ARKANSAS REGISTER

Proposed Rule Cover Sheet

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Name of Department Department of Human Services

Agency or Division Name Division of Developmental Disabilities Services

Other Subdivision or Department, If Applicable N/A

Previous Agency Name, If Applicable N/A

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TOC not required

215.295 Early Intervention Day Treatment (EIDT) Screening 4-1-24

A developmental screening must be performed prior to signing a DHS-642 ER referring a beneficiary for their initial evaluations to determine eligibility for early intervention day treatment (EIDT) services.

A. A developmental screening is only required prior to initially referring a beneficiary for EIDT services. A developmental screening is not required to be performed on a beneficiary already receiving EIDT services.

B. The developmental screening must have been administered within the twelve (12) months immediately preceding the date of the DMS-642 ER.

C. The developmental screen instrument used must be a validated tool recommended by the American Academy of Pediatrics.

215.320 Early Childhood (Ages 12 months–4 years) ~~1~~4-1-24

A. History (Initial/Interval) to be performed at ages 12, 15, 18, 24, and 30* months and ages 3 and 4 years.

B. Measurements to be performed

1. Height and Weight at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years.
2. Head Circumference at ages 12, 15, 18, and 24 months.
3. Blood Pressure at 30 months* and ages 3 and 4 years

   * Note for infants and children with specific risk conditions.
4. BMI (Body Mass Index) at ages 24 and 30 months, and ages 3 and 4 years.

C. Sensory Screening, subjective, by history

1. Vision at ages 12, 15, 18, 24, and 30 months
2. Hearing at ages 12, 15, 18, 24, and 30 months and age 3 years.

D. Sensory Screening, objective, by a standard testing method

1. Vision at ages 3 and 4 years. Note: If the 3-year-old patient is uncooperative, re-screen within 6 months.
2. Hearing at age 4 years.

E. Developmental/Surveillance and Psychosocial Behavioral Assessment to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years. To be performed by history and appropriate physical examination and, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.

F. Physical Examination to be performed at ages 12, 15, 18, 24, and 30 months and 3 and 4 years. At each visit, a complete physical examination is essential, with the infant totally unclothed or with the older child undressed and suitably draped.

G. Procedures – General

These may be modified depending upon the entry point into the schedule and the individual need.

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1. Immunization(s) to be performed at ages 12, 15, 18, 24, and 30 months and 3 and 4 years. Every visit should be an opportunity to update and complete a child's immunizations.
2. Hematocrit or Hemoglobin risk assessment at 4 months with appropriate testing and follow up action if high risk to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years.

H. Other Procedures

Testing should be done upon recognition of high-risk factors.

1. Lead screening risk assessment to be performed at ages 12 and 24 months. Additionally, screening should be done in accordance with state law where applicable, with appropriate action to follow if high risk positive.
2. Tuberculin test to be performed at ages 12 and 24 months and ages 3 and 4 years. Testing should be done upon recognition of high-risk factors per recommendations of the Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.
3. Risk Assessment for Hyperlipidemia to be performed at ages 24 months and 4 years with fasting screen. If family history cannot be ascertained and other risk factors are present, screening should be at the discretion of the physician.

I. Anticipatory Guidance to be performed at ages 12, 15, 18, 24, and 30 months and at ages 3 and 4 years. Age-appropriate discussion and counseling should be an integral part of each visit for care.

1. Injury prevention to be performed at ages 12, 15, 18, 24, and 30 months and at 3 and 4 years.
2. Violence prevention to be performed at ages 12, 15, 18, 24, and 30 months and at 3 and 4 years.
3. Nutrition counseling to be performed at ages 12 15, 18, 24, and 30 months and 3 and 4 years. Age-appropriate nutrition counseling should be an integral part of each visit.

J. Oral Health Risk Assessment:

The Bright Futures/AAP "Recommendation for Preventative Pediatric Health Care," (i.e., Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. **View the Bright/AAP Periodicity Schedule.**

Subsequent examinations should be as prescribed by the dentist and recommended by the Child Health Services (EPSDT) dental schedule.

K. Two (2) Developmental Screens to be performed ~~no more than once per year~~ between the ages thirteen (13) months ~~and~~to forty-eight (48) months and a third (3rd) developmental screen to be performed between forty-eight (48) and sixty (60) months using validated tools recommended by the American Academy of Pediatrics in alignment with the Bright Futures Periodicity Schedule. **View the Bright/AAP Periodicity Schedule**. An extension of benefits is required to bill more than one (1) screening per twelve (12) month period and more than three (3) total screens between thirteen (13) and sixty (60) months of age.

L. Autism Screen to be performed at ages 18 and 24 months (or 30 months if screen was not completed at 24 months) using a standardized tool such as the Modified Checklist for Autism in Toddlers (M-CHAT) or the Pervasive Developmental Disorders Screening Tests-II (PDDSDT-II) Stage1. Any additional test must be approved by DMS prior to use.

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TOC required

201.000 Arkansas Medicaid Participation Requirements for Early Intervention Day Treatment (EIDT) Providers

~~8-1-22~~4-1-24

A provider must meet the following participation requirements to qualify as an Early Intervention Day Treatment (EIDT) provider under Arkansas Medicaid:

A. ~~Obtain an Early Intervention Day Treatment license issued by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance (DPSQA);~~

~~B.~~ Complete the provider participation and enrollment requirements contained within ~~S~~section 140.000 of this Medicaid manual; ~~and~~

~~C~~B. Except as provided in ~~S~~section 201.200 of this Medicaid manual, obtain a child-care facility license issued by the Arkansas Department of Education; and~~DPSQA.~~

C. Obtain an Early Intervention Day Treatment license issued by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance (see Ark. Code Ann. §§ 20-48-1101 et seq. and DDS Policy 1089-B regarding requirements to obtain an Early Intervention Day Treatment license).

~~EIDT providers may furnish and claim reimbursement for covered EIDT services subject to all requirements and restrictions set forth and referenced in this manual.~~

~~201.100 EIDT Providers in Arkansas and Bordering States~~

~~8-1-22~~

~~EIDT providers in Arkansas and within fifty (50) miles of the state line in the six (6) bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled as EIDT providers if they meet all Arkansas Medicaid participation requirements.~~

201.1200 Academic Medical Center Specializing in Developmental Pediatrics

~~8-1-22~~4-1-24

A. An academic medical center specializing in developmental pediatrics is eligible for reimbursement as an EIDT provider if it:

1. Is located in Arkansas;
2. Provides multi-disciplinary diagnostic and evaluation services to children throughout Arkansas;
3. Specializes in developmental pediatrics;
4. Serves as a large, multi-referral program and referral source for non-academic medical center EIDT providers within Arkansas;
5. Provides training to pediatric residents and other professionals in the delivery of multi-disciplinary diagnostics and evaluation ~~of~~ services to children with developmental disabilities and other special health care needs; and
6. Does not provide treatment services to children.

B. An EIDT provider operating as an academic medical center is not required to be a licensed child care facility.

C. An EIDT provider that operates as an academic medical center may bill diagnostic and evaluation codes outside of those used by a non-academic medical center EIDT program, but may not bill EIDT treatment codes. **View or print the academic medical center billable EIDT procedure codes and descriptions**.

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202.100 Documentation Requirements for All Medicaid Providers

~~8-1-22~~4-1-24

See ~~s~~Section 140.000 of this Medicaid manual for the documentation that is required for all Arkansas Medicaid providers.

202.200 EIDT Documentation Requirements

~~8-1-22~~4-1-24

A. EIDT providers must maintain in each ~~client~~ beneficiary's service record ~~sufficient, contemporaneous written documentation demonstrating the medical necessity of all covered EIDT services included on a client's individual treatment plan (ITP)~~.

1. An initial evaluation referral signed and dated by the beneficiary's primary care provider (PCP) (see section 212.200);
2. The annual treatment prescription for EIDT services signed and dated by the beneficiary's PCP (see section 212.300);
3. The individualized treatment plan (ITP); and
4. Discharge notes and summary, if applicable.

B. The service record of a ~~client~~beneficiary who has not yet ~~to meet the~~ reached school age ~~requirement for~~(see section 212.100(B) ~~Kindergarten enrollment or who has filed a signed Kindergarten waiver~~ must include ~~:~~

~~1. Either:~~

~~a. A developmental screen administered by the Department of Human Services' contracted third-party vendor, the results of which indicate the client should be referred for further evaluation; or~~

~~b. A developmental screen waiver (See Section 212.300); and~~

2. ~~T~~the results of an annual comprehensive developmental evaluation ~~(See~~pursuant to ~~S~~section 212.400 ~~.)~~of this Medicaid manual.

C. The service record of a ~~client~~ school age beneficiary ~~enrolled in school~~ must include ~~have~~ a documented qualifying diagnosis pursuant to ~~S~~section 212.500 of this Medicaid manual.

D. ~~-~~EIDT providers must maintain in each ~~client~~beneficiary's service record the following documentation for all ~~day habilitative and~~ nursing services performed pursuant to ~~S~~section~~s 214.120 and 222~~214.1540 of this Medicaid manual:

1. ~~The specific services furnished each day;~~
2. ~~-~~The date and beginning and ending time for each of the nursing services performed each day;
3. ~~3~~. A description of the specific services provided and activities performed each day; and
4. Name(s) and credential(s) of the person(s) ~~providing~~ delivering each nursing service each day.~~;~~

~~4. Which client ITP goal(s) and objective(s) the day's services awere intended to address; and~~

~~5. Weekly or more frequent progress notes, signed or initialed by the person(s) providing the service(s) describing the client's status with respect to ITP goals and objectives for that service.~~

E. EIDT providers must maintain in each beneficiary's service record the following documentation for all day habilitative services performed pursuant to section 222.120 of this Medicaid manual:

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1. The date and beginning and ending time for the services performed each day;
2. Name(s) and credential(s) of the person(s) delivering services each day;
3. Which of the beneficiary's ITP goal(s) and objective(s) the week's services were intended to address; and
4. Weekly or more frequent progress notes signed or initialed by the Early Childhood Development Specialist (ECDS) overseeing the beneficiary's ITP describing the beneficiary's status with respect to ITP goals and objectives.

F. EIDT providers must maintain in the ~~client's~~ beneficiary's service record all the documentation specified in ~~S~~section 204.200 of Section II of the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services Medicaid manual for all occupational therapy, physical therapy, and speech-language pathology services performed pursuant to ~~S~~sections 22~~14~~.130 and 222.140 of this Medicaid manual.

G~~F~~. EIDT providers must maintain the following documentation related to EIDT transportation services performed pursuant to ~~S~~section 22~~14~~.210 of this Medicaid manual:

1. A separate transportation log must be maintained for each trip that a vehicle is used by an EIDT to transport ~~clients~~ one (1) or more beneficiaries that lists:
   a. Each transported ~~client~~beneficiary's:
      i. Name;
      ii. Age;
      iii. Date of birth;
      iv. Medicaid ID number;
      v. Exact address of pick up and drop off; and
      vi. Exact time of pick up and drop off.
   b. The driver of the vehicle;
   c. Each attendant or any other persons transported; and
   d. Odometer reading for vehicle at the~~a~~ trip's:
      i. Initial pick up; and
      ii. Final drop off.
2. The driver of each vehicle must sign and date each transportation log verifying that each ~~client~~beneficiary that received transportation services from the EIDT was safely transported to and from:
   a. The ~~client~~ beneficary's home (or other scheduled pick-up or drop-off location); or
   b. The EIDT facility.
3. An EIDT must maintain all transportation logs for five (5) years from the date of transportation.

G. An EIDT provider must maintain documentation verifying the required qualifications of any individual performing occupational therapy, physical therapy, speech-language pathology, or nursing services on behalf of the EIDT. Refer to section 202.000 of this Medicaid manual.

H. An EIDT provider must maintain a copy of the contractual agreement with any individual contracted to perform occupational therapy, physical therapy, speech-language pathology or nursing services on behalf of the EIDT.

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202.300 Electronic Signatures 8-1-224-1-24

Arkansas Medicaid will accept electronic signatures in compliance with Ark.ansas Code Ann. § 25-31-103, et seq.

210.000 PROGRAM COVERAGELIGIBILITY

211.000 IntroductionScope 8-1-224-1-24

Arkansas Medicaid will reimburse licensed and enrolled EIDT providers for medically necessary covered EIDT services when such services are provided to an eligible client pursuant to an individualized treatment plan in compliance with this Medicaid manual to beneficiaries enrolled in the Child Health Services (EPSDT) Program who meet the eligibility requirements of this Medicaid manual. Medicaid reimbursement is conditional upon compliance with this Medicaid manual, manual update transmittals, and official program correspondence.

212.100 Age Requirement 8-1-224-1-24

A. A clientbeneficiary must be under the age of twenty-twone (212) to receive covered EIDT services.

B. Covered EIDT services may be provided year-round to clientsbeneficiaries who have not yet reached school age. For purposes of this Medicaid manual, a beneficiary has not yet reached school age if the beneficiary has:

1. Who have yet toNot meet the age requirement for Kkindergarten enrollment; or
2. Who have fFiled a signed Kkindergarten waiver and their first (1st) grade school year has not started.

C. Covered EIDT services may be provided to school age clients beneficiaries (i.e. beneficiaries who have met the age requirement for kindergarten) during the summer when school is not in session to prevent a clientbeneficiary from regressing over the summer.

212.200 Referral to Evaluate 4-1-24

A. A beneficiary must receive an evaluation referral for EIDT services on a DMS-642 ER "Early Intervention Day Treatment (EIDT) Evaluation Referral" (View or print the form DMS-642 ER) signed and dated by the beneficiary's primary care provider (PCP). If a beneficiary is already enrolled in an EIDT program as of April 1, 2024, then an active treatment prescription for the EIDT services on a valid DMS-640 dated between April 1, 2023, and March 31, 2024, may be used as a substitute and a new DMS-642 ER is not required.

B. An evaluation referral is only required for the *initial* qualifying evaluations related to EIDT core services.

1. No evaluation referral is required for an EIDT provider to perform the annual reevaluation required to demonstrate the continued eligibility of a beneficiary with an active treatment prescription for the particular EIDT core service that is about to expire.

2. A school age beneficiary attending an EIDT during the summer when school is not in session does not require a new DMS-642 ER evaluation referral if they attended an EIDT the summer immediately prior to the beneficiary's current school year.

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3. If a beneficiary already has an active treatment prescription for occupational therapy, physical therapy, or speech-language pathology services through a private clinic or school at the time of their initial evaluation referral for EIDT services, then a new evaluation is not required. The PCP's active DMS-640 treatment prescription related to the private clinic or school occupational therapy, physical therapy, or speech-language pathology treatment services will be accepted in place of a DMS-642 ER evaluation referral for the service.

Example: Based on the results of a development screen, a PCP believes a three (3) year old beneficiary could qualify for year-round EIDT services. The beneficiary is currently receiving occupational therapy services through a private therapy clinic, and the PCP thinks the beneficiary may also qualify for physical therapy services. The PCP is required to complete (and an EIDT provider is required to maintain in the beneficiary's service record) the following:

- Comprehensive Developmental Evaluation: since the beneficiary has not yet reached school age and is not currently receiving EIDT services, the PCP would need to sign and date a DMS-642 ER with the "Developmental Evaluation" box checked.
    - If after evaluation the beneficiary qualifies for EIDT services, a new DMS-642 ER is not required to perform the annual reevaluations to demonstrate the beneficiary's continued eligibility for EIDT services if the beneficiary is still enrolled at the EIDT at the time. The EIDT provider can perform and submit a claim for the required comprehensive developmental reevaluation the next year when due without a new DMS-642 ER from the PCP.
    - If after evaluation the beneficiary does not qualify for EIDT services, the PCP would have to issue a second DHS-642 ER with the "Developmental Evaluation" box checked for the EIDT provider to perform and submit a claim for another developmental evaluation later.
- Occupational Therapy: since the beneficiary already has an active treatment prescription for occupational therapy services through a private clinic, there is no need to perform an additional occupational therapy evaluation as part of the EIDT evaluation referral (unless the active occupational therapy treatment prescription is set to expire).
    - The DMS-640 active treatment prescription related to the occupational therapy treatment services by the private clinic at the time of EIDT service referral is all that must be maintained by the EIDT provider.
    - However, if the PCP is already completing a DMS-642 ER related to initial developmental or other evaluations, the PCP may for clarity purposes also check the "Occupational Therapy" box on the same DMS-642 ER to clearly demonstrate on a single document the full array of potential EIDT services for which the PCP believes the beneficiary may qualify.
- Physical Therapy: since the beneficiary is not currently receiving physical therapy services, the PCP would need to check the "Physical Therapy" box on the same DMS-642 ER used for the developmental evaluation (see first bullet).
    - If after evaluation the beneficiary qualifies for physical therapy services, a new DMS-642 ER is not required to perform the annual reevaluations to demonstrate the beneficiary's continued eligibility for physical therapy services if the beneficiary is still receiving physical therapy from the EIDT at that time. The EIDT provider can perform and submit a claim for the required physical therapy reevaluation the next year when due without a new DMS-642 ER from the PCP.

- If after evaluation the beneficiary does not qualify for physical therapy treatment services, the PCP would have to issue a second DHS-642 ER with the "Physical Therapy" box checked for the EIDT provider to perform and submit a claim for another physical therapy evaluation later.

212.2300 Treatment Prescription 8-1-224-1-24

A. EIDT core services require an ~~written~~ annual treatment prescription signed and dated by the ~~client~~beneficiary's primary care provider ~~(PCP) or attending licensed physician~~.

B. A prescription for co~~ve~~re~~d~~d EIDT services is valid for ~~one~~ twelve (12) ~~year~~months, unless a shorter period is specified. The prescription must be renewed at least once a year for covered EIDT services to continue.

C. The annual treatment prescription for year-round EIDT services must be on a form DMS-642 YTP "Early Intervention Day Treatment Services Year-Round Treatment Prescription." **View or print the form DMS-642 YTP**. Beneficiaries who are already enrolled in an EIDT pursuant to a valid treatment prescription (on a DMS-640) as of April 1, 2024, are not required to obtain a new treatment prescription on a form DMS-642 YTP until their existing EIDT treatment prescription expires.~~When prescribing EIDT services, the client's PCP or attending licensed physician shall not make any self-referrals in violation of state or federal law.~~

D. The annual treatment prescription for EIDT services during the summer when school is not in session must be on a form DMS-642 STP "Early Intervention Day Treatment Services Summer Only Treatment Prescription." **View or print the form DMS-642 STP**.

~~212.300 Developmental Screen or Waiver for Clients yet to Reach School Age~~ ~~8-1-22~~

~~A. A client who has yet to meet the age requirement for Kindergarten enrollment or who has filed a signed Kindergarten waiver must receive one of the following to receive EIDT services:~~

~~1. An age appropriate developmental screen administered by the Arkansas Department of Human Services' (DHS) contracted third party vendor, the results of which indicate the client should be referred for further evaluation; or~~

~~2. A developmental screen waiver.~~

~~B. A developmental screen waiver is granted when a client:~~

~~1. Has been determined to require an institutional level of care (as shown on a DMS-703); or~~

~~2. Has a qualifying diagnosis as defined in Section 212.500 of this manual.~~

~~3. A developmental screen waiver request and all relevant medical documentation must be submitted to DHS's contracted third party vendor for review. A clinician for the vendor will review the submitted documentation to determine if a developmental screen waiver is granted.~~

~~C. School age clients receiving covered EIDT services only during the summer when school is not in session do not have to receive a developmental screen.~~

212.400 Comprehensive Developmental Evaluation for ~~Clients~~ Beneficiaries yet to Reach School Age 8-1-224-1-24

A. A ~~client~~ beneficiary ~~that~~who has not yet reached school age (see section 212.100(B)~~up to age six (6) if the Kindergarten year has been waived~~) must have a documented

developmental disability or delay based on the results of an annual comprehensive developmental evaluation ~~to receive covered EIDT services~~.

B. The annual comprehensive ~~annual~~ developmental evaluation must include the administration of a norm referenced (standardized) ~~evaluation~~ instrument and a criterion referenced instrument~~evaluation~~. ~~.~~**View or print the list of accepted norm referenced and criterion referenced evaluation instruments**.

~~1. The norm-referenced evaluation must be one of the two (2) latest editions of the following:~~

~~a. Battelle Developmental Inventory (BDI); or~~

~~b. Brigance Inventory of Early Development Standardized.~~

~~2. The criterion-referenced evaluation must be age-appropriate and one of the two (2) latest editions of the following:~~

~~a. Hawaii Early Learning Profile (HELP);~~

~~b. Learning Accomplishment Profile (LAP);~~

~~c. Early Learning Accomplishment Profile (E-LAP); or~~

~~d. Brigance Inventory of Early Development - Early Childhood Edition.~~

C. The results of the annual comprehensive developmental evaluation must show:

1. For ages from birth~~zero (0)~~ up to thirty-six (36) months, a score on both the norm and criterion referenced ~~evaluations~~ instruments that indicate a developmental delay of twenty-five percent (25%) or greater in at least two (2) of the following five (5) domains:

~~a.~~ M~~m~~otor (the delay can be shown in either gross motor, fine motor, or total motor)~~,~~;

b. ~~S~~social~~,~~;

c. ~~c~~Cognitive~~,~~;

d. ~~s~~Self-help or adaptive~~,~~; or

e. ~~or c~~Communication~~,~~;

2. For ages three (3) through six (6):

a. A score on the norm referenced ~~evaluation~~ instrument of at least two (2) standard deviations below the mean in at least two (2) of the following five (5) domains:

i. ~~M~~~~m~~otor (the delay can be in gross motor, fine motor, or total motor)~~,~~;

ii. ~~S~~social~~,~~;

iii. ~~c~~Cognitive~~,~~;

iv. ~~s~~Self-help or adaptive~~,~~ or

v. ~~c~~Communication; and

b. A score of on the criterion referenced ~~evaluation~~ instrument indicating a twenty-five percent (25%) or greater developmental delay; and

3. The norm referenced and criterion referenced instruments must both indicate the same two (2) ~~areas~~ domains of delay regardless of the beneficiary's age~~on both the norm-referenced evaluation and the criterion-referenced evaluation~~.

D. Each evaluator must document that they ~~wea~~re qualified to administer each instrument and that the test protocols for each instrument ~~used~~ were followed.

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~~A.~~ School age ~~clients~~ beneficiaries up to the age of twenty-one (21) must have a documented qualifying intellectual or developmental disability diagnosis as defined in Ark. Code Ann. § 20-48-101(4). ~~that originated before the age of twenty-two (22) and is expected to continue indefinitely to receive covered EIDT services during the summer when school is not in session.~~

~~B. A qualifying intellectual or developmental disability diagnosis is any one of the following:~~

~~1. A diagnosis of Cerebral Palsy established by the results of a medical examination performed by the client's primary care provider (PCP) or attending licensed physician;~~

~~2. A diagnosis of Spina Bifida established by the results of a medical examination performed by the client's PCP or attending licensed physician;~~

~~3. A diagnosis of Down Syndrome established by the results of a medical examination performed by the client's PCP or attending licensed physician;~~

~~4. A diagnosis of Epilepsy established by the results of a medical examination performed by the client's primary care provider (PCP) or attending licensed physician;~~

~~5. A diagnosis of Autism Spectrum Disorder established by the results of evaluations performed by at least two (2) of the following three (3) licensed professionals either individually or as a team: physician psychologist, and speech pathologist; or~~

~~6. A diagnosis of intellectual and developmental disability or other similar condition found to be closely related to intellectual or developmental disability because it results in an impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual or developmental disability or requires treatment and services similar to that required for a person with an intellectual or developmental disability, based on the results of a team evaluation performed by the client's primary care provider (PCP) or attending licensed physician and a licensed psychologist.~~

~~C. The qualifying diagnosis must constitute a substantial handicap to the client's ability to function without appropriate support services such as daily living and social activities services, medical services, physical therapy, speech-language pathology, and occupational therapy.~~

212.600 Medically Necessary Speech-Language Pathology, Occupational Therapy, Physical Therapy, or Nursing Services

~~8-1-22~~4-1-24

A. In addition to meeting the applicable comprehensive developmental evaluation scoring thresholds in ~~S~~section 212.400 or having a qualifying diagnosis as defined in ~~S~~section 212.500 of this Medicaid manual, as applicable, one of the following services must also be medically necessary for a ~~client~~beneficiary to be eligible to receive covered EIDT services:

1. Physical therapy;
2. Occupational therapy;
3. Speech-language pathology; or
4. Nursing.

B. Medical necessity for occupational therapy, physical therapy, and speech-language pathology services is established in accordance with sections 212.300 and 212.400 of this Medicaid manual, and ~~s~~Section II of the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services Medicaid manual.

C. Medical necessity for nursing services is established by a medical diagnosis and a comprehensive nursing evaluation approved by the ~~client~~beneficiary's primary care provider ~~or attending licensed physician that prescribes the EIDT services~~.

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220.000 PROGRAM SERVICES

2213.000 Non-covered Services 8-1-224-1-24

A. Arkansas Medicaid will only reimburse for those covered EIDT services listed in sSections 22214.000 through 222.210 of this Medicaid manual, subject to all applicable limits. Additionally, Arkansas Medicaid will only reimburse for EIDT services when such services are provided to a client meeting the eligibility requirements in Section 212.000 by an EIDT meeting the requirements of this manual.

B. Covered EIDT services are clinic-based services and cannot be delivered through telemedicine or at any location other than the licensed EIDT facility.

C. Core EIDT services are reimbursable if, and only to the extent, authorized in the beneficiary's individualized treatment plan. See section 224.000 of this Medicaid manual.

22214.000 Covered EIDT Services 8-1-224-1-24

Covered EIDT services are either core services or optional services.

1. All covered EIDT services must be provided at the EIDT facility, or, in the case of EIDT transportation services, only involve the transportation of clients to or from the EIDT facility.

2. All covered EIDT services must be provided by individuals employed or contracted with the EIDT provider.

22214.100 EIDT Core Services 8-1-224-1-24

EIDT core services are those covered EIDT services that a provider must offer to its enrolled clientbeneficiaries to be licensed as an EIDT provider.

A. All core EIDT services must be provided at the EIDT facility.

B. All core EIDT services must be provided by individuals employed or contracted by the licensed EIDT provider.

22214.110 EIDT Evaluation and Treatment Planning Services 8-1-224-1-24

A. An EIDT provider may be reimbursed for medically necessary EIDT evaluation and treatment planning services. EIDT evaluation services involve the administration of a comprehensive developmental evaluation. See section 212.400 of this Medicaid manual. An EIDT provider may only be reimbursed for EIDT evaluation services when those services are medically necessaryand treatment planning services are a component of the process of determining a client's eligibility for EIDT services and developing the client's individual treatment plan (ITP).

B. For a beneficiaryClients who hasve not yet reached school to meet the age (see section 212.100(B))requirement for Kindergarten medical necessity for EIDT evaluation services enrollment or who have filed a signed Kindergarten waiver,is established as follows medical necessity for EIDT evaluation and treatment planning services with:

1. If the beneficiary is not already enrolled in an EIDT program, medical necessity is established by a DMS-642 ER evaluation referral signed and dated by the

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beneficiary's primary care provider (PCP) pursuant to section 212.200 of this Medicaid manual.~~The results of an age-appropriate developmental screen performed by the Department of Human Service's contracted third-party vendor; or~~

a. A DMS-642 ER evaluation referral is only required for a beneficiary's *initial* comprehensive evaluation.

b. An evaluation referral demonstrates medical necessity for a single comprehensive developmental evaluation.

- Example: If a beneficiary does not qualify for EIDT services based on the results of an initial developmental evaluation, and the beneficiary's PCP wants the beneficiary reevaluated six (6) months later, then the PCP would have to issue another evaluation referral on a separate DMS-642 ER at that time for the EIDT provider to reimbursed for administering the second developmental evaluation.

2. If the beneficiary is currently enrolled in an EIDT program, medical necessity to administer the required annual comprehensive developmental reevaluation is demonstrated by an active treatment prescription (DMS-642 YTP) at the time of reevaluation (see section 212.300 of this Medicaid manual). No DMS-642 ER evaluation referral is required to perform the ongoing annual comprehensive developmental evaluation required each year to demonstrate the continued eligibility of a beneficiary already receiving EIDT services~~A developmental screen waiver granted pursuant to Section 212.300~~.

C. For ~~S~~school age ~~clients~~ beneficiaries up to the age of twenty-one (21), medical necessity for EIDT evaluation services is established by~~medical necessity for EIDT evaluation and treatment planning services through~~ a qualifying diagnosis pursuant to ~~S~~section 212.500 of this Medicaid manual.

D. EIDT evaluation ~~and treatment planning~~ services are ~~covered once per calendar year and~~ reimbursed on a per unit basis. The billable unit includes time spent administering and scoring the norm referenced (standardized) instrument and criterion referenced instrument,~~evaluation, scoring an evaluation,~~ interpreting the results, and ~~writing an~~completing the comprehensive developmental evaluation ~~report, and developing the ITP~~. **View or print the billable EIDT evaluation services procedure codes and descriptions**.

2~~2~~214.120 Day Habilitative Services

~~8-1-22~~4-1-24

A. An EIDT provider may be reimbursed for medically necessary day habilitative services.

B. Medical necessity for day habilitative services is established:

1. For a ~~client~~ beneficiary who has not ~~yet to meet the~~ reached school age (see section 212.100(B)) ~~requirement for Kindergarten enrollment or who had filed a signed Kindergarten waiver, medical necessity for EIDT day habilitative services is established~~ by the results of a comprehensive developmental evaluation ~~described in~~ pursuant to ~~S~~section 212.400 of this Medicaid manual.

2. For school age ~~clients~~ beneficiaries up to the age of twenty-one (21), ~~medical necessity for day habilitative services is established~~ by a qualifying diagnosis pursuant to s~~S~~ection 212.500 of this Medicaid manual.

~~B~~C. EIDT day habilitative services are instruction:

1. In the skill areas of:
   a. Cognition;

b. Communication;

c. Social and emotional;

d. Motor; and

e. Adaptive; or

2. To reinforce skills learned and practiced as part of occupational therapy, physical therapy, or speech-language pathology services.

~~C~~D. EIDT day habilitative services must be designed to attain the habilitation goals and objectives specified in the ~~client's~~ beneficiary's individualized treatment plan.

~~D~~E. EIDT day habilitative services must be overseen by an Early Childhood Development Specialist (ECDS) who:

1. Is a licensed:

a. Speech-Language Pathologist~~y~~;

b. ~~,~~ Occupational Therapist;~~,~~

c. Physical Therapist;~~,~~ or

d. Developmental Therapist; or

2. Has a bachelor's degree, plus at least one (1) of the following:

a. An early childhood or early childhood special education certificate;

b. A child development associate certificate;

c. A 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

iv. Elementary education; or

v. Child and family studies.

~~E~~F. There must be one (1) ECDS for every forty (40) ~~client~~beneficiaries enrolled at an EIDT.

~~F~~G. ~~-~~EIDT day habilitative services are reimbursed on a per unit basis. No more than five (5) hours of EIDT day habilitative services may be billed per day ~~without an extension of benefits~~. The unit of service calculation includes naptime~~,~~ but does not include time spent in transit to and from the EIDT facility. **View or print the billable EIDT day habilitative services procedure code~~s~~ and description~~s~~.**

2~~2~~2~~14~~.130 Occupational Therapy, Physical Therapy, and Speech-Language Pathology Evaluation ~~and Treatment~~ Services

~~8-1-22~~4-1-24

A. An EIDT provider may be reimbursed for medically necessary occupational therapy, physical therapy, and speech-language pathology evaluation ~~and treatment~~ services.

1. Medical necessity for occupational therapy, physical therapy, and speech-language pathology evaluation services is demonstrated by an initial evaluation referral signed and dated by the beneficiary's primary care provider (PCP).

2. Evaluation referrals must be on a form DMS-642 ER "Early Intervention Day Treatment Services Evaluation Referral." See section 212.200 of this Medicaid manual. **View or print the form DMS-642 ER.**

3. An evaluation referral is only required for *initial* occupational therapy, physical therapy, and speech-language pathology evaluations

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4. No evaluation referral is required to perform the required annual re-evaluation of a beneficiary who is already receiving occupational therapy, physical therapy, or speech-language pathology treatment services. Medical necessity is demonstrated by the fact the beneficiary is currently receiving the service.~~Occupational therapy, physical therapy, and speech-language pathology evaluation and treatment services must be medically necessary in accordance with Section II of the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services Medicaid manual.~~

~~2. A qualifying diagnosis pursuant to Section 212.500 of this manual alone does not establish the medical necessity of occupational therapy, physical therapy, or speech-language pathology services.~~

B. Occupational therapy, physical therapy, and speech-language pathology evaluation services must be performed in compliance with Section II of the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services Medicaid manual~~An EIDT provider must contract with or employ its qualified occupational therapy, physical therapy, and speech-language pathology practitioners~~.

1. The EIDT provider must identify the licensed practitioner as the performing provider on the claim when billing Arkansas Medicaid for the service.

2. ~~The~~Each licensed practitioner listed as the performing provider must be an enrolled Arkansas Medicaid provider~~ and the group provider requirements of Section 201.120 of Section II of the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services Medicaid manual) must be met~~.

C. All occupational therapy, physical therapy, and speech-language pathology evaluation services must be billed in accordance with Section II of the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services Medicaid manual.~~ **View or print the billable Occupational Therapy, Physical Therapy, and Speech-language Pathology services procedure codes and descriptions**~~.~~

1. Occupational therapy and physical therapy evaluation services are reimbursed through untimed procedure codes based on a beneficiary's diagnosis and situational complexity. A single billable unit includes all time spent administering and scoring a standardized instrument(s), clinical observation, administering supplemental tests and tools, writing an evaluation report, and time spent developing the treatment plan.

2. Speech-language pathology evaluation services are reimbursed on a per unit basis. Speech-language pathologists should bill only for face-to-face time with the beneficiary while conducting the evaluation. Time spent scoring an evaluation, writing an evaluation report/comprehensive assessment, and time spent developing a treatment plan should not be billed unless performed during the face-to-face evaluation of the beneficiary.

3. **View or print the billable Occupational Therapy, Physical Therapy, and Speech-language Pathology evaluation services procedure codes and descriptions.**

222.140 Occupational Therapy, Physical Therapy, and Speech-Language Pathology Treatment Services **4-1-24**

A. An EIDT provider may be reimbursed for medically necessary occupational therapy, physical therapy, and speech-language pathology treatment services. Medical necessity for occupational therapy, physical therapy, and speech-language pathology treatment services is demonstrated by:

1. The results of a comprehensive evaluation conducted in accordance with Section II of the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services Medicaid manual; and

2. A written treatment prescription signed and dated by the beneficiary's primary care provider.

   a. Treatment prescriptions relating to year-round EIDT occupational therapy, physical therapy, and speech-language pathology treatment services must be on a form DMS-642 YTP "Early Intervention Day Treatment Services Year-Round Treatment Prescription." See section 212.300 of this Medicaid manual. **View or print the form DMS-642 YTP.**

   b. Treatment prescriptions relating to summer only EIDT occupational therapy, physical therapy, and speech-language pathology treatment services must be on a form DMS-642 YTP "Early Intervention Day Treatment Services Summer Only Treatment Prescription." See section 212.300 of this Medicaid manual. **View or print the form DMS-642 STP.**

   c. Beneficiaries who are already receiving occupational therapy, physical therapy, and speech-language pathology treatment services pursuant to a valid treatment prescription (on a DMS-640) when those services are transitioning over to an EIDT are not required to obtain a new treatment prescription on a form DMS-642 YTP or DMS-642 STP until their existing treatment prescription expires.

B. EIDT providers are all-inclusive habilitative therapy treatment providers, meaning a beneficiary attending an EIDT must have all their medically necessary habilitative occupational therapy, physical therapy, and speech-language pathology treatment services performed by the EIDT program at the EIDT clinic.

   1. A beneficiary should not receive habilitative occupational therapy, physical therapy, or speech-language pathology services in any other setting or through any other Medicaid program when enrolled in an EIDT.

   2. This restriction does not apply to:

      a. Rehabilitative therapies prescribed to regain lost skills or functioning due to illness or injury; or

      b. Specialized habilitative therapeutic activities that are unable to be performed at an EIDT clinic (such as~~i.e.~~ aquatic therapy, or animal-assisted therapy activities).

C. Occupational therapy, physical therapy, and speech-language pathology treatment services must be performed in compliance with Section II of the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services Medicaid manual.

   1. The EIDT provider must identify the licensed practitioner as the performing provider on the claim when billing Arkansas Medicaid for the service.

   2. Each licensed practitioner listed as a performing provider must be an enrolled Arkansas Medicaid provider.

D. All occupational therapy, physical therapy, and speech-language pathology treatment services are reimbursed on a per unit basis with up to six (6) units per week billable without an extension of benefits. See Section II of the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services Medicaid manual regarding submitting a request for an extension of benefits. **View or print the billable Occupational Therapy, Physical Therapy, and Speech-language Pathology treatment services procedure codes and descriptions**.

2~~22~~14.15~~4~~0 Nursing Services

~~8-1-22~~4-1-24

A. An EIDT provider may be reimbursed for medically necessary nursing services.

1. Medical necessity for nursing services is established by a medical diagnosis and a comprehensive nursing evaluation approved by the ~~client~~beneficiary's primary care provider (PCP) ~~or attending licensed physician who prescribed the EIDT services~~.
2. The nursing evaluation must specify the required nursing services.
3. The ~~client's~~ beneficiary's PCP ~~or attending licensed physician~~ must prescribe the specific number of medically necessary nursing service units per day.

B. EIDT nursing services must be:

1. Performed by a licensed registered nurse or licensed practical nurse; and
2. Within the performing nurse's scope of practice as set forth by the Arkansas State Board of Nursing.

C. ~~For the purposes of this manual,~~ EIDT nursing services are defined as the following, or similar, activities:

1. Assisting ventilator dependent ~~clients~~beneficiaries;
2. Tracheostomy suctioning and care;
3. Feeding tube administration, care, and maintenance;
4. Catheterizations;
5. Breathing treatments;
6. Monitoring of vital statistics, including diabetes sugar checks, insulin, blood draws, and pulse ox;
7. Cecostomy tube administration, care, and maintenance;
8. Ileostomy tube administration, care, and maintenance; and
9. Administration of medication when the administration of medication is not the ~~client~~beneficiary's only medically necessary nursing service.

D.

1. The EIDT provider must identify the licensed registered nurse or licensed practical nurse as the performing provider on the claim when billing for the service.
2. Each licensed registered nurse or licensed practical nurse listed as a performing provider must be an enrolled Arkansas Medicaid provider.

~~D~~E. EIDT nursing services are reimbursed on a per unit basis. ~~Arkansas Medicaid will reimburse~~with up to ~~one (1) hour~~twelve (12) units ~~of EIDT nursing services~~ per day billable without an ~~prior authorization~~extension of benefits. The unit of service calculation does not include ~~T~~time spent taking a ~~client~~beneficiary's temperature and performing other acts of standard first aid ~~is not included in the units of an EIDT nursing service calculation~~.
View or print the billable EIDT nursing services procedure codes and decriptions.

2~~1~~422.200 EIDT Optional Services ~~8-1-22~~4-1-24

EIDT optional services are those covered EIDT services that a licensed EIDT provider may, but is not required to, offer to its ~~client~~beneficiaries.

2~~22~~14.210 EIDT Transportation Services ~~8-1-22~~4-1-24

A. An EIDT provider may be reimbursed for providing its ~~clients~~ beneficiaries with transportation services to and from its EIDT clinic, meaning transporting the beneficiary from:

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1. Their home (or other scheduled original pick-up location) directly to the EIDT clinic; and

2. The EIDT clinic directly back to the beneficiary's scheduled drop-off location after the completion of the day's EIDT core services~~facility~~.

B. EIDT transportation services are reimburseable if each of the following is met:

1. The transportation is provided by a licensed EIDT provider;

2. The ~~client~~ beneficiary transported is receiving EIDT services from the EIDT that is providing the EIDT transportation service; and

3. The transportation is provided only to or from the EIDT provider's facility.

C. EIDT transportation services are reimbursed on a per person, per mile basis.

~~–~~1. Billable mileage for a beneficiary is the number of miles from the beneficiary's pick-up address to the drop-off address using the shortest direct driving route.

2. Mileage is computed to the tenth of a mile.

a. If the shortest direct driving route between the beneficiary's pick-up address and the drop-off address is less than one-tenth of a mile, then billable mileage is one-tenth of a mile.

b. Billable mileage should otherwise be rounded down to nearest tenth of a mile.

3. The number of miles a beneficiary rides on a vehicle during a trip is irrelevant to the computation of billable mileage (unless the beneficiary is the only passenger, and the shortest direct driving route is used). Odometer readings are not used for the computation of billable mileage.

4. When transporting more than one ~~client~~beneficiary, an EIDT provider must make all reasonable efforts to minimize the total number of miles and amount of time ~~for~~ each ~~client~~beneficiary is riding on a vehicle each trip. For example, when transporting multiple ~~clients~~ beneficiaries to an EIDT facility the ~~client~~beneficiary with a pick-up location farthest away from the EIDT facility should be picked up first, and the ~~client~~beneficiary with the pick-up location closest to the EIDT facility should be picked up last.

D. View or print the billable EIDT transportation services procedure codes and description.

2~~24~~15.000 Individualized Treatment Plan (ITP) ~~8-1-22~~4-1-24

A. Each ~~client~~beneficiary receiving ~~covered~~ EIDT services must have an individualized treatment plan (ITP).

1. An ITP is a written, individualized plan ~~to improve or maintain the client's condition based upon evaluation of the client~~developed and updated by the Early Childhood Developmental Specialist (ECDS) in collaboration with:~~.~~

a. Each therapist overseeing the delivery of any occupational therapy, physical therapy, or speech-language pathology services received by the beneficiary at the EIDT;

b. The parent/guardian of the beneficiary; and

c. Any other individuals requested by the parent/guardian.

2. The ITP must be reviewed~~evaluated~~ and, if necessary, updated at least annually by the ~~Early Childhood Development Specialist (~~ECDS~~) assigned to the client~~.

3. The ECDS's signature and the date ~~signed~~ reviewed or updated must be recorded on the ITP.

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4. Each supervising therapist's signature and the date signed must be recorded on the ITP, if applicable.

B. Each ITP must at a minimum contain:

1. The beneficiary's identification information, which includes without limitation the beneficiary's:
   a. Full name;
   b. Address;
   c. Date of birth;
   d. Medicaid number; and
   e. Effective date of EIDT eligibility; and
2. The name of the ECDS responsible for ITP development and service delivery oversight;
3. ~~A written description of t~~The goals and objectives for each covered EIDT service. Each ~~client~~beneficiary goal and objective must be~~;~~:
   a. Written in the form of a:
      i. ~~regular~~Typical function, task, or activity the ~~client~~ beneficiary is working toward successfully performing; or
      ii. Behavior the beneficiary is working toward eliminating;
   b. Measurable; and
   c. Specific to each individual ~~client~~beneficiary~~.~~;
4. A written description of ~~T~~the specific medical and remedial services, therapies, and activities that will be ~~provided~~ performed and how and to which goals and objectives each of those services, therapies, and activities are linked~~designed to achieve the client's goals and objectives;~~
5. ~~Any evaluations or other documentation that supports the medical necessity of the covered EDIT service specified in the ITP;~~
6. A schedule of service delivery that includes the frequency and duration of each type of ~~covered~~ EIDT service;
7. The job title(s) or credential(s) of the personnel that will furnish each ~~covered~~ EIDT service; and
8. The criteria or other data that will be collected and used to measure the beneficiary's progress towards their goals and objectives; and
9. The schedule for completing re-evaluations of the ~~client~~beneficiary's condition and updating the ITP.

C. The total number and types of goals and objectives included on a beneficiary's ITP must correlate with and support the frequency, intensity, and duration of the prescribed core EIDT services, and be clinically appropriate for the beneficiary.

2~~2~~30.000 EXTENSION OF BENEFITS~~PRIOR AUTHORIZATION~~

A. ~~Prior authorization~~ An extension of benefits is required for an EIDT provider to be reimbursed for:

1. ~~A~~Over five (5) hours of day habilitative services in a single day;
2. ~~B~~Over ninety (90) minutes per week of any of the following EIDT services:
   a. ~~1~~. Occupational therapy treatment services,
   b. ~~2~~. Physical therapy treatment services, or

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c3. Speech-language pathology treatment services; and

C3. Over one (1) hour of nursing services in a single day; and

D4. Over eight (8) total combined hours of core EIDT services the following services in a single day:

1. Day habilitative;

2. Occupational therapy;

3. Physical therapy;

4. Speech-language pathology; and

5. Nursing.

B. **View or print instructions for submitting a request for extension of benefits for core EIDT services**

2350.000 REIMBURSEMENT

2351.000 Method of Reimbursement

8-1-22 4-1-24

A. Except as otherwise provided in this Medicaid manual, covered EIDT services use fee schedule reimbursement methodology. Under fee schedule methodology, reimbursement is made at the lower of the billed charge for the service or the maximum allowable reimbursement for the service under Arkansas Medicaid. The maximum allowable reimbursement for a service is the same for all EIDT providers.

B. The following standard reimbursement rules apply to all EIDT services:

A1. A full unit of service must be rendered to bill a unit of service.

B2. Partial units of service may not be rounded up and are not reimbursable.

C3. Non-consecutive periods of service delivery over the course of a single day may be aggregated when computing a unit of service.

4. Time spent cleaning or prepping a treatment area before or after services is not billable.

5. If a single beneficiary is receiving a single unit of services involving multiple clinicians or other billable professionals, only a single unit can be billed for that time. Concurrent billing of the same time by multiple billable professionals is not allowed.

6. Time spent on documentation alone is not billable as a service.

2531.100 Fee Schedules

8-1-22 4-1-24

A. Arkansas Medicaid provides fee schedules on the Division of Medical Services website. **View or print the EIDT fee schedule**.

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

C. Fee schedules and procedure codes do not guarantee payment, coverage, or the reimbursement amount. Fee schedule and procedure code information may be changed or updated at any time.

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TOC not required

222.830 Early Childhood (Ages 12 Months–4 Years) ~~1-1-24~~1-1-24

A. History (Initial/Interval) to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years.

B. Measurements to be performed

1. Height and Weight at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years.
2. Head Circumference at ages 12, 15, 18, and 24 months.
3. Blood Pressure at ages 30 months*, 3 and 4 years.

   *Note: For infants and children with specific risk conditions.
4. BMI (Body Mass Index) at ages 24 and 30 months, 3 and 4 years.

C. Sensory Screening, subjective, by history

1. Vision at ages 12, 15, 18, 24, and 30 months
2. Hearing at ages 12, 15, 18, 24, and 30 months and age 3 years.

D. Sensory Screening, objective, by a standard testing method

1. Vision at ages 3 and 4 years. Note: If the 3-year-old patient is uncooperative, re-screen within 6 months.
2. Hearing at age 4 years.

E. Developmental/Surveillance and Psychosocial/Behavioral Assessment to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years. To be performed by history and appropriate physical examination and, if suspicious, by specific objective developmental testing. Parenting skills should be fostered at every visit.

F. Physical Examination to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years. At each visit, a complete physical examination is essential, with the infant totally unclothed or with the older child undressed and suitably draped.

G. Procedures – General

These may be modified depending upon the entry point into the schedule and the individual need.

1. Immunization(s) to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years. Every visit should be an opportunity to update and complete a child's immunizations.
2. Hematocrit or Hemoglobin risk assessment at 4 months with appropriate testing and follow up action if high risk to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years.

H. Other Procedures

Testing should be done upon recognition of high-risk factors.

1. Lead screening risk assessment to be performed at ages 12 and 24 months. Additionally, screening should be done in accordance with state law where applicable, with appropriate action to follow if high risk positive.
2. Tuberculin test to be performed at ages 12 and 24 months and ages 3 and 4 years. Testing should be done upon recognition of high-risk factors per recommendations of

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the Committee on Infectious Diseases, published in the current edition of *AAP Red Book: Report of the Committee on Infectious Diseases*. Testing should be performed on recognition of high-risk factors.

3. Risk Assessment for Hyperlipidemia to be performed at ages 24 months and 4 years with fasting screen, if family history cannot be ascertained, and other risk factors are present, screening should be at the discretion of the physician.

I. Anticipatory Guidance to be performed at ages 12, 15, 18, 24, and 30 months and at ages 3 and 4 years. Age-appropriate discussion and counseling should be an integral part of each visit for care.

1. Injury prevention to be performed at ages 12, 15, 18, 24, and 30 months and at ages 3 and 4 years.
2. Violence prevention to be performed at ages 12, 15, 18, 24, and 30 months and at ages 3 and 4 years.
3. Nutrition counseling to be performed at ages 12, 15, 18, 24, and 30 months and ages 3 and 4 years. Age-appropriate nutrition counseling should be an integral part of each visit.

J. Oral Health Risk assessment: The Bright Futures/AAP "Recommendation for Preventative Pediatric Health Care," (i.e, Periodicity Schedule) recommends all children receive a risk assessment at the 6- and 9-month visits. For the 12-, 18-, 24-, 30-month, and the 3- and 6-year visits, risk assessment should continue if a dental home has not been established. **View the Bright/AAP Periodicity Schedule.**

Subsequent examinations should be as prescribed by the dentist and recommended by the Child Health Services (EPSDT) dental schedule.

K. Two (2) Developmental Screens to be performed ~~no more than once per year~~ between the ages of thirteen (13) months to forty-eight (48) months and a third (3rd) developmental screen to be performed between forty-eight (48) and sixty (60) months using validated tools recommended by the American Academy of Pediatrics in alignment with the Bright Futures Periodicity Schedule. **View the Bright/AAP Periodicity Schedule**. ~~Children may not receive more than one screen per twelve month period and no more than two screens without a~~An extension of benefits is required to bill more than one (1) screening per twelve (12) month period and more than three (3) total screens between thirteen (13) and sixty (60) months of age.

L. Autism Screen to be performed at age 18 and 24 months (or 30 months if screen was not completed at 24 months) using a standardized tool such as the Modified Checklist for Autism in Toddlers (M-CHAT) or the Pervasive Developmental Disorders Screening Tests-II (PDDSDT-II) Stage1. Any additional test must be approved by DMS prior to use.

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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 clinics ~~services~~ provide ~~diagnosis and~~ clinic-based evaluation and treatment services for the purpose of early intervention and prevention ~~for~~ to 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.~~Beneficiaries that have yet to reach school-age may receive EIDT services year-round. School-age beneficiaries can only receive EIDT services during the summer when school is not in session.

A beneficiary must receive an evaluation referral signed and dated by the beneficiary's primary care provider (PCP) to receive EIDT services. For a beneficiary that has yet to reach school-age, the beneficiary's PCP must have completed an approved developmental screen for the beneficiary within the twelve (12) months immediately preceding the date of the evaluation referral. A comprehensive developmental evaluation is a required component of determining EIDT eligibility for beneficiaries who have yet to reach school age. School-age beneficiaries must have a documented qualifying intellectual or developmental disability diagnosis as defined in Ark. Code Ann. § 20-48-101(4) to receive EIDT services during the summer when school is not in session.

A prescription is required for all early intervention and prevention services at an EIDT clinic. If the beneficiary's PCP determines EIDT services are medically necessary based on the results of the beneficiary's evaluations or qualifying medical diagnosis, then the PCP would issue a prescription on a DMS-642 YTP (year-round treatment prescription), or on a DMS-642 STP (summer only treatment prescription) depending on whether the beneficiary had reached school age. The PCP will include the amount and duration of each EIDT service a beneficiary is to receive on the appropriate form. A beneficiary receiving EIDT services is required to receive a new comprehensive developmental evaluation, if applicable, and prescription every twelve (12) months to continue receiving EIDT services.

Since EIDT services are clinic-based services, these services cannot be delivered through telemedicine or at any location other than the licensed EIDT clinic. EIDT providers are considered all-inclusive, meaning a beneficiary attending an EIDT should have all of their habilitative occupational therapy, physical therapy, and speech-language pathology service needs performed by the EIDT program at the EIDT clinic.

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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 (**EIDT**)

~~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 **and average number of units were** 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 performed by EIDT providers certified as Academic Medical Centers (AMCs) that are 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 **October** 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. The maximum Medicaid rates for ~~P~~psychological diagnosis/evaluation services provided by ~~Early Intervention Day Treatment (~~EIDT~~)~~ providers certified as ~~Academic Medical Centers (~~AMCs~~) are reimbursed~~ were set as of July 1, 2017, based on the information gained from the peer state analysis and the consideration of adjustment factors such as Bureau of Labor Statistics (BLS) along with Geographic Pricing Cost Index (GPCI) to account for economic differences, the state was able to select appropriate rates from fee schedules published by peer states. Once this rate information was filtered according to Arkansas requirements a "state average rate" was developed. This "state average rate" consisting of the mean from every peer state's published rate for a given procedure served as the base rate for the service, which could then be adjusted by previous mentioned factors (BLS), (GPCI)~~from the Outpatient Behavioral Health 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 Medicaid per unit rate for ~~**one hour of**~~ day habilitati~~ve~~~~on~~ services ~~is~~ increased to $18.27 effective January 1, 2020. One (1) unit equals one (1) hour. The~~is~~ new rate was calculated based on analysis of ~~current~~ state fiscal year 2019 and ~~-~~2020 costs 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. There is a maximum limit of~~**services without an extension of benefits are**~~ five (5) hours of day habilitative services per day. ~~State developed fee schedule rates are the same for both public and private providers of EIDT services.~~

5. The maximum Medicaid per unit rate for ~~five minutes of registered~~ nursing services performed by a licensed registered nurse is $4.77. The maximum Medicaid per unit rate for

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~~five (5) minutes of licensed practical~~ nursing services performed by a licensed practical nurse is $3.17. One (1) unit equals five (5) minutes of nursing services. Reimbursement rates for registered nurses and licensed practical nurses ~~is based on the~~were developed and established as described for Private Duty Nursing ~~Fee Schedule as described~~ in Attachment 4.19-B, Item 8.

6. The ~~Title XIX~~ maximum Medicaid per unit rates for occupational, physical and speech-language pathology ~~therapy diagnosis and~~ evaluation and treatment services at an EIDT is equal to the ~~Title XIX (Medicaid)~~ maximum Medicaid per unit rates established for private clinic occupational therapy, physical therapy, and speech-language pathology~~the stand-alone~~ therapy ~~program~~services under EPSDT. Refer to the ~~stand-alone~~ private clinic therapy services reimbursement methodology development~~as~~ described in Attachment 4.19-B, Item 4.b. (19).

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

MARKUP

FINANCIAL IMPACT STATEMENT

PLEASE ANSWER ALL QUESTIONS COMPLETELY.

DEPARTMENT Department of Human Services
BOARD/COMMISSION Division of Developmental Disabilities Services
PERSON COMPLETING THIS STATEMENT Jason Callan
TELEPHONE NO. (501) 320-6540 **EMAIL** Jason.Callan@dhs.arkansas.gov

To comply with Ark. Code Ann. § 25-15-204(e), please complete the Financial Impact Statement and email it with the questionnaire, summary, markup and clean copy of the rule, and other documents. Please attach additional pages, if necessary.

TITLE OF THIS RULE Developmental Screen for Children 48 to 60 months of Age

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 no, please explain:

   (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 reason for adoption of the more costly rule is based on the interests of public health, safety, or welfare, and if so, how; and

   (d) whether the reason for adoption of the more costly rule is within the scope of the agency's statutory authority, and if so, how.

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

General Revenue_____
Federal Funds_____
Cash Funds_____
Special Revenue_____
Other (Identify)_____

Total_____

Next Fiscal Year

General Revenue_____
Federal Funds_____
Cash Funds_____
Special Revenue_____
Other (Identify)_____

Total_____

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

Current Fiscal Year

General Revenue -$66,872
Federal Funds -$171,956
Cash Funds_____
Special Revenue_____
Other (Identify)_____

Total -$ 238,828.00

Next Fiscal Year

General Revenue -$267,488
Federal Funds -$687,826
Cash Funds_____
Special Revenue_____
Other (Identify)_____

Total -$ 955,313.00

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

Current Fiscal Year
$_____

Next Fiscal Year
$_____

6. What is the total estimated cost by fiscal year to a state, county, or 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
$ -66,872.00

Next Fiscal Year
$ -267,488.00

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.

Statement of Necessity and Rule Summary
Developmental Screen for Children 48-60 months of Age

Why is this change necessary? Please provide the circumstances that necessitate the change.

The Division of Developmental Disabilities Services (DDS), working jointly with the Division of Medical Services, adds language to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and ARKids-B Medicaid manuals, allowing primary care providers (PCPs) to perform a developmental screening for children between forty-eight (48) and sixty (60) months of age. Adding the developmental screen will enhance early identification of developmental needs for children and increase the quality of referrals for specialized services. The new screening will be incorporated into the Patient Centered Medical Home (PCMH) quality metrics.

DDS also adds language to the EPSDT Medicaid manual requiring PCPs to perform a developmental screen prior to referring a child for their initial evaluations to determine eligibility for Early Intervention Day Treatment (EIDT) services. Requiring PCPs to perform this developmental screen will allow the DDS to cease using its third-party contractor, Optum, to perform the developmental screens required for EIDT admission after April 1, 2024.

What is the change? Please provide a summary of the change.

Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment Medicaid Manual

- Section 215.295: Added "Early Intervention Day Treatment (EIDT) Screening"; and
- Section 215.320: Updated with added screen between forty-eight (48) and sixty (60) months of age.

ARKids First - B Medicaid Manual

- Section 222.830: Updated with added screen between forty-eight (48) and sixty (60) months of age.

Early Intervention Day Treatment Medicaid Manual

- Section 202.200: Added and clarified existing service documentation requirements;
- Section 212.100: Corrected mistake in EPSDT age range;
- Section 212.200: Added a link to new required DHS-642 ER evaluation referral form;
- Section 212.300: Clarified and added a link to new required DHS-642 YTP treatment prescription form;
- Section 212.300 : Deleted developmental screen from Optum requirement;
- Section 212.400 : Removed list of evaluation instruments and added a link to permissible list of evaluation instruments;
- Section 212.500: Referenced back to applicable statute;
- Section 222.110: Clarified changes throughout;
- Section 222.130: Clarified changes throughout;
- Section 222.140: Added language regarding EIDT OT, PT, and Speech treatment services;

- Section 222.150: Added requirement that performing nurses be enrolled as Medicaid providers listed as performing providers on EIDT billing;
- Section 222.210: Added clarifying language throughout;
- Section 224.000: Added clarifying language throughout; and
- Section 251.000: Added clarifying language.

NOTICE OF RULE MAKING

The Department of Human Services announces for a public comment period of thirty (30) calendar days a notice of rulemaking for the following proposed rule under one or more of the following chapters, subchapters, or sections of the Arkansas Code: §§ 25-10-129, 20-76-201, and 20-77-107.

The Division of Developmental Disabilities Services (DDS), working jointly with the Division of Medical Services, proposes a rule adding language to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and ARKids-B Medicaid manuals, allowing primary care providers (PCPs) to perform a developmental screening for children between forty-eight (48) and sixty (60) months of age to enhance early identification of developmental needs for children and increase the quality of referrals for specialized services. The new screening will be incorporated into the Patient Centered Medical Home (PCMH) quality metrics. Additionally, PCPs will be required to perform a developmental screen prior to referring a child for their initial evaluations to determine eligibility for Early Intervention Day Treatment (EIDT) services resulting in termination of the third-party screening contractor after April 1, 2024. The rule results in annual cost savings calculated at $238,828.00 for state fiscal year (SFY) 2024 and $955,313.00 for SFY 2025.

There are no other changes to Early Periodic Screening, Diagnosis, and Treatment services (EPSDT). DHS assures continued access to EPSDT services in compliance with 42 C.F.R. §440.345.

The proposed rule is available for review at the Department of Human Services (DHS) Office of Rules Promulgation, 2nd floor Donaghey Plaza South Building, 7th and Main Streets, P. O. Box 1437, Slot S295, Little Rock, Arkansas 72203-1437. You may also access and download the proposed rule at ar.gov/dhs-proposed-rules. This notice also shall be posted at the local office of the Division of County Operations (DCO) of DHS in every county in the state. Public comments must be submitted in writing at the above address or at the following email address: ORP@dhs.arkansas.gov. All public comments must be received by DHS no later than February 12, 2024. Please note that public comments submitted in response to this notice are considered public documents. A public comment, including the commenter's name and any personal information contained within the public comment, will be made publicly available and may be seen by various people.

A public hearing by remote access only through a Zoom webinar will be held on January 24, 2024 at 10:30 a.m. and public comments may be submitted at the hearing. Individuals can access this public hearing at https://us02web.zoom.us/j/82241125721. The webinar ID is 822 4112 5721. If you would like the electronic link, "one-tap" mobile information, listening only dial-in phone numbers, or international phone numbers, please contact ORP at ORP@dhs.arkansas.gov.

If you need this material in a different format, such as large print, contact the Office of Rules Promulgation at 501-320-6428. 4502172997

Thomas Tarpley, Interim Director
Division of Developmental Disabilities Services