy assistant (15-minute unit; maximum of 6 units per week)

The following procedure codes must be used for therapy services in the EIDT Program for Medicaid beneficiaries of all ages.

Physical Therapy Procedure Codes

Procedure Code	Required Modifier(s)	Description
97001	—	Evaluation for physical therapy (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30)

Procedure Code	Required Modifier(s)	Description
97110	—	Individual physical therapy by Physical Therapist (15-minute unit; maximum of 6 units per week)
97110	UB	Individual physical therapy by physical therapy assistant (15-minute unit; maximum of 6 units per week)
97150	—	Group physical therapy by Physical Therapist (15-minute unit; maximum of 6 units per week, maximum of 4 clients per group)
97150	UB	Group physical therapy by physical therapy assistant (15-minute unit; maximum of 6 units per week, maximum of 4 clients per group)

Speech Therapy Procedure Codes

Procedure Code	Required Modifier(s)	Description
92521	UA	⁂Evaluation of speech fluency (e.g. stuttering, cluttering) (maximum of four 30-minute units per state fiscal year, July 1 through June 30)
92522	UA	⁂Evaluation of speech sound production (e.g. articulation, phonological process, apraxia, dysarthria) (maximum of four 30-minute units per state fiscal year, July 1 through June 30)
92523	UA	⁂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) (maximum of four 30-minute units per state fiscal year, July 1 through June 30)
92524	UA	⁂Behavioral and qualitative analysis of voice and resonance (maximum of four 30-minute units per state fiscal year, July 1 through June 30)
92507	—	Individual speech session by Speech Therapist (15-minute unit; maximum of 6 units per week)
92507	UB	Individual speech therapy by speech language pathology assistant (15-minute unit; maximum of 6 units per week)
92508	—	Group speech session by Speech Therapist (15-minute unit; maximum of 6 units per week, maximum of 4 clients per group)
92508	UB	Group speech therapy by speech language pathology assistant (15-minute unit; maximum of 6 units per week, maximum of 4 clients per group)

NOTE: ⁂(...) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the service. When using a procedure code with this symbol, the service must meet the indicated Arkansas Medicaid description.

There is a weekly maximum of 6 units for each discipline: occupational, physical, and speech therapy.

232.200 National Place of Service (POS) Codes 7-1-18

Electronic and paper claims now require the same National Place of Service code.

Place of Service	POS Codes
Day Care Facility/EIDT Clinic	99

232.300 Billing Instructions – Paper Only 7-1-18

DHS' billing vendor offers providers several options for electronic billing. Therefore, claims submitted on paper are lower priority and are paid once a month. The only claims exempt from this rule are those that require attachments or manual pricing.

Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. **View a sample form CMS-1500.**

Carefully follow these instructions to help DHS' billing vendor efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Hewlett Packard Enterprise Claims Department. **View or print the DHS billing vendor Claims Department contact information.**

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

232.310 Completion of CMS-1500 Claim Form 7-1-18

Field Name and Number		Instructions for Completion
1.	(type of coverage)	Not required.
1a.	INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2.	PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3.	PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
	SEX	Check M for male or F for female.
4.	INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5.	PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).

Field Name and Number		Instructions for Completion
	CITY	Name of the city in which the beneficiary or participant resides.
	STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
	ZIP CODE	Five-digit zip code; nine digits for post office box.
	TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6.	PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7.	INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
	CITY	
	STATE	
	ZIP CODE	
	TELEPHONE (Include Area Code)	
8.	RESERVED	Reserved for NUCC use.
9.	OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
	a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
	b. RESERVED	Reserved for NUCC use.
	SEX	Not required.
	c. RESERVED	Reserved for NUCC use.
	d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10.	IS PATIENT'S CONDITION RELATED TO:	
	a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
	b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
	PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
	c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.

Field Name and Number	Instructions for Completion
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.

Field Name and Number	Instructions for Completion
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is required for EIDT services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a. (blank)	The 9-digit Arkansas Medicaid provider ID number of the referring physician.
17b. NPI	Not required.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	For tracking purposes, occupational, physical and speech therapy providers are required to enter one of the following therapy codes:
Code	Category
A	Individuals from birth through 2 years who are receiving therapy services under an Individualized Family Services Plan (IFSP) through the Division of Developmental Disabilities Services.
B	Individuals ages 0 through 5 years (if individual has not reached age 5 by September 15) who are receiving therapy services under an Individualized Plan (IP) through the Division of Developmental Disabilities Services.

Field Name and Number	Instructions for Completion
	NOTE: This code is to be used only when all three of the following conditions are in place: 1) the individual receiving services has not attained age 5 by September 15 of the current school year, 2) the individual receiving services is receiving the services under an Individualized Plan, 3) the Individualized Plan is through the Division of Developmental Disabilities Services.
When using code C or D, providers must also include the 4-digit LEA (local education agency) code assigned to each school district. For example: C1234	
C (and 4-digit LEA code)	Individuals ages 3 through 5 years (if individual has not reached age 5 by September 15) who are receiving therapy services under an Individualized Education Plan (IEP) through an education service cooperative.
	NOTE: This code is to be used only when all three of the following conditions are in place: 1) the individual receiving services is between the ages of 3 through 5 years and has not attained age 5 by September 15 of the current school year, 2) the individual receiving services is receiving the services under an Individualized Education Plan, 3) the Individualized Education Plan is through an education service cooperative.
D (and 4-digit LEA code)	Individuals ages 5 (by September 15) to 21 years who are receiving therapy services under an Individualized Education Plan (IEP) through a school district.
	NOTE: This code is to be used only when all three of the following conditions are in place: 1) the individual receiving services is between the ages of 5 (by September 15 of the current school year) to 21 years. 2) the individual receiving services is receiving the services under an Individualized Education Plan, 3) the Individualized Education Plan is through a school district.
E	Individuals ages 18 years and up who are receiving therapy services through the Division of Developmental Disabilities Services.
F	Individuals ages 18 years and up who are receiving therapy services through individual or group providers not included in any of the previous categories (A-E).
G	Individuals ages birth through 17 years who are receiving therapy/pathology services through individual or group providers not included in any of the previous categories (A-F).
	Not used.
20. OUTSIDE LAB?	Not required.

Field Name and Number	Instructions for Completion
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of the ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 262.200 for codes.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	One CPT or HCPCS procedure code for each detail. See Sections 262.100 through 262.140.
MODIFIER	Modifier(s) if applicable. See Section 262.120.

Field Name and Number	Instructions for Completion
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. $ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	The 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail.
NPI	Not required.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do not include in this total the automatically deducted Medicaid or co-payments.
30. RESERVED	Reserved for NUCC use.
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.

Field Name and Number	Instructions for Completion
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Not required.
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

232.400 Special Billing Procedures 7-1-18

Not applicable to this program.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
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TO: **Arkansas Medicaid Health Care Providers – Developmental Day Treatment Clinic Services**

EFFECTIVE DATE: **July 1, 2018**

SUBJECT: **Provider Manual Update Transmittal DDTCS-1-18**

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
ALL	VARIOUS	—	—

Explanation of Updates

The Developmental Day Treatment Clinic Services program is being retired and replaced with the Adult Developmental Day Treatment program. Please review update ADDT-New-18 on the Arkansas Medicaid website for more information.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

If you need this material in an alternative format, such as large print, please contact the Program Development and Quality Assurance Unit at (501) 320-6429.

Arkansas Medicaid provider manuals (including update transmittals), official notices, notices of rule making and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Rose M. Naff
Director

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
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TO: **Arkansas Medicaid Health Care Providers – Child Health Management Services**

EFFECTIVE DATE: **July 1, 2018**

SUBJECT: **Provider Manual Update Transmittal CHMS-1-18**

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
ALL	VARIOUS	—	—

Explanation of Updates

The Child Health Management Services program is being retired and replaced with the Early Intervention Day Treatment program. Please review update EIDT-New-18 on the Arkansas Medicaid website for more information.

The paper version of this update transmittal includes revised pages that may be filed in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you have questions regarding this transmittal, please contact the Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

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Thank you for your participation in the Arkansas Medicaid Program.

Rose M. Naff
Director

4.b Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(2) Apnea (Cardiorespiratory) Monitors

Apnea (cardiorespiratory) monitors are provided for eligible recipients in the EPSDT Program. Use of the apnea monitors must be medically necessary and prescribed by a physician. Prior authorization is not required for the initial one month period. If the apnea monitor is needed longer than the initial month, prior authorization is required.

(3) **Early Intervention Day Treatment (EIDT) Services**

EIDT services provide diagnosis and evaluation for the purpose of early intervention and prevention for eligible recipients in the EPSDT Program. Services are provided, if identified by an Independent Assessment in accordance with the Independent Assessment Manual, in multi-disciplinary clinic based setting as defined in 42 CFR § 440.90.

4.b Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age, and Treatment of Conditions Found. (Continued)

(2) Apnea (Cardiorespiratory) Monitors

Apnea (cardiorespiratory) monitors are provided for eligible recipients in the EPSDT Program. Use of the apnea monitors must be medically necessary and prescribed by a physician. Prior authorization is not required for the initial one month period. If the apnea monitor is needed longer than the initial month, prior authorization is required.

(3) **Early Childhood Intervention Day Treatment (EIDT) Services**

EIDT services provide diagnosis and evaluation for the purpose of early intervention and prevention for eligible recipients in the EPSDT Program. Services are provided, if identified by an Independent Assessment in accordance with the Independent Assessment Manual, in multi-disciplinary clinic based setting as defined in 42 CFR § 440.90.

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found. (Continued)

(3) **Early Intervention Day Treatment (EDIT)**

Reimbursement for **comprehensive** evaluation is based on the lesser of the amount billed or the Title XIX (Medicaid) charge allowed. **The Title XIX maximum was established based on a 1980 survey conducted by Developmental Disabilities Services (DDS) of 85 Arkansas Developmental Day Treatment providers of their operational costs excluding their therapy services. An average operational cost was derived for each service. Then an average number of units was derived for each service. The average operational cost for each service was divided by the average units for that particular service to arrive at a maximum rate.**

The Title XIX (Medicaid) maximum rates were established based on the following:

1. Auditory, developmental and neuropsychological testing services listed in the 1990 Blue Cross/Blue Shield Fee Schedule that are not subject to the other specifically identified reimbursement criteria are reimbursed based on 80% of the October, 1990 Blue Cross/Blue Shield Fee Schedule amounts. For those services that were not included on the 1990 Blue Cross/Blue Shield Fee Schedule, rates are established per the most current Blue Cross/Blue Shield Fee Schedule amount less 2.5% and then multiplied by 66%.

2. Psychological diagnosis/evaluation services are reimbursed from the Rehabilitative Services for Persons with Mental Illness (RSPMI) Fee Schedule as described in Attachment 4.19-B, Item 13.d.1.

3. Medical professional services reimbursement is based on the physician's fee schedule. Refer to the physician's reimbursement methodology as described in Attachment 4.19-B, Item 5.

4. The maximum rates for nutritional services are based on the entry-level salary for a Dietician (Grade 19). Department of Human Services position. The cost categories include Salary ($22,795), overhead and administration ($2,276…using salary as the allocation base) and benefits ($4,559…using salary as the allocation base). These costs were allocated at 10% for overhead/administration and 20% for benefits. A 30 minute visit will equal one unit of services. As such, the unit of services rate is $7.12 as calculated by [$22,795 + $2,276 + $4,559 = $29,630/2080 (52 weeks x 40 hours per week) = $14.24 per hour.]

5. **The maximum rate for habilitative services is $16.46. This rate was calculated based on analysis of current 2005 cost to provide quality services in compliance with governing regulations. The rates have been demonstrated to be consistent with the Clinic Upper Payment Limit at 42 CFR 447.321. One unit of service equals 1 hour of service with a maximum of 5 hours per day. State developed fee schedule rates are the same for both public and private providers of EIDT services.**

6. **The maximum rate for nursing services is $14.30. Reimbursement for registered nurse and licensed practical nurses is based on the Private Duty Nursing Fee Schedule as described in Attachment 4.19B, Item 8.**

7. The Title XIX maximum for occupational, physical and speech therapy diagnosis and evaluation is equal to the Title XIX (Medicaid) maximum established for the stand-alone therapy program. Refer to the stand-alone therapy reimbursement methodology as described in Attachment 4.19-B, Item 4b. (19).

Extensions of benefits will be provided for all EIDT services, if medically necessary.

Policy Type	Subject of Policy	Policy No.
Administrative	Agency Definition of Disability/Eligibility for Services	1035

1. Purpose. This policy has been prepared to set minimum parameters for determining eligibility to receive services from Developmental Disabilities Services (DDS).

2. Scope. All individuals and their families applying for services offered by DDS.

3. Definitions. For purposes of this policy, Primary Disability/Condition, Primary Diagnosis, and Other Disabilities are defined as follows:

   A. Primary Disability - That condition which renders the most serious impairment and/or condition which has the greatest impact on an individual's ability to function, as outlined in Arkansas Statute Ann. 20-48-101.

   B. Primary Diagnosis - A medical designation, determined by a physician, usually denoting etiology of disabling condition.

   C. Other Disabilities - Any condition(s) which accompanies the primary disability, and further hinders the development of an individual.

4. Eligibility Criteria.

   A. Diagnosis of developmental disability under definition cited in Arkansas Code Ann. § 20-48-101.

      1) Is attributable to intellectual disability, cerebral palsy, spina bifida, Down syndrome, epilepsy or autism spectrum disorder.

         a. Intellectual Disability - As established by scores of intelligence which fall two or more standard deviations below the mean of a standardized test of intelligence administered by a legally qualified professional; Infants/Preschool, 0-5 years - developmental scales, administered by qualified personnel authorized in the manual accompanying the instrument used, which indicate impairment of general functioning similar to that of developmentally disabled persons;

         b. Cerebral Palsy - As established by the results of a medical examination provided by a licensed physician;

         c. Spina bifida – As established by the results of a medical examination provided by a licensed physician.

         d. Down syndrome – As established by the diagnosis of a licensed physician.

e. Epilepsy - As established by the results of a neurological and/or licensed physician;

f. Autism Spectrum Disorder - As established by the results of a team evaluation including at least a licensed physician and a licensed psychologist and a licensed Speech Pathologist;

NOTE: Each of these four conditions is sufficient for determination of eligibility independent of each other. This means that a person who is intellectually disabled does not have to have a diagnosis of autism spectrum disorder, epilepsy, spina bifida, down syndrome, or cerebral palsy. Conversely, a person who has autism spectrum disorder, cerebral palsy, epilepsy, spina bifida, or Down syndrome does not have to have an intellectual disability to receive services.

2) Is attributable to any other condition of a person found to be closely related to intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with intellectual disability or requires treatment and services similar to those required for such persons. This determination must be based on the results of a team evaluation including at least a licensed Physician and a licensed Psychologist.

a) In the case of individuals being evaluated for service, eligibility determination shall be based upon establishment of intelligence scores which fall two or more standard deviations below the mean of a standardized test of intelligence OR, is attributable to any other condition found to be closely related to an intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to those of persons with an intellectual disability, or requires treatment and services similar to those required for such persons.

b) Persons age 5 and over will be eligible for services if their I.Q. scores fall two or more standard deviations below the mean of a standardized test.

c) For persons ages 3 to 5, eligibility is based on an assessment that reflects functioning on a level two or more standard deviations from the mean in two or more areas as determined by a standardized test.

d.) For infants and toddlers 0-36 months, eligibility for DDS Services will be indicated by a 25% delay in two or more areas based on an assessment instrument which yields scores in months. The areas to be assessed include: cognition; communication; social/emotion; motor; and adaptive.

3) Is attributable to dyslexia resulting from intellectual disability, cerebral palsy, epilepsy spina bifida, Down syndrome or autism spectrum disorder as established by the results of a team evaluation including at least a licensed Physician and a licensed Psychologist.

NOTE: In the case of individuals being evaluated for service, eligibility shall be based upon their condition closely related to an intellectual disability by virtue of their adaptive behavior functioning.

B. The disability must originate prior to the date the person attains the age of twenty - two (22).

NOTE: When age becomes a factor in eligibility determination under the Arkansas Law, such a case will be evaluated on its own merit as to whether the condition resulting from the disability was present before age twenty-two (22). In such cases, the determining authority will be the Assistant Director of Client Services and/or the Director for Developmental Disabilities Services.

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C. The disability has continued or can be expected to continue indefinitely.

D. The disability constitutes a substantial handicap to the person's ability to function without appropriate support services including, but not limited to, daily living and social activities, medical services, physical therapy, speech therapy, occupational therapy, job training and employment.

5. Services. Given the availability of funds and subject to budget restrictions, DDS will provide services to eligible persons.

6. Appeal. Should the individual and parent/guardian disagree with the decision made, they retain the right of appeal following DDS Policy #1076.

Replacement Notation: This policy replaces DDS Commissioner's Office Policy 1035, Eligibility for Services, effective June 29, 1981; May 10, 1982; and October 7, 1983 and DDS Deputy Director's Policy #1035, January 8, 1987; December 1, 1993.

Effective Date:

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References: Arkansas Code Ann. 20-48-101, DDS Policy #1075, and DDS Policy #1020

Administrative Rules & Regulations Sub Committee of the Arkansas Legislative Council: January 16, 2018

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ATTACHMENT 1
DDS Administrative Policy No. 1035 – Agency Definition of Disability
Eligibility for Services

1. Referral is to include a memorandum by DDS Counselor with reason(s) for referral, why DDS eligibility is not clear, what are the reasons for dispute, and the referring person's own recommendation.

2. Adaptive Behavior Scale (within the last year).

3. Current Medical status (within the last year).

4. Psychological evaluation (within the last year) if eligibility request is based on psychological reasons.

5. Results of special evaluations relevant to eligibility determination.

6. Documentation by Service Coordinator of client observation within the last three (3) months.

7. Social History completed within the last 90 days by DDS Counselor.

8. The most recent Individual Education Plan if person is school age.

9. For individuals who are not school age, program plan of current or past services providers, if any.