# DHS Responses to Public Comments Regarding Rule 265 Developmental Screens for Children (48 to 60 months)

**Michelle Edwards**

**Community School of Cleburne County, Inc.**

**Comment:**

Re: Early Intervention Day Treatment Manual

212.200 A & 212.300 C – These sections reference that beneficiaries currently enrolled in an EIDT program with an active treatment prescription for the EIDT services on a valid DMS-640 dated between April 1, 2023 and March 31, 2024, may use the current DMS-640 as a substitute for the new DMS-642 ER. The current DMS-640 is a prescription specifically for Therapy services – not EIDT services. Active treatment prescriptions specifically for EIDT services are not required to be on a DMS-640. We use the DMS-693 – but, I don't believe there is a specific form requirement for EIDT referral and prescription in the current manual. All current Therapy services provided in an EIDT are required to be on a DMS-640 prescription – but, EIDT services are not. I'm concerned that, during a retrospective review, if we do not have EIDT services prescribed on a DMS-640 (which is not currently required) that we will be found to be not in compliance based on the wording of the proposed rules.

222.1540 – Nursing Services

D2 – Each licensed registered nurse or licensed practical nurse listed as a performing provider must be an enrolled Arkansas Medicaid provider.

This is a new requirement – while we have LPN and RN on staff - we've not had them enrolled as Medicaid Providers. In reviewing the application for new Medicaid Providers – there is not a category that seems applicable to our nursing staff/services. There are categories for APNs, Nurse Midwife, and Nurse Practitioners – but, our LPNs and RN do not qualify for those Provider types. What category applies to them? Private Duty Nursing? There needs to be some explanation so our nursing staff is able to apply for the appropriate Medicaid Provider type that is being required for them.

We want to provide our doctors with information regarding the screening and referral changes so there is no confusion as to what is required from them for our services when we request information from them. What is not addressed in the Child Health Services/Early and Periodic Screening, Diagnosis, and Treatment Manual is if a child has had an EPSDT within the past year – but, a valid developmental screen instrument was not used to screen the child at the time of that visit. Can those screens be done during a subsequent office visit or how is that handled? Also – will the list of screening instruments that are "validated tools recommended by the American Academy of Pediatrics" be accessible through a link in this document?

**Response:** Thank you for your comment.

- The words "…on a valid DMS-640…" will be removed from Section 212.200(A.) of the Early Intervention Day Treatment Medicaid manual.
- RNs and LPNs would enroll as Medicaid Provider Type 95. DHS is in the process of finalizing which specialty(ies) would be used. Once proposed EIDT Medicaid manual changes are approved, specific guidance will be distributed.
- There will be a link to the American Academy of Pediatrics, Bright Futures website included in Section 222.830(K.) of the EPSDT Medicaid manual that provides a list of recommended tools.

**Ashley Kemp**

**Comment:**

In section 212.400 of the proposed changes there is a link with a list of accepted developments evals. Also in that section it appears the BDI the HELP the LAP and the E-LAP and the Brigance are going away. None are on the list of accepted evals. Is this the case? Is the new list with mostly Speech evaluation going to be used to test for Developmental therapy?

**Response:** Thank you for your comment. All the links attached in the proposed EIDT Medicaid manual were incorrect. The correct links will be active in the EIDT Medicaid manual on the effective date.

**Alesha Crowder, M.S., CCC-SLP**

**UAMS: Project for Adolescent and Child Evaluations**

**Comment:**

The speech-language evaluation codes (i.e., 92521-92524) are untimed and take the work of scoring, developing the plan of care, and report writing into account in the value of the evaluation code. These important non face-to-face portions of a comprehensive speech-language evaluation are "baked in" to the code value.

According to the American Speech-Language Hearing Association, the time associated with each CPT code includes pre-service time (before you see the patient), intra-service time (one-to-one evaluation or treatment with the patient), and post-service time (after the evaluation or treatment service has been completed).

The proposed language in the EIDT manual, section 214.130 C-2 stating that "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" is not reflective of the value of the above mentioned CPT codes.

It should additionally be noted that Medicaid requires that results from a comprehensive assessment in the suspected area of deficit must be reported, with specific guidelines for what must be included in

that assessment report. Removing scoring, interpretation, report writing, and treatment planning unless it is completed while face-to-face with the beneficiary puts an undue burden on the beneficiary and the beneficiary's caregivers to remain with a clinician for an extended period of time, beyond what is already a lengthy evaluation session.

**Response:** Thank you for your comment.

- Proposed Section 222.130(B.) and (C.) of the Early Intervention Day Treatment Medicaid manual will be deleted in its entirety and replaced with the following Section 222.130(B.) "Occupational therapy, physical therapy, and speech-language pathology evaluation services must be performed and billed in compliance 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 evaluation services procedure codes and descriptions**."
- Proposed Section 222.140(C.) and (D.) of the Early Intervention Day Treatment Medicaid manual will be deleted in its entirety and replaced with the following Section 222.140(C.) "Occupational therapy, physical therapy, and speech-language pathology treatment services must be performed and billed in compliance 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 treatment services procedure codes and descriptions**."

**Brooke Gardner**

**UAMS: Project for Adolescent and Child Evaluations**

**Comment:**

I am writing to urge you to reconsider the proposed changes to the EIDT manual that include wording that SLPs can only bill for face-to-face time. Providing a quality speech/language evaluation involves so much more than the time spent testing a client. There is necessary time needed to obtain medical/social/educational history, the interpretation of results, devising an appropriate treatment plan, providing reports to families, and parent/caregiver education. This proposed change will significantly affect the quality of the evaluations, treatment plans, reports, and information we provide to our clients and families! Thank you for your time and consideration.

**Response:** Thank you for your comment.

- Proposed Section 222.130(B.) and (C.) of the Early Intervention Day Treatment Medicaid manual will be deleted in its entirety and replaced with the following Section 222.130(B.) "Occupational therapy, physical therapy, and speech-language pathology evaluation services must be performed and billed in compliance 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 evaluation services procedure codes and descriptions**."

- Proposed Section 222.140(C.) and (D.) of the Early Intervention Day Treatment Medicaid manual will be deleted in its entirety and replaced with the following Section 222.140(C.) "Occupational therapy, physical therapy, and speech-language pathology treatment services must be performed and billed in compliance 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 treatment services procedure codes and descriptions**."

**Leah Coleman**

**Kidspiration Pediatric Therapy Services and Outpatient Therapy**

**Comment:**

Public Comments from the EIDT Association (formerly CHMS):

202.200 C. This section for school aged kids says to see Section 212.500 and that section is all crossed out. It would be helpful to have ARk. Code Ann. 20-48-101

(4) listed in this section.

212.200 B3. Under Occupational Therapy it says DMS-640 but should it be DMS-642? Also, in this section, if the private provider already has the DMS-642 ER, does the EIDT need a copy of that? The EIDT would need to get a new DMS-642YTP even if the child had a valid one at a private clinic? If a child transfers from a different EIDT, what paperwork is needed-just a new DMS-642 YTP? A copy of the DMS-642ER?

222.150 D1. Can a nurse enroll as a Medicaid provider since they can't be a stand alone provider?

224.000 A1-2. It doesn't mention signatures, just the people that should be contributing to the ITP. Does that mean signatures are not required? The ECDS needs to update annually but the others don't need to participate in the annual update?

224.000 A4. (ITP) What does 'therapist's signature, if applicable' mean? When is it or is it not applicable?

230.000A1. How does a provider ask for more than 5 hours of day hab in a single day?

Is there a place that specifies if an EIDT must keep track of the developmental screen given by the PCP? Or if the PCP sends the DMS-642 ER, the EIDT can move forward?

**Response:** Thank you for your comment.

- The proposed Section 212.500 of the Early Intervention Day Treatment (EIDT) Medicaid Manual (which is referenced by Section 202.200(C.)) is not completely crossed out. The current proposed language is "School age 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)."

- Proposed Section 212.200(B.)(3) of the EIDT Medicaid manual covers a situation where a beneficiary has been receiving out-patient therapy services and later enrolls in an EIDT. If a beneficiary has an active treatment prescription for an out-patient therapy at the time they enroll in an EIDT, a provider can demonstrate compliance with Section 212.200 for that therapy by including in the beneficiary's service record (i) the beneficiary's active out-patient treatment prescription (on a valid DMS-640) as of the date of EIDT enrollment, or (ii) by having the PCP check the specific therapy box on the DMS-642ER that was completed to refer the beneficiary for EIDT evaluation.

- All DMS-642 forms are specific to services provided by an EIDT, so only an EIDT provider should have a form DMS-642. Any out-patient therapy evaluation referral or treatment prescription would still be pursuant to DMS-640.

- An active treatment prescription for a therapy on a valid DMS-640 at the time a beneficiary enrolls in an EIDT can be relied upon by an EIDT until expiration (at which point it would have to be renewed on a DMS-642YTP or DMS-642STP). Since the PCP will have to issue a DMS-642YTP or DMS-642STP as part of a beneficiary's initial enrollment with an EIDT, it might be cleanest to have the PCP "renew" that existing out-patient therapy prescription on that DMS-642YTP or STP so that all EIDT services will have the same treatment prescription expiration dates.

- Signatures are not required from everyone participating in ITP development under Section 224.000(A.)(1.) of the EIDT Medicaid Manual, although it would probably be best practice to have anyone participating to sign.

- Section 224.000(A.)(4) of the EIDT Medicaid manual will be changed to remove ", if applicable".

- Providers request services beyond the authorized limits through a request for an extension of benefits.

- EIDT providers are not required to maintain copies of developmental screens performed by a beneficiary's PCP.

**Joan Hamilton, M.S., CCC-SLP**

**UAMS Department of Pediatrics: Foster Care – PACE**

**Victoria Buchanan, M.S., CCC-SLP**

**Audra Pogue, PA**

**Comment:**

With regard to section 214.130 C-2 of the Arkansas Medicaid EIDT Manual:

The proposed language in the EIDT manual, section 214.130 C-2 stating that "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" is not reflective of the value of speech-language evaluation CPT codes (92521-92524).

The speech-language evaluation codes (i.e., 92521-92524) are untimed and take the work of scoring, developing the plan of care, and report writing into account in the value of the evaluation code. These important non face-to-face portions of a comprehensive speech-language evaluation are "baked in" to the code value.

According to the American Speech-Language Hearing Association, the time associated with each CPT code includes pre-service time (before you see the patient), intra-service time (one-to-one evaluation or treatment with the patient), and post-service time (after the evaluation or treatment service has been completed).

It should additionally be noted that Medicaid requires that results from a comprehensive assessment in the suspected area of deficit must be reported, with specific guidelines for what must be included in that assessment report. Removing scoring, interpretation, report writing, and treatment planning unless it is completed while face-to-face with the beneficiary puts an undue burden on the beneficiary and the beneficiary's caregivers to remain with a clinician for an extended period of time, beyond what is already a lengthy evaluation session.

Regarding the memo dated July 10, 2023 titled "Updated OT, PT, and Speech Evaluation and Re-evaluation Guidance," the statement that specifies that speech-language pathology clinicians must follow the American Medical Association standard of only allowing face-to-face time with the beneficiary during evaluation and treatment planning appears to be a misguided statement. I have not successfully located any such American Medical Association standard. I researched the difference between complex codes and time-based codes, and while the speech-language evaluation codes 92521-92524 are not time based, even if they were to be considered as such it they should fall under AMA guidelines for time-based codes. An AMA presentation (link: https://www.ama-assn.org/system/files/2020-04/e-m-office-visit-changes.pdf) notes that as of January 1, 2021, total time on the date of the encounter for outpatient evaluation and management services includes physician and/or other QHP face-to-face and non-face-to-face time (pages 69-70). Page 71 states that Total Time on the date of the encounter recognizes the important non-face-to-face activities. Pages 73 and 74 go on to clarify that physician/other QHP times includes the following activities: preparing to see the patient, obtaining and or reviewing separately obtained history, performing a medically necessary appropriate examination and/or evaluation, counseling and educating the patient/family/caregiver, ordering medications, tests, or procedures, referring and communicating with other health care professionals, documenting clinical information in the electronic or other health to health record, independently interpreting results, and care coordination.

I hope that the proposed language in section 214.130 C-2 will be reconsidered. Thank you for your attention to this important issue.

**Response:** Thank you for your comment.

- Proposed Section 222.130(B.) and (C.) of the Early Intervention Day Treatment Medicaid manual will be deleted in its entirety and replaced with the following Section 222.130(B.) "Occupational therapy, physical therapy, and speech-language pathology evaluation services must be performed and billed in compliance 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 evaluation services procedure codes and descriptions**."
- Proposed Section 222.140(C.) and (D.) of the Early Intervention Day Treatment Medicaid manual will be deleted in its entirety and replaced with the following Section 222.140(C.) "Occupational therapy, physical therapy, and speech-language pathology treatment services must be performed and billed in compliance 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 treatment services procedure codes and descriptions**."

**David Ivers**

**Easterseals Arkansas**

**Comment:**

Easterseals Arkansas appreciates the work that has gone into preparation of the proposed rules. We submit the following additional comments:

**220.150.D.2 Each licensed registered nurse or licensed practical nurse listed as a performing**

**provider must be an enrolled Arkansas Medicaid provider**

*Comment: Please remove this requirement. The preceding paragraph D.1 requires providers to identify the performing nurse, which makes sense. But requiring nurses to enroll as Medicaid providers to then be linked to an EDIT group number is not practical, especially when relying on staffing agencies for some or all nursing services. The only person being harmed by this will be the beneficiaries, as it will curtail access if we can no longer use staffing agency nurses.*

**212.200 Referral to Evaluate**

*Comment: This section changes what used to be one form for PCPs to complete for all evaluations and treatment prescriptions. The proposed rule changes this process so that physicians and providers will have to deal with 5 different prescriptions instead of one. This is an unnecessary administrative burden that will cause delays in service and thus becomes an access issue. Please simplify this to allow one form to achieve the same outcome.*

**212.400 B Comprehensive Developmental Evaluations for Beneficiaries Yet to Reach School Age**

*Comment: The link to developmental evaluations does not work. It looks like speech instruments were linked by mistake.*

**Response:** Thank you for your comment.

- The only way the State can ensure actively licensed and in good-standing nursing staff are performing EIDT nursing services is through Medicaid enrollment. This brings licensed registered nurses and licensed practical nurses in line with requirements applicable to other board licensed professionals performing Medicaid services for individuals with intellectual and developmental disabilities at an EIDT.

- The State created an EIDT evaluation referral form that is separate from a treatment prescription form due to a historical lack of compliance with the step of an evaluation referral serving as a separate act from the later issuance of a prescription for services after a review of those evaluation results. Typically, this took the form of PCPs referring a beneficiary for evaluations on the same form they were prescribing services. Creating a separate evaluation form should alleviate this issue. The decision to create two different EIDT treatment prescription forms, one for year-round EIDT service and another for summer only EIDT services (the DMS-642YTP for year-round and 642STP for summer only) was made at the request of and after consultation with EIDT providers and PCPs.

- All the links attached in the proposed EIDT Medicaid manual were incorrect. The correct links will be active in the EIDT Medicaid manual on the effective date.

**Janie Sexton, Executive Director**

**Building Bridges Developmental and Community Services, Inc.**

**Comment:**

DDPA Comments regarding developmental screening

a. Section 212.400 has a link to acceptable developmental evaluation protocols, but when you click the link its only speech protocols listed-where can a list/link to the developmental protocols be found?

b. 212.200 referral to evaluate:
Confirming that if a child is already receiving out-patient therapy, a new evaluation referral prescription is not required to continue therapy in an EIDT provided that the child does qualify on the EIDT developmental evaluation.

If the out-patient clinic did not use the required protocols for Medicaid, the EIDT provider may have to perform additional evaluations. Would that require a new evaluation referral prescription?

For the school age EIDT, the EIDT provider may have to provide an additional therapy evaluation if the evaluation on record is more than 1 year old. School-based therapy often only evaluates every 3 years. Is that the expectation?

If a child does not receive a specific therapy such as PT, can the physician provide a referral for that service for the summer EIDT program?

If there is already a treatment prescription in place for out-patient therapy, will the EIDT provider have a means to access the treatment script? Would the expectation be that the out-patient clinic would share the prescription with the EIDT provider or would the EIDT seek a copy of that prescription from the physician? It is not clear how that will be accessed.

c. 212.500: diagnoses are marked out, with reference to the statute-it would be helpful to have the qualifying diagnoses listed in the manual as opposed to referring to a statute.

d. Where can the examples of the new treatment and referral scripts for EIDT year-round and summer program be found? Having multiple scripts for the programs may be confusing and cumbersome for the physician and make service access delayed.

222.150 Nursing

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.

If a staffing agency is used for nursing, it may be difficult to have them enrolled as a Medicaid provider when different nurses may be sent. This overall may be a cumbersome burden on the service provider. Why is this necessary?

**Response:** Thank you for your comment.

- All the links attached in the proposed EIDT Medicaid manual were incorrect. The correct links will be active in the EIDT Medicaid manual on the effective date.
- If a beneficiary has an active treatment prescription for an out-patient therapy at the time they enroll in an EIDT, an EIDT provider can demonstrate compliance with Section 212.200 for that therapy by including in the beneficiary's service record (i) the beneficiary's active out-patient treatment prescription (on a valid DMS-640) as of the date of EIDT enrollment, or (ii) by having the PCP check the specific therapy box on the DMS-642ER that was completed to refer the beneficiary for initial EIDT evaluation. It does not negate the overall need for the PCP to refer the beneficiary for initial EIDT evaluation by completing a DMS-642ER. A DMS-642ER is required to be completed by the beneficiary's PCP for an initial EIDT evaluation regardless of whether the beneficiary was receiving out-patient therapy at the time or not.
- An active treatment prescription for out-patient therapy pursuant to a valid DMS-640 at the time a beneficiary enrolls in an EIDT can continue to be relied upon by an EIDT until expiration (at which point it would have to be renewed on a DMS-642YTP or DMS-642STP). Since the PCP will have to issue a treatment prescription on a DMS-642YTP or DMS-642STP for a beneficiary's initial enrollment with an EIDT anyway (for those other EIDT services the beneficiary is not

receiving at enrollment), it might be cleanest to have the PCP "renew" that active therapy prescription on the DMS-642YTP or STP so that all EIDT services will have the same treatment prescription expiration dates.

- If an evaluation or prescription related to out-patient therapy was not in compliance with Medicaid requirements, then an EIDT provider would be required to have a DMS-642ER for the EIDT evaluation referral for all EIDT services to be performed and a DMS-642YTP or STP (as applicable) for the EIDT treatment prescription.
- Since the three (3) year evaluation rule only applies to schools, an EIDT would be required to meet the annual evaluation requirement. If this was the first time a school-age beneficiary has been referred for EIDT services (i.e. the beneficiary did not receive EIDT services the prior summer) then a DMS-642ER would be required since it would be the initial evaluation referral for EIDT services. If such a beneficiary had been receiving therapy at school pursuant to an active treatment prescription on a valid DMS-640 at the time of their initial summer EIDT referral, then if the EIDT provider had a copy of that DMS-640, the EIDT provider could go ahead and perform any required evaluation without waiting on the DMS-642ER.
- PCPs can issue a DMS-642ER referral to evaluate for any EIDT service for a school-age summer beneficiary.
- An EIDT provider could request a copy of the DMS-640 active treatment prescription from either the outpatient clinic or PCP (or have the parent request a copy from those parties). Even if direct access to the DMS-640 is unavailable, an EIDT provider could be protected by having the PCP renew the active treatment prescription by checking that therapy box on the DMS-642YTP or STP they must complete to prescribe EIDT services.
- The reference to the statute in Section 212.500 of the EIDT Medicaid manual is intentional so that the Medicaid manual would not have to repromulgated if the statute defining the qualifying diagnosis should be amended.
- The form DMS-642ER, DMS-642YTP, and DMS-642STP will be available as active links in the Medicaid manual once effective, and once the proposed changes are legislatively approved the state will disseminate the final versions of the new forms.
- The only way the State can ensure actively licensed and in good-standing nursing staff are performing EIDT nursing services is through Medicaid enrollment. This brings licensed registered nurses and licensed practical nurses in line with requirements applicable to other board licensed professionals performing Medicaid services for individuals with intellectual and developmental disabilities.