TOC required

201.000 Arkansas Medicaid Participation Requirements for Early Intervention Day Treatment (EIDT) Providers~~Introduction to Early Intervention Day Treatment (EIDT)~~ ~~7-1-18~~1-1-21

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

A. Complete the Provider Participation and enrollment requirements contained within Section 140.000 of the Arkansas Medicaid provider manual;

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

C. Except as provided in Section 201.200, obtain a Child Care Facility license issued by DPSQA.

EIDT providers may furnish and claim reimbursement for covered EIDT services subject to all requirements and restrictions set forth and referenced in this manual. ~~Arkansas Code Annotated §§ 20-48-1101—1108, authorizes the use of a successor program for early intervention day treatment for children. The Department of Human Services, Division of Developmental Disabilities Services ("DDS") is responsible for the implementation, general administration, and oversight of the successor program for early intervention day treatment for children. Division of Provider Services and Quality Assurance (DPSQA) is responsible for certification and licensure criteria as the regulatory entity governing this successor program.~~

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

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

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

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

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

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

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

~~Determination of underserved status for expansion of services~~

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

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

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

201.100 **EIDT Providers in Arkansas and Bordering States~~Licensing Requirements~~** ~~7-1-18~~1-1-21

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 Program participation requirements.

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

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

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

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

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

201.200 **Academic Medical Center Program Specializing in Development Pediatrics~~Providers in Arkansas and Bordering States~~** ~~7-1-18~~1-1-21

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

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, as well as a referral source for non-academic medical center EIDT programs within the state;
5. Is staffed to provide training of pediatric residents and other professionals in the multi-disciplinary diagnostics and evaluation of children with developmental disabilities and other special health care needs; and,
6. Does not provide treatment services to children.

B. An EIDT operating as an academic medical center is not required to be a licensed Child Care Facility.

C. An EIDT 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 codes**.

~~90791, U996101, U1, UA9920299215, U19917390791, U1, U9961059920392551T10169088796111992049256 7T102596101 UA96118992059258796101, UA, UB9920199205, U195961Providers in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) within fifty (50) miles of the state line may be enrolled as EIDT providers if they meet all Arkansas Medicaid participation requirements.~~

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

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

~~A. Is located in the state of Arkansas;~~

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

~~C. Specializes in developmental pediatrics;~~

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

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

~~F. Does not provide treatment services to children.~~

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

~~90791, U9~~	~~96101, U1, UA~~	~~99202~~	~~99215, U1~~	~~99173~~
~~90791, U1, U9~~	~~96105~~	~~99203~~	~~92551~~	~~T1016~~
~~90887~~	~~96111~~	~~99204~~	~~92567~~	~~T1025~~
~~96101 UA~~	~~96118~~	~~99205~~	~~92587~~	
~~96101, UA, UB~~	~~99201~~	~~99205, U1~~	~~95961~~	

202.000 Documentation Requirements ~~for All Medicaid Providers~~ ~~7-1-18~~1-1-21

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

202.100 Documentation Requirements for All Medicaid Providers~~EIDT Record Requirements~~ ~~7-1-18~~1-1-21

See Section 140.000 of the Arkansas Medicaid provider manual for the documentation that is required for all Arkansas Medicaid Program providers.

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

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

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

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

~~1. The specific services furnished daily;~~

~~2. The date and beginning and ending time the services were performed daily;~~

~~3. Name(s) and credential(s) of the person(s) providing the service(s), daily;~~

~~4. The relationship of the daily services to the goals and objectives described in the beneficiary's individual treatment plan (ITP); and~~

~~5. At a minimum, weekly progress notes describing each beneficiary's status with respect to his or her goals and objectives that are signed or initialed by the person(s) providing the service(s).~~

202.200 EIDT Record Requirements~~Electronic Signatures~~ ~~7-1-18~~**1-1-21**

A. EIDT providers must maintain medical records for each beneficiary that include sufficient, contemporaneous written documentation demonstrating the medical necessity of all EIDT services provided.

B. The record of a beneficiary who has yet to meet the age requirement for Kindergarten enrollment or who has filed a signed Kindergarten waiver must include:

1. The results of the developmental screen performed by the Department of Human Services' Third-Party Vendor, or an approved waiver of that developmental screen (See Section 212.300); and

2. The results of an annual comprehensive developmental evaluation (See Section 212.400).

C. The record of a beneficiary enrolled in school must have a documented developmental disability diagnosis that originated before the age of twenty-two (22) and is expected to continue indefinitely (See Section 212.500).

D. Service documentation for each beneficiary must include the following items:

1. The specific covered EIDT services furnished each day;

2. The date and beginning and ending time for each of the covered EIDT services performed each day;

3. Name(s) and credential(s) of the person(s) providing each covered EIDT service each day;

4. The relationship of each day's covered EIDT services to the goals and objectives described in the beneficiary's Individual Treatment Plan (ITP); and

5. Weekly or more frequent progress notes, signed or initialed by the person(s) providing the covered EIDT service(s), describing each beneficiary's status with respect to his or her ITP goals and objectives.~~Medicaid will accept electronic signatures if the electronic signatures comply with Arkansas Code Ann. §§ 25-31-103 et seq.~~

202.300 Electronic Signatures **1-1-21**

The Arkansas Medicaid Program will accept electronic signatures in compliance with Arkansas Code Ann. §§ 25-31-103 et seq.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

210.000 PROGRAM COVERAGE

211.000 Introduction

~~7-1-18~~1-1-21

The Arkansas Medicaid Program assists eligible individuals to obtain medical care in accordance with the guidelines specified in Section I of the Arkansas Medicaid provider manual.~~this Manual.~~ The Arkansas Medicaid Program will reimburse enrolled providers~~Reimbursement may be made~~ for medically necessary~~,~~ covered Early Intervention Day Treatment (EIDT) ~~S~~services when such services are provided to an eligible beneficiary pursuant to an Individual Treatment Plan by a licensed EIDT meeting the requirements in this manual. ~~provided to Medicaid beneficiaries, aged 0-21, at qualified provider facilities. Services may be provided year-round to beneficiaries aged 0-6, and during the summer months for beneficiaries aged 6-21~~.

212.000 Establishing Eligibility

~~7-1-18~~1-1-21

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

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

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

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

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

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

~~1. Intellectual Disability~~

~~2. Spina bifida~~

~~3. Cerebral palsy~~

~~4. Autism spectrum disorder~~

~~5. Epilepsy/seizure disorder~~

~~6. Down syndrome~~

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

212.100 **~~Eligibility Criteria~~Age Requirement** ~~7-1-18~~1-1-21

A beneficiary must be under the age of twenty-two (22) to be enrolled in an EIDT program and receive covered EIDT services through the Arkansas Medicaid Program.

A. Covered EIDT services may be provided year-round to beneficiaries who have yet to meet the age requirement for Kindergarten enrollment or who have filed a signed Kindergarten waiver.

B. Covered EIDT services may be provided to school age beneficiaries up to the age of twenty-one (21) during the summer when school is not in session to prevent a beneficiary from regressing over the summer.

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

~~A. Hawaii Early Learning Profile (HELP)~~

~~B. Learning Accomplishment Profile (LAP)~~

~~C. Early Learning Accomplishment Profile (E-LAP)~~

~~D. Brigance Inventory of Early Development (IED)~~

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

~~A. Evaluation that shows:~~

~~1. For ages 0-36 months, a score of 25% or greater delay in at least two of five domains: motor, social, cognitive, self-help/adaptive, or communication on both the BDI and the criterion referenced;~~

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

~~3. The same two areas of delay on both the BDI and the criterion referenced test.~~

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

~~1. Physical therapy,~~

~~2. Occupational therapy,~~

~~3. Speech therapy, or~~

~~4. Nursing services~~

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

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

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

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

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

212.200 Prescription **1-1-21**

The Arkansas Medicaid Program will reimburse providers for covered EIDT services only when the beneficiary's physician has determined that covered EIDT services are medically necessary.

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

B. The physician must issue written prescriptions for a comprehensive developmental evaluation and EIDT services that are dated and signed with his or her signature. A prescription is valid for one (1) year, unless a shorter period is specified. The prescription must be renewed at least once a year for EIDT services to continue.

C. When prescribing EIDT services, the physician shall not make any self-referrals in violation of state or federal law.

212.300 Developmental Screen or Waiver for Beneficiaries yet to Reach School Age **1-1-21**

A beneficiary who has yet to meet the age requirement for Kindergarten enrollment or who has filed a signed Kindergarten waiver must receive an age appropriate developmental screen performed by DHS' Third Party Vendor that indicates the beneficiary has been referred for further evaluation or have a waiver of the developmental screen requirement in order to be eligible to enroll in an EIDT program and receive covered EIDT services.

A. A waiver of the developmental screen requirement is available when the beneficiary has been deemed to meet the institutional level of care (as shown on a DMS-703), or has one of the following diagnoses:

1. Intellectual Disability
2. Spina Bifida
3. Cerebral Palsy
4. Autism Spectrum Disorder
5. Epilepsy/Seizure Disorder
6. Down Syndrome

B. In order to obtain a waiver of the developmental screen requirement, the beneficiary's physician or the EIDT provider must send all relevant documentation to DHS' Third Party Vendor for review. A clinician for DHS' Third Party Vendor will review the submitted documentation to determine if a developmental screen is required.

C. School age beneficiaries up to the age twenty-one (21) receiving covered EIDT services only during the summer when school is not in session do not have to undergo a developmental screen performed by DHS' Third Party Vendor.

212.400 Comprehensive Developmental Evaluation for Beneficiaries yet to Reach School Age 1-1-21

A beneficiary that has not yet reached school age (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 in order to be eligible to enroll in an EIDT program and receive covered EIDT services. The comprehensive annual developmental evaluation must include a norm referenced (standardized) evaluation and a criterion referenced evaluation. Each evaluator must document that they were qualified to administer each instrument and that the test protocols for each instrument used were followed.

A. The norm referenced evaluation must be one of the two ~~most current~~latest editions of one of the following:

1. Battelle Developmental Inventory (BDI)
2. Brigance Inventory of Early Development Standardized

B. The criterion referenced evaluation must be age appropriate and one of the ~~most current~~two latest editions of one of the following:

1. Hawaii Early Learning Profile (HELP)
2. Learning Accomplishment Profile (LAP)
3. Early Learning Accomplishment Profile (E-LAP)
4. Brigance Inventory of Early Development - Early Childhood Edition

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

1. For ages zero (0) up to thirty-six (36) months, a score of twenty-five percent (25%) or greater delay in at least two (2) of five (5) domains: motor (the delay can be shown in either gross motor, fine motor, or total motor), social, cognitive, self-help or adaptive, or communication on both the norm referenced evaluation and the criterion referenced evaluation;
2. For ages three (3) through six (6), a score of at least two (2) standard deviations below the mean in at least two (2) of the five (5) domains: motor (the delay can be shown in either gross motor, fine motor, or total motor), social, cognitive, self-help or adaptive, or communication on the norm referenced evaluation and twenty-five percent (25%) or greater delay on the criterion referenced evaluation; and
3. The same two (2) areas of delay on both the norm referenced evaluation and the criterion referenced evaluation.

212.500 Qualifying Diagnosis for School Age Beneficiaries 1-1-21

School age beneficiaries up to the age of twenty-one (21) must have a documented intellectual or developmental disability diagnosis that originated before the age of twenty-two (22) and is expected to continue indefinitely in order to be eligible to enroll in an EIDT program and receive covered EIDT services during the summer when school is not in session.

A. 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 a licensed physician;
2. A diagnosis of Spina Bifida established by the results of a medical examination performed by a licensed physician;
3. A diagnosis of Down Syndrome established by the results of a medical examination performed by a licensed physician;
4. A diagnosis of Epilepsy established by the results of a medical examination performed by a licensed physician;
5. A diagnosis of Autism Spectrum Disorder established by the results of a team evaluation which must include a licensed physician, licensed psychologist, and licensed 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 a licensed physician and a licensed psychologist.

B. The intellectual or developmental disability must constitute a substantial handicap to the beneficiary's ability to function without appropriate support services such as daily living and social activities services, medical services, physical therapy, speech-language therapy, and occupational therapy.

212.600 Medically Necessary Speech-Language Therapy, Occupational Therapy, Physical Therapy, or Nursing Services 1-1-21

A. In addition to meeting the applicable comprehensive developmental evaluation scoring thresholds in Section 212.400 or having a qualifying developmental disability diagnosis in Section 212.500, as applicable, one of the following services must be medically necessary in order for a beneficiary to be eligible to enroll in an EIDT program and receive covered EIDT services:

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

B. Medical necessity for occupational, physical, and speech-language evaluation and therapy services is established in accordance with the Arkansas Medicaid provider manual for Occupational, Physical, and Speech-Language Therapy Services, Section II.

C. Medical necessity for nursing services is established by a medical diagnosis and a comprehensive nursing evaluation approved by the physician that designates the need for EIDT services.

213.000 ~~Core Services~~Non-covered Services ~~7-1-18~~1-1-21

The Arkansas Medicaid Program will only reimburse for those EIDT services listed in Sections 214.000. Additionally, the Arkansas Medicaid Program will only reimburse for EIDT services when such services are provided to a Medicaid beneficiary meeting the eligibility requirements in Section 212.000 by an EIDT meeting the requirements of this manual.

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

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

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

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

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

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

~~213.100 Nursing Services~~ ~~7-1-18~~

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

~~213.200 Non-covered Services~~ ~~7-1-18~~

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

214.000 ~~Description of~~Covered EIDT ~~Core~~ Services

Covered EIDT services are provided in licensed EIDT clinics and include the following:

A. EIDT evaluation and treatment planning services;

B. Day habilitative services;

C. Speech-language evaluation and speech-language therapy services;

D. Physical therapy evaluation and physical therapy services;

E. Occupational therapy evaluation and occupational therapy services; and

F. Nursing services.

214.100 EIDT Evaluation and Treatment Planning Services ~~7-1-18~~1-1-21

An EIDT may be reimbursed by the Arkansas Medicaid Program for medically necessary EIDT evaluation and treatment planning services. EIDT evaluation and treatment planning services are a component of the process of determining a beneficiary's eligibility for EIDT services and developing the beneficiary's Individualized ~~ed~~ Treatment Plan (ITP).

For beneficiaries who have yet to meet the age requirement for Kindergarten enrollment or who have filed a signed Kindergarten waiver, medical necessity for EIDT evaluation and treatment planning services is demonstrated by the results of an age appropriate developmental screen performed by DHS' Third Party Assessor, unless a clinician for DHS' Third Party Vendor has reviewed diagnosis and other medical documentation submitted in accordance with Section 212.300 and determined a developmental screen is not required.

For school age beneficiaries up to the age of twenty-one (21), medical necessity is established through a developmental disability diagnosis by the beneficiary's physician that designates the need for EIDT evaluation and treatment planning services.

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 an evaluation, scoring the evaluation, and writing an evaluation report along with time spent developing the ITP. **View or print the billable EIDT evaluation and treatment planning codes**.~~The evaluation service is a component of the process of determining a person's eligibility for habilitative services and habilitative services in the summer. Evaluation services are covered separately from habilitative services.~~

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

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

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

214.200 Day Habilitative Services ~~for Ages 0-6~~ ~~7-1-18~~1-1-21

A. An EIDT may be reimbursed by the Arkansas Medicaid Program for medically necessary day habilitative services.

1. For a beneficiary who has yet to meet the age requirement for Kindergarten enrollment or who had filed a signed Kindergarten waiver, medical necessity for EIDT day habilitative services is demonstrated by the results of a comprehensive developmental evaluation described in Section 212.400.

2. For school age beneficiaries up to the age of twenty-one (21), medical necessity for day habilitative services is established through a developmental disability diagnosis by the beneficiary's physician that designates the need for day habilitative services.

~~A~~B. EIDT day ~~H~~habilitative ~~S~~services are instruction in areas of cognition, communication, social and/ emotional, motor, and adaptive skills~~;~~ or to reinforce skills learned and practiced in occupational, physical, or speech-language therapy. EIDT day ~~H~~habilitati~~ve~~on activities must be designed to teach habilitation goals and objectives specified in the beneficiary's ~~client's~~ Individual Treatment Plan ~~(ITP).~~ ~~(Refer to Section 216.000 of this manual.)~~

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

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

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

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

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

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

~~1. During naptime:~~

~~a. A minimum of 50% of the staff shall remain with children 3 years of age and older.~~

~~b. Staff ratios must be maintained at 100% for children under the age of 3.~~

~~2. Additional staff must be provided for children with significant medical or behavior needs that require more individual attention.~~

~~D~~E. ~~One unit of habilitative services equals one hour.~~ EIDT day habilitative services are reimbursed on a per unit basis. No more than five (5) ~~units~~ hours of EIDT day habilitative services may be billed per day without an extension of benefits. ~~This~~ The unit of service calculation includes naptime~~.~~, but does not include time spent in transit from the beneficiary's place of residence to the EIDT facility and from the facility back to the beneficiary's place of residence. **View or print the billable day habilitative EIDT codes**.

214.300 Occupational, Physical, and Speech-Language Evaluation and Therapy Services ~~7-1-18~~1-1-21

A. An EIDT may be reimbursed for medically necessary occupational, physical, and speech-language evaluation and therapy services. Occupational, physical, and speech-language evaluation and therapy services must be medically necessary in accordance with the Arkansas Medicaid provider manual for Occupational, Physical, and Speech-Language Therapy Services, Section II. A developmental disability diagnosis alone does not demonstrate the medical necessity of occupational, physical, or speech-language therapy.

B. An EIDT may contract with or employ its qualified occupational, physical, and speech-language therapy practitioners. The EIDT must identify the qualified individual therapy practitioner as the performing provider on the claim when the EIDT bills the Arkansas Medicaid Program for the therapy service. The qualified therapy practitioner must be enrolled with the Arkansas Medicaid Program and the criteria for group providers of therapy services would apply (See Section 201.100 of the Occupational, Physical, and Speech-Language Therapy Services manual).

C. All occupational, physical, and speech-language therapy services furnished by an EIDT must be provided and billed in accordance with the Arkansas Medicaid provider manual for Occupational, Physical, and Speech-Language Therapy Services, Section II. **View or print the billable occupational, physical, and speech-language therapy EIDT codes.** ~~Occupational, physical, and speech therapy services must be medically necessary to the treatment of the beneficiary's developmental disability or delay, in accordance with the Medicaid Provider Manual for Occupational, Physical, and Speech Therapy Services, Section II. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy.~~

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

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

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

~~1. Intellectual Disability~~

~~2. Spina Bifida~~

~~3. Cerebral Palsy~~

~~4. Autism Spectrum Disorder~~

~~5. Epilepsy/Seizure Disorder~~

~~6. Down Syndrome~~

~~7. A condition found to be closely related to intellectual disability because it results in impairment of general intellectual functioning or adaptive behavior similar to those persons with intellectual disability or requires treatment and services similar to those required for such persons. This determination must be based on the results of a team evaluation including at least a licensed Physician and a licensed Psychologist.~~

~~AND~~

~~B. Receive at least one of the following services:~~

~~1. Occupational Therapy~~

~~2. Speech Therapy~~

~~3. Physical Therapy~~

~~4. Nursing~~

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

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

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

214.400 Nursing Services 1-1-21

A. An EIDT may be reimbursed by the Arkansas Medicaid Program for medically necessary nursing services. Medical necessity for nursing services is established by a medical diagnosis and a comprehensive nursing evaluation approved by the physician that designates the need for EIDT services. The evaluation must specify the required nursing services, and the physician must prescribe the number of nursing service units per day.

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

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

1. Assisting ventilator-dependent 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 or ileostomy tube administration, care, and maintenance; and
8. Administration of medication; however, EIDT nursing services are not considered medically necessary if the administration of medication is the only nursing service needed by a beneficiary.

D. EIDT nursing services are reimbursed on a per unit basis. The Arkansas Medicaid Program will reimburse up to one (1) hour of EIDT nursing services per day without prior authorization. Time spent taking a beneficiary's temperature and performing other acts of standard first aid is not included in the units of EIDT nursing service calculation. **View or print the billable EIDT nursing codes**.

215.000 Individual Treatment Plan (ITP) 1-1-21

A. Each beneficiary enrolled in an EIDT program must have an Individual Treatment Plan (ITP) that is developed, re-evaluated, and updated at least annually. The ITP is a written, individualized plan to improve the beneficiary's condition that at a minimum must contain:

1. A written description of the beneficiary's treatment objectives;
2. The beneficiary's treatment regimen, which includes the specific medical and remedial services, therapies, and activities that will be used to achieve the

beneficiary's treatment objectives and how those services, therapies, and activities are designed to achieve the treatment objectives;

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

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

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

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

B. The ITP must be developed, re-evaluated, and updated by the Early Childhood Development Specialist (ECDS) assigned to the beneficiary. The ECDS's original signature and date signed must be recorded on the ITP.

~~**215.100 Nursing Services** 7-1-18~~

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

~~A. Assisting ventilator-dependent beneficiaries;~~

~~B. Tracheostomy: suctioning and care~~

~~C. Feeding tube: feeding, care and maintenance~~

~~D. Catheterizations~~

~~E. Breathing treatments~~

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

~~G. Administration of medication~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

220.000 REIMBURSEMENT AND RECOUPMENTPRIOR AUTHORIZATION

Prior authorization is required for the Arkansas Medicaid Program to reimburse a licensed EIDT provider for:

A. Over five (5) hours of EIDT day habilitative services in a single day;

B. Over ninety (90) minutes per week of occupational, physical, or speech-language therapy services;

C. Over one (1) hour per day of covered EIDT nursing services; and,

D. Over eight (8) total hours of covered EIDT services in a single day.

221.000 Method of Reimbursement 7-1-18

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

221.100 Fee Schedules 7-1-18

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

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

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

~~222.000 Retrospective Reviews~~ ~~7-1-18~~

~~Arkansas Medicaid conducts retrospective review of the core EIDT services:~~

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

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

~~223.000 Recoupment~~ ~~7-1-18~~

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

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

~~224.000 Administrative Reconsideration~~ ~~7-1-18~~

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

~~224.100 Appeal Process~~ ~~7-1-18~~

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

230.000 ~~BILLING PROCEDURES~~REIMBURSEMENT

231.000 ~~Introduction to Billing~~Method of Reimbursement ~~7-1-20~~1-1-21

EIDT services use “fee schedule” reimbursement methodology. Under the fee schedule methodology, reimbursement is made at the lower of the billed charge or the maximum allowable reimbursement for the procedure under the Arkansas Medicaid Program. The maximum allowable reimbursement for a procedure is the same for all EIDT providers.

~~Early Intervention Day Treatment providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.~~

~~Section III of this manual contains information about available options for electronic claims submission.~~

231.100 Fee Schedules 1-1-21

The Arkansas Medicaid Program provides fee schedules on the Arkansas Medicaid website. **View or print the EIDT fee schedule**. Fee schedules do not address coverage limitations or special instructions applied by the Arkansas Medicaid Program before final payment is determined. 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 to correct a discrepancy or error.

~~232.000 CMS-1500 Billing Procedures~~

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

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

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

~~Occupational Therapy Procedure Codes~~

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

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

Physical Therapy Procedure Codes

Procedure Code	Required Modifier(s)	Description
97001	—	Evaluation for physical therapy (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30)
97110	—	Individual physical therapy by Physical Therapist (15-minute unit; maximum of 6 units per week)
97110	UB	Individual physical therapy by physical therapy assistant (15-minute unit; maximum of 6 units per week)
97150	—	Group physical therapy by Physical Therapist (15-minute unit; maximum of 6 units per week, maximum of 4 clients per group)
97150	UB	Group physical therapy by physical therapy assistant (15-minute unit; maximum of 6 units per week, maximum of 4 clients per group)

Speech Therapy Procedure Codes

Procedure Code	Required Modifier(s)	Description
92521	UA	⁂Evaluation of speech fluency (e.g. stuttering, cluttering) (maximum of four 30-minute units per state fiscal year, July 1 through June 30)

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

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

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

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

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

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

232.300 Billing Instructions – Paper Only 7-1-18

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

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

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

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

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

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

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
SEX	Check M for male or F for female.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary or participant resides.
STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/ emergency telephone.
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
CITY	
STATE	

Field Name and Number	Instructions for Completion
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. RESERVED	Reserved for NUCC use.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.

Field Name and Number	Instructions for Completion
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.
15. OTHER DATE	Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines. The "Other Date" identifies additional date information about the beneficiary's condition or treatment Use qualifiers: 454 Initial Treatment 304 Latest Visit or Consultation 453 Acute Manifestation of a Chronic Condition 439 Accident 455 Last X-Ray 471 Prescription 090 Report Start (Assumed Care Date) 091 Report End (Relinquished Care Date) 444 First Visit or Consultation
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is required for EIDT services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a. (blank)	The 9-digit Arkansas Medicaid provider ID number of the referring physician.
17b. NPI	Not required.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.

Field Name and Number	Instructions for Completion
19. ADDITIONAL CLAIM INFORMATION	For tracking purposes, occupational, physical and speech therapy providers are required to enter one of the following therapy codes:
Code	Category
A	Individuals from birth through 2 years who are receiving therapy services under an Individualized Family Services Plan (IFSP) through the Division of Developmental Disabilities Services.
B	Individuals ages 0 through 5 years (if individual has not reached age 5 by September 15) who are receiving therapy services under an Individualized Plan (IP) through the Division of Developmental Disabilities Services. **NOTE: This code is to be used only when all three of the following conditions are in place: 1) the individual receiving services has not attained age 5 by September 15 of the current school year, 2) the individual receiving services is receiving the services under an Individualized Plan, 3) the Individualized Plan is through the Division of Developmental Disabilities Services.**
When using code C or D, providers must also include the 4-digit LEA (local education agency) code assigned to each school district. For example: C1234	
C (and 4-digit LEA code)	Individuals ages 3 through 5 years (if individual has not reached age 5 by September 15) who are receiving therapy services under an Individualized Education Plan (IEP) through an education service cooperative. **NOTE: This code is to be used only when all three of the following conditions are in place: 1) the individual receiving services is between the ages of 3 through 5 years and has not attained age 5 by September 15 of the current school year, 2) the individual receiving services is receiving the services under an Individualized Education Plan, 3) the Individualized Education Plan is through an education service cooperative.**
D (and 4-digit LEA code)	Individuals ages 5 (by September 15) to 21 years who are receiving therapy services under an Individualized Education Plan (IEP) through a school district. **NOTE: This code is to be used only when all three of the following conditions are in place: 1) the individual receiving services is between the ages of 5 (by September 15 of the current school year) to 21 years. 2) the individual receiving services is receiving the services under an Individualized Education Plan, 3) the Individualized Education Plan is through a school district.**

Field Name and Number	Instructions for Completion
E	Individuals ages 18 years and up who are receiving therapy services through the Division of Developmental Disabilities Services.
F	Individuals ages 18 years and up who are receiving therapy services through individual or group providers not included in any of the previous categories (A-E).
G	Individuals ages birth through 17 years who are receiving therapy/pathology services through individual or group providers not included in any of the previous categories (A-F).
	Not used.
20. OUTSIDE LAB?	Not required.
$ CHARGES	Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	Enter the applicable ICD indicator to identify which version of the ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 262.200 for codes.

Field Name and Number	Instructions for Completion
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	One CPT or HCPCS procedure code for each detail. See Sections 262.100 through 262.140.
MODIFIER	Modifier(s) if applicable. See Section 262.120.
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. $ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other beneficiary of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	The 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail.
NPI	Not required.
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT N O.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F – the sum all charges on the claim.
29. AMOUNT PAID	Enter the total of payments previously received on this claim. Do not include amounts previously paid by Medicaid. *Do **not** include in this total the automatically deducted Medicaid or co-payments.
30. RESERVED	Reserved for NUCC use.

Field Name and Number	Instructions for Completion
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Not required.
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

232.400 Special Billing Procedures 7-1-18

Not applicable to this program.

Rules for the Division of Developmental Disabilities

Early Intervention Day Treatment

LAST UPDATED: January 1, 2021

Subchapter 1. General.

101. Authority.

(a) These standards are promulgated under the authority of Ark. Code Ann. § 20-48-201 to -212, Ark. Code Ann. § 20-48-1101 to -1108, Ark. Code Ann. § 25-10-102, and Ark. Code Ann. § 25-15-217.

(b) (1) The Division of Provider Services and Quality Assurance (DPSQA) shall perform all regulatory functions regarding the licensure and monitoring of Early Intervention Day Treatment programs on behalf of the Division of Developmental Disabilities Services.

(2) The Division of Developmental Disabilities Services (DDS) shall determine whether and to what an extent a county is underserved.

(c) (1) The Division of Child Care and Early Childhood Education (DCCECE) shall perform all regulatory functions regarding the licensure and monitoring of child care centers.

(2) DPSQA may perform regulatory functions regarding the monitoring of child care centers that are licensed as Early Intervention Day Treatment programs on behalf of DCCECE.

102. Purpose.

The purpose of these standards is to:

(a) Serve as the minimum standards for early intervention day treatment programs and facilities; and

(b) Ensure that all beneficiaries receive all early intervention day treatment services recommended by a physician for the maximum reduction of physical or mental disability and restoration of the beneficiary to the best functional level.

103. Definitions.

(a) "Academic medical center" means a medical center located in Arkansas that consists of a medical school and its primary teaching hospitals and clinical programs.

(b) "Adverse regulatory action" means a denial of an EIDT license and any enforcement action taken by DPSQA pursuant to Section 803 to 807.

(c) "Applicant" means an applicant for an EIDT license.

(d) "Child care center" means a child care center licensed as a child care center by DCCECE pursuant to the Minimum Licensing Standards for Child Care Centers.

(e) "Child care center license" means a license to operate a child care center issued by DCCECE pursuant to the Minimum Licensing Standards for Child Care Centers.

(f) (1) "Change in ownership" means one or more transactions within a twelve (12) month period that result in a change in greater than fifty percent (50%) of the financial interests, governing body, operational control, or other operational or ownership interests of the EIDT.

(2) "Change in ownership" does not include a change of less than fifty percent (50%) in the membership of the EIDT's board of directors, board of trustees, or other governing body.

(g) "Directed in-service training plan" means a plan of action that:

(1) Provides training to assist an EIDT in complying with these standards and correcting deficiencies;

(2) Includes the topics covered in the training and materials used in the training;

(3) Specifies the length of the training;

(4) Specifies the staff required to attend the training; and

(5) Is approved by DPSQA.

(h) "Early intervention day treatment" means diagnostic, screening, evaluative, preventative, therapeutic, palliative, and rehabilitative and habilitative, including speech, occupational, and physical therapies and any medical or remedial services recommended by a physician for the maximum reduction of physical or mental disabilities and the restoration of the child to the best possible functional level.

(i) "ECDS" means an early childhood developmental specialist, which is an employee responsible for the development of beneficiary individual treatment plans (referred to as "ITPs"), the supervision of habilitative services delivery to beneficiaries, and who satisfies at least one of the following criteria:

(1) Is licensed as a speech therapist, occupational therapist, physical therapist, or developmental therapist; or

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

(A) An Early Childhood or Early Childhood Special Education certificate;

(B) Current child development associate's certificate;

(C) Current birth to pre-K credential; or

(D) Documented experience working with children with special needs and twelve (12) hours of completed college courses in early childhood, child development, special education, elementary education, or child and family studies.

(j) "Early intervention day treatment services" means services that are available under the Early Intervention Day Treatment program for Medicaid beneficiaries as defined in Section II of the Early Intervention Day Treatment Medicaid Manual.

(k) "EIDT" means an early intervention day treatment program, which is a pediatric day treatment program run by one or more ECDS that provides early intervention day treatment service prescribed by a physician to children with intellectual and developmental disabilities, developmental delays, or a medical condition that puts them at risk for developmental delay.

(l) "EIDT license" means a non-transferable license issued by DPSQA to an EIDT for a specific location that meets these standards.

(m) (1) "Employee" means an employee, owner, independent contractor, or other agent of an EIDT and includes without limitation full-time employees, part-time employees, transportation contractors, and any other person who acts on behalf of an EIDT or has an ownership, financial, or voting interest in the EIDT.

(2) "Employee" does not mean an independent contractor if:

(i) The independent contractor does not assist in the day-to-day operations of the EIDT; and

(ii) The independent contractor has no beneficiary contact."

(n) "First Connections" means the DDS program that administers, monitors, and carries out all activities and responsibilities for the State of Arkansas under Part C of the Individuals with Disabilities Education Act to ensure appropriate early intervention services are available to all infants and toddlers from birth to thirty-six (36) months of age who are suspected of having a developmental delay (and their families.)

(o) "First Connections Central Intake Unit" means the DDS unit in the First Connections program that serves as the program's single referral point of entry to minimize duplication and expedite service delivery.

(p) "Irreconcilable conflict" means a conflict between two standards where an EIDT cannot comply with both standards at the same time.

(q) "ITP" means a beneficiary's individual treatment plan, which is a written, individualized service plan for an EIDT beneficiary to improve the EIDT beneficiary's condition.

(r) "Local Education Agency" means the school district or education service cooperative offering preschool services to the area where the beneficiary resides.

(s) (1) "Marketing" means the accurate and honest advertisement of an EIDT that does not also constitute solicitation.

(2) "Marketing" includes without limitation:

(A) Advertising using traditional media;

(B) Distributing brochures or other informational materials regarding the services offered by the EIDT;

(C) Conducting tours of the EIDT to interested beneficiaries and their families;

(D) Mentioning services offered by the EIDT in which the beneficiary or his or her family might have an interest; or

(E) Hosting informational gatherings during which the services offered by the EIDT are described.

(t) "Medication error" means the loss of medication, unavailability of medication, falsification of medication logs, theft of medication, missed doses of medication, incorrect medications administered, incorrect doses of medication, incorrect time of administration, incorrect method of administration, and the discovery of an unlocked medication container that is always supposed to be locked.

(u) "Plan of correction" means a plan of action that:

(1) Provides the steps an EIDT must take to correct noncompliance with these standards;

(2) Sets a timeframe for each specific action provided in the plan; and

(3) Is approved by DPSQA.

(v) "Residence" means the county where a beneficiary is listed as residing in the Arkansas Medicaid Management System.

(w) "Serious injury" means any injury to a beneficiary that:

(1) May cause death;

(2) May result in substantial permanent impairment;

(3) Requires the attention of an emergency medical technician, a paramedic, or a doctor; or

(4) Requires hospitalization.

(x) (1) "Solicitation" means the initiation of contact with a beneficiary or his or her family by an EIDT when the beneficiary is currently receiving services from another provider and the EIDT is attempting to convince the beneficiary or his or her family to switch to or otherwise use the services of the ADDT that initiated the contact.

(2) "Solicitation" includes without limitation the following acts to induce a beneficiary or his or her family by:

(A) Contacting the family of a beneficiary that is currently receiving services from another provider;

(B) Offering cash or gift incentives to a beneficiary or his or her family;

(C) Offering free goods or services not available to other similarly situated beneficiaries or their families;

(D) Making negative comments to a beneficiary or his or her family regarding the quality of services performed by another service provider;

(E) Promising to provide services in excess of those necessary;

(F) Giving a beneficiary or his or her family the false impression, directly or indirectly, that the EIDT is the only service provider that can perform the services desired by the beneficiary or his or her family; or

(G) Engaging in any activity that DPSQA reasonably determines to be "solicitation."

(y) "Student observer" means a student visiting an EIDT on one-time or periodic basis to observe classroom activities or other similar activities that do not involve direct contact with beneficiaries.

(z) "Underserved county" means a county that is underserved regarding early intervention day treatment services.

Subchapter 2. Licensing.

201. License Required.

(a) (1) An EIDT must have an EIDT license issued by DPSQA pursuant to these standards for the location at which the EIDT will provide services.

(2) An EIDT must comply with all requirements of these standards.

(b) (1) An EIDT license is specific to a single location.

(2) A separate EIDT license is required for each location even if the same person or entity has an EIDT at other locations.

(3) A location may only have one EIDT license attributed to it at any one time.

(c) An EIDT may be operated through an academic medical center program if the program:

(1) Specializes in developmental pediatrics; and

(2) Is staffed and operated by the academic medical center under the direction of a board-certified or board-eligible developmental pediatrician;

(d) (1) An EIDT must have a child care center license in good standing for the EIDT's location unless the EIDT is operating as an academic medical center.

(2) (A) An EIDT must comply with all requirements of the applicable Minimum Licensing Standards for Child Care Centers.

(B) A violation of the applicable Minimum Licensing Standards for Child Care Centers constitutes a violation of these standards.

(e) (1) In the event of a conflict between these standards and the Minimum Licensing Standards for Child Care Centers, the stricter requirement shall apply.

(2) In the event of an irreconcilable conflict between these standards and the Minimum Licensing Standards for Child Care Centers, these standards shall govern to the extent not governed by federal laws or rules or state law.

202. Licensure Application.

(a) (1) To apply for an EIDT license, an applicant must submit a complete application to DPSQA.

(2) A complete application includes:

(A) Documentation demonstrating the applicant's entire ownership, including without limitation all the applicant's financial, governing body, and business interests;

(B) Documentation of the applicant's management, including without limitation the management structure and members of the management team;

(C) Documentation of the applicant's current contractors and the contractors that the applicant intends to use as part of operating the EIDT;

(D) Documentation of all required state and national criminal background checks for employees and operators;

(E) Documentation of all required Child Maltreatment Registry checks and Adult Maltreatment Registry checks for employees and operators;

(F) Documentation demonstrating compliance with these standards; and

(G) All other documentation or other information requested by DPSQA.

(b) To apply to change the ownership of an existing EIDT, the EIDT must submit a complete application described in Section 202(a)(2).

203. <u>Licensure Process</u>.

(a) DPSQA may approve an application for an EIDT license and issue an EIDT license if:

(1) The applicant submits a complete application under Section 202(a);

(2) DPSQA determines that the applicant has successfully passed all required criminal background and maltreatment checks.

(3) DPSQA determines that the applicant satisfies these standards; and

(4) DPSQA determines that one of the following conditions are met:

(A) DDS has determined that the county in which the new EIDT would be located is an underserved county;

(B) The applicant has one or more EIDT licensed locations in the same county in which the new EIDT would be located; or

(C) The applicant has one or more EIDT licensed locations in a county contiguous to the county in which the new EIDT would be located and the existing location serves at least thirty (30) children who are eligible, enrolled, and participating in the existing location, but reside in the county in which the EIDT would be located.

(b) DPSQA may approve an application to change the ownership of an existing EIDT and change the ownership of an existing EIDT license if:

(1) The applicant submits a complete application under Section 202;

(2) DPSQA determines that all employees and operators have successfully passed all required criminal background and maltreatment checks; and

(3) DPSQA determines that the applicant satisfies these standards.

(c) DPSQA shall issue new EIDT licenses in accordance with the order of priority required by section 20-48-1105 of the Arkansas Code.

(d) EIDT licenses do not expire until terminated under these standards.

204. <u>Notice of Underserved Status</u>.

DDS shall provide written notice of any underserved determination made under Section 203(a) as required in section 20-48-1106 of the Arkansas Code.

Subchapter 3. Administration.

301. Organization and Ownership.

(a) The EIDT must be authorized and in good standing to do business under the laws of the State of Arkansas.

(b) (1) An EIDT must appoint a single manager as the point of contact for all DDS and DPSQA matters and provide DDS and DPSQA with updated contact information for that manager.

(2) This manager must have authority over the EIDT, all EIDT employees, and ensuring that DDS and DPSQA requests, concerns, inquiries, and enforcement actions are addressed and resolved to the satisfaction of DDS and DPSQA.

(c) (1) An EIDT cannot transfer its EIDT license to any person or entity.

(2) An EIDT cannot change its ownership unless DPSQA approves the application of the new ownership pursuant to Sections 202 and 203.

(3) An EIDT cannot change its name or otherwise operate under a different name than the name listed on the EIDT license without prior written approval from DPSQA.

302. Employees and Staffing Requirements.

(a) (1) An EIDT must appropriately supervise all beneficiaries based on each beneficiary's needs.

(2) An EIDT must have enough employees on-site to supervise beneficiaries at the EIDT location.

(b) (1) An EIDT must comply with all requirements applicable to employees under these standards and all requirements applicable to employees of child care centers, including without limitation criminal background checks and adult and child maltreatment checks.

(2) An EIDT must verify an employee still meets all requirements upon the request of DPSQA or whenever the EIDT receives information after hiring that would create a reasonable belief that the employee no longer meets all requirements including without limitation requirements related to criminal background checks and adult and child maltreatment checks.

(c) (1) An EIDT must conduct child maltreatment, adult maltreatment and criminal

background checks for all employees as required by law and applicable Minimum Licensing Standards for Child Care Centers.

(2) Except as provided in this section, all EIDT employees, contractors, sub-contractors, interns, volunteers, and trainees, as well as all other persons who have routine contact with beneficiaries within the EIDT or who provide services within the EIDT, must successfully pass all required criminal background checks and adult and child maltreatment checks.

(d) (1) Employees must be sixteen (16) years of age or older.

(2) Employees under eighteen (18) years of age must be:

(A) Directly and visually supervised by an adult employee when in direct contact with beneficiaries; and

(B) Enrolled in high school or GED curriculum.

(3) Student observers:

(A) Cannot be counted toward staff-to-beneficiary ratios;

(B) Cannot have disciplinary control over an EIDT beneficiary;

(C) Cannot be left alone with a beneficiary; and

(D) Are not required to have criminal background, child maltreatment, or adult maltreatment checks.

(4) A beneficiary's custodian or legal guardian is not required to have criminal background, child maltreatment, or adult maltreatment check if the custodian or legal guardian only volunteers on a field trip and is not left alone with any beneficiary.

(e) (1) Except as provided in subsection (2) below, the EIDT must provide at least the following minimum staff-to-beneficiary ratio for all beneficiaries:

Age Group	**Ratio**
0 to 18 months	1:4
18 to 36 months	1:6
3 to 4 years	1:8
4 years and above	1:9

(2) The EIDT may reduce the staff-to-beneficiary ratio by up to fifty percent (50%) during naptime for beneficiaries who are two and one-half (2 ½) years of age and

older, if at least seventy-five percent (75%) of the staff-to-beneficiary ratio is maintained throughout the EIDT facility.

(f) (1) An EIDT must document all scheduled and actual employee staffing.

(2) The documentation required for employee staffing includes without limitation employee names, job title or credential, shift role, shift days, and shift times.

303. Employee Training.

(a) All employees involved in any way with services provided to beneficiaries or who have routine contact with beneficiaries must receive the following training before having contact with beneficiaries and no later than thirty (30) days after beginning employment:

(1) Basic health and safety practices;

(2) Infection control and infection control procedures;

(3) Identification and mitigation of unsafe environmental factors;

(4) Emergency and evacuation procedures required in Section 308;

(5) Identification and prevention of adult and child maltreatment;

(6) Mandated reporter requirements; and

(7) Reporting incidents and accidents as required in these standards.

(b) Employees required to receive training prescribed in subdivision (a) must receive annual re-training on those topics at least once every twelve (12) months.

304. Employee Records.

(a) An EIDT must maintain a personnel file for each employee that includes:

(1) A detailed job description;

(2) All required criminal background checks;

(3) All required Child Maltreatment Registry checks;

(4) All required Adult Maltreatment Registry checks;

(5) All conducted drug screen results;

(6) Signed statement that employee will comply with the EIDT's drug screen and drug use policies;

(7) Copy of current state or federal identification;

(8) Copy of valid state-issued driver's license, if driving is required in the job description;

(9) Documentation demonstrating that the employee received all training required in Section 303;

(10) Documentation demonstrating that the employee obtained and maintained in good standing all professional licensures, certifications, or credentials for the employee or the service the employee is performing that are required for the employee or the service the employee is performing; and

(11) Documentation demonstrating that the employee meets all continuing education, in-service, or other training requirements applicable to that employee under these standards and any professional licensures, certifications, or credentials held by that employee.

(b) (1) An EIDT must ensure that each personnel record is kept confidential and available only to:

(A) Employees who need to know the information contained in the personnel record;

(B) Persons or entities who need to know the information contained in the personnel record;

(C) DPSQA and any governmental entity with jurisdiction or other authority to access the personnel record;

(D) The employee; and

(E) Any other individual authorized in writing by the employee.

(2) (A) An EIDT must keep personnel records in a file cabinet or room that is always locked.

(B) (i) An EIDT may use electronic records in addition to or in place of physical records to comply with these standards.

(ii) An EIDT provider that uses electronic records must take

reasonable steps to backup all electronic records and reconstruct a personnel record in the event of a breakdown in the EIDT's electronic records system.

(c) An EIDT must retain all employee records for five (5) years from the date an employee is no longer an employee of the EIDT or, if longer, the final conclusion of all reviews, appeals, investigations, administrative actions, or judicial actions related to that employee that are pending at the end of the five-year period.

305. <u>Beneficiary Service Records</u>.

(a) (1) An EIDT must maintain a separate, updated and complete service record for each beneficiary documenting the services provided to the beneficiary and all other documentation required under these standards.

(2) Each beneficiary service record must be uniformly organized and readily available for review by DPSQA at the EIDT's location.

(b) A beneficiary's service record must include a summary document at the front that includes:

(1) The beneficiary's full name;

(2) The beneficiary's address and county of residence;

(3) The beneficiary's telephone number and email address;

(4) The beneficiary's date of birth;

(5) The beneficiary's primary language;

(6) The beneficiary's diagnoses;

(7) The beneficiary's medications, dosage, and frequency, if applicable;

(8) The beneficiary's known allergies;

(9) The beneficiary's entry date into the EIDT;

(10) The beneficiary's exit date from the EIDT;

(11) The beneficiary's Medicaid Number;

(12) The beneficiary's commercial or private health insurance information or managed care organization information, if applicable;

(13) The name, address, phone number, email address, and relationship of the beneficiary's custodian or legal guardian; and

(14) The name, address, and phone number of the beneficiary's primary care physician.

(c) A beneficiary's service record must include at least the following information and documentation:

(1) The beneficiary's ITP;

(2) The beneficiary's behavioral management plan;

(3) The beneficiary's daily activity logs;

(4) The beneficiary's medication management plan and medication logs;

(5) Copies of any assessments or evaluations completed on the beneficiary; and

(6) Copies of any orders that place the beneficiary in the custody of another person or entity.

(d) (1) An EIDT must ensure that each beneficiary service record is kept confidential and available only to:

(A) Employees who need to know the information contained in the beneficiary's service record;

(B) Persons or entities who need to know the information contained in the beneficiary service record in order to provide services to the beneficiary;

(C) DPSQA and any governmental entity with jurisdiction or other authority to access the beneficiary's service record;

(D) The beneficiary's legal guardian or custodian; and

(E) Any other individual authorized in writing by the legal guardian or custodian.

(2) (A) An EIDT must keep beneficiary service records in a file cabinet or room that is always locked.

(B) (i) An EIDT may use electronic records in addition to or in place of physical records to comply with these standards.

(ii) An EIDT provider that uses electronic records must take reasonable steps to backup all electronic records and reconstruct a beneficiary's service record in the event of a breakdown in the EIDT's electronic records system.

(e) An EIDT must retain all beneficiary service records for five (5) years from the date the beneficiary last exits from the EIDT or, if longer, the final conclusion of all reviews, appeals, investigations, administrative actions, or judicial actions related to beneficiary that are pending at the end of the five-year period.

306. Marketing and Solicitation.

(a) An EIDT can market its services.

(b) An EIDT cannot solicit a beneficiary or his or her family.

307. Third-party Service Agreements.

(a) An EIDT may contract in writing with third-party vendors to provide services or otherwise satisfy requirements under these standards.

(b) An EIDT must ensure that all third-party vendors comply with these standards and all other applicable laws, rules, and regulations.

Subchapter 4. Facility Requirements.

401. <u>General Requirements</u>.

(a) An EIDT facility must:

(1) Be heated, air-conditioned, well-lighted, well-ventilated, and well-maintained at a comfortable temperature;

(2) Be safe, clean, maintained, in good repair, and sanitary, including without limitation as to the facility's exterior, surrounding property, and interior floors and ceilings;

(3) Be free of offensive odors and potentially hazardous objects including without limitation explosives and broken equipment;

(4) Have drinking water available to beneficiaries and employees;

(5) Have an emergency alarm system throughout the facility to alert employees and beneficiaries when there is an emergency;

(6) Have at least one (1) toilet and one (1) sink for every fifteen (15) beneficiaries, with running hot and cold water, toilet tissue, liquid soap, and paper towels or air dryers;

(7) Have bathrooms that provide for individual privacy and are appropriate for all beneficiaries with regard to size and accessibility;

(8) Have at least one operable telephone on site that is available at all hours and reachable with a phone number for outside callers;

(9) Have working smoke and carbon monoxide detectors in all areas used by beneficiaries or employees;

(10) Have a first aid kit that includes at least the following:

(A) Adhesive band-aids of various sizes;

(B) Sterile gauze squares;

(C) Adhesive tape;

(D) Roll of gauze bandages;

(E) Antiseptic;

(F) Thermometer;

(G) Scissors;

(H) Disposable gloves; and

(I) Tweezers;

(11) Have enough fire extinguishers in number and location to satisfy all applicable laws and rules, but no fewer than two fire extinguishers;

(12) Have hallways and corridors at least six (6) feet in width;

(13) Have screens for all windows and doors used for ventilation;

(14) Have screens or guards attached to the floor or wall to protect floor furnaces, heaters, hot radiators, exposed water heaters, air conditioners, and electric fans;

(15) Have no lead-based paint;

(16) Have lighted "exit" signs at all exit locations;

(17) Have written instructions and diagrams noting emergency evacuation routes and shelters to be used in case of fire, severe weather, or other emergency posted at least every twenty-five (25) feet, in all stairwells, in and by all elevators, and in each room used by beneficiaries;

(18) Have a copy of Title VI and VII of the Civil Rights Law of 1964 and all required legal notices prominently posted as required;

(19) Have an emergency power system to provide lighting and power to essential electrical devices throughout the EIDT, including without limitation power to exit lighting and fire detection, fire alarm, and fire extinguishing systems;

(20) Have chemicals, toxic substances, and flammable substances stored in locked storage cabinets or closets;

(21) Have the EIDT's telephone, hours of operation, and hours of access, if applicable, posted at all public entrances;

(22) Prohibit the possession of firearms or other weapons except by authorized law enforcement personnel; and

(23) Prohibit smoking, use of tobacco products, and the consumption of prescription medication without a prescription, alcohol, and illegal drugs.

Subchapter 5. Enrollments, Exits, and Referrals.

501. Enrollments.

(a) An EIDT may enroll and provide services to a beneficiary who is eligible to receive EIDT services.

(b) An EIDT must document the enrollment of all beneficiaries to the EIDT.

502. Exits.

(a) An EIDT may exit a beneficiary from its program if the person becomes ineligible for EIDT services, chooses to enroll with another EIDT, or for any other lawful reason.

(b) An EIDT must document the exit of all beneficiaries from its program.

(c) An EIDT must provide reasonable assistance to all beneficiaries exiting its program including without limitation by:

(1) Assisting the beneficiary in transferring to another EIDT or other service provider; and

(2) Providing copies of such a beneficiary's records to the beneficiary, the beneficiary's legal custodian or guardian, and the EIDT or other service provider to which the beneficiary transfers after exiting the program.

503. Referrals to the First Connections Program.

(a) (1) An EIDT must, within two (2) working days of first contact, refer to the First Connections program all infants and toddlers from birth to thirty-six (36) months of age for whom there is a diagnosis or suspicion of a developmental delay or disability.

(2) The referral must be made to the First Connections Central Intake Unit.

(b) Each EIDT is responsible for documenting that a proper and timely referral to First Connections has been made pursuant to these standards.

504. Referrals to Local Education Agencies.

(a) (1) Each EIDT must, within two (2) working days of first contact, refer to the appropriate Local Education Agency each beneficiary who is at least three (3) years old, has not entered Kindergarten, and for whom there is a diagnosis or suspicion of a developmental delay or disability.

(2) For beneficiaries who turn three (3) years of age while receiving services at the EIDT, the referral must be made at least ninety (90) days prior to the beneficiary's third birthday.

(3) If the beneficiary begins services less than ninety (90) days prior to their third birthday, the referral should be made within two (2) working days of first contact,

(4) The referral must be made to the Local Education Agency where that beneficiary resides.

(b) Each EIDT is responsible for documenting that a proper and timely referral to the appropriate Local Education Agency has been made pursuant to these standards.

505. <u>Appropriate Referrals for Beneficiaries Failing to Qualify</u>.

(a) An EIDT must provide the custodian or legal guardian of a beneficiary with appropriate information and referrals to other available services if:

(1) The EIDT assists the beneficiary with obtaining a developmental screen or performs a comprehensive developmental evaluation as part of the process of determining the beneficiary's eligibility for EDIT services; and

(2) The developmental screen or comprehensive developmental evaluation indicates the beneficiary is not eligible to receive EIDT services.

(b) Other available services include without limitation any early head start, head start, and home visiting programs.

(c) Each EIDT is responsible for maintaining documentation evidencing that a reasonable attempt was made to provide the referrals, materials, and information described in (a) to the beneficiary's custodian or legal guardian.

Subchapter 6. Program and Services.

601. Arrivals, Departures, and Transportation.

(a) (1) An EIDT must ensure that beneficiaries safely arrive to and depart from an EIDT facility.

(2) (A) An EIDT must document the arrival and departure of each beneficiary to and from an EIDT facility.

(B) Documentation of arrivals to and departures from an EIDT must include without limitation the beneficiary's name, date of birth, date and time of arrival and departure, name of the person or entity that provided transportation, and method of transportation.

(3) (A) A manager or designee of an EIDT must:

(i) Review the beneficiary arrival and departure documentation each day and compare it with the EIDT's attendance record;

(ii) Sign and date the beneficiary arrival and departure documentation verifying that all beneficiaries for the day safely arrived to and departed from the EIDT facility.

(B) An EIDT must maintain beneficiary arrival and departure documentation for one (1) year from the date of transportation.

(b) An EIDT that elects to provide transportation services to any beneficiary must comply with all vehicle and other transportation requirements in the Minimum Licensing Standards for Child Care Centers, including without limitation when the transportation is provided to a beneficiary by any person or entity on behalf of the EIDT and regardless of whether the person is an employee, or the transportation is a billed service.

602. Medications.

(a) (1) An EIDT must develop a medication management plan for all beneficiaries with prescribed medication that may be administered at the EIDT.

(2) A medication management plan must include without limitation:

(A) The name of each medication;

(B) The name of the prescribing physician or other health care professional if the medication is by prescription;

(C) A description of each medication prescribed and any symptom or symptoms to be addressed by each medication;

(D) How each medication will be administered, including without limitation times of administration, doses, delivery, and persons that may lawfully administer each medication;

(E) How each medication will be charted;

(F) A list of the potential side effects caused by each medication; and

(G) The consent to the administration of each medication by the beneficiary or, if the person lacks capacity to consent, by the beneficiary's legal guardian or custodian.

(b) (1) An EIDT must maintain a medication log detailing the administration of all medication to a beneficiary, including without limitation prescribed medication and over-the-counter medications.

(2) Each medication log must be uniformly organized and document the following for each administration of a medication:

(A) The name and dosage of medication administered;

(B) The symptom for which the medication was used to address;

(C) The method the medication was administered;

(D) The date and time the medication was administered;

(E) The name of the employee who administered the medication or assisted in the administration of the medication;

(F) Any adverse reaction or other side effect from the medication;

(G) Any transfer of medication from its original container into individual dosage containers by the beneficiary's custodian or legal guardian;

(H) Any error in administering the medication and the name of the supervisor to which the error was reported; and

(I) The prescription and the name of the prescribing physician or other health care professional if the medication was not previously listed in the medication management plan.

(3) Medication errors must be:

(A) Immediately reported to a supervisor;

(B) Documented in the medication log; and

(C) Reported as required under all applicable laws and rules including without limitation the laws and rules governing controlled substances.

(c) All medications stored for a beneficiary by an EIDT must be:

(1) Kept in the original medication container unless the beneficiary's custodian or legal guardian transfers the medication into individual dosage containers;

(2) Labeled with the beneficiary's name;

(3) Stored in an area, medication cart, or container that is always locked; and

(4) Returned to a beneficiary's custodian or legal guardian, destroyed, or otherwise disposed of in accordance with applicable laws and rules, if the medication is no longer to be administered to a beneficiary.

(d) An EIDT must store all medications requiring cold storage in a separate refrigerator that is used only for purpose of storing medications.

603. <u>Behavior Management Plans</u>.

(a) An EIDT may implement a written behavior management plan for a beneficiary if a beneficiary exhibits challenging behaviors on a chronic basis.

(b) A behavior management plan:

(1) Must be approved by an ECDS;

(2) Must involve the fewest and shortest interventions possible; and

(3) Cannot punish or use interventions that are physically or emotionally painful, frighten, or put the beneficiary at medical risk.

(c) (1) (A) An EIDT must reevaluate behavior management plans at least quarterly.

(B) An EIDT must refer the beneficiary to an appropriately licensed professional for re-evaluation if the behavior management plan is not achieving the desired results.

(2) An EIDT must regularly collect and review data regarding the use and effectiveness of all behavior management plans.

(3) The collection and review of data regarding the use and effectiveness of behavior management plans must include at least:

(A) The date and time any intervention is used;

(B) The duration of each intervention;

(C) The employee or employees involved in each intervention; and

(D) The event or circumstances that triggered the need for the intervention.

Subchapter 7. Incident and Accident Reporting.

701. Incidents to be Reported.

(a) An EIDT must report all alleged, suspected, observed, or reported occurrences of any of the following events:

(1) Death of a beneficiary;

(2) Serious injury to a beneficiary;

(3) Adult or child maltreatment of a beneficiary;

(4) Any event where an employee threatens or strikes a beneficiary;

(5) Unauthorized use on a beneficiary of restrictive intervention, including seclusion or physical, chemical, or mechanical restraint;

(6) Any situation when the whereabouts of a beneficiary are unknown for more than two (2) hours;

(7) Any unanticipated situation when services to the beneficiary are interrupted for more than two (2) hours;

(8) Events involving a risk of death, serious physical or psychological injury, or serious illness to a beneficiary;

(9) Medication errors made by an employee that cause or have the potential to cause death, serious injury, or serious illness to a beneficiary;

(10) Any act or admission that jeopardizes the health, safety, or quality of life of a beneficiary;

(11) Motor vehicle accidents involving a beneficiary;

(12) A positive case of a beneficiary or a staff member for any infectious disease that is the subject of a public health emergency declared by the Governor, ADH, the President of the United States, or the United States Department of Health and Human Services; or

(13) Any event that requires notification of the police, fire department, or coroner.

(b) Any EIDT may report any other occurrences impacting the health, safety, or quality of life of a beneficiary.

702. Reporting Requirements.

(a) An EIDT must:

(1) Submit all reports of the following events within one (1) hour of the event:

(A) Death of a beneficiary;

(B) Serious injury to a beneficiary; or

(C) Any incident that an EIDT should reasonably know might be of interest to the public or the media.

(2) Submit reports of all other incidents within forty-eight (48) hours of the event.

(b) An EIDT must submit reports of all incidents to DPSQA as provided through DPSQA's website: https://humanservices.arkansas.gov/about-dhs/dpsqa/.

(c) Reporting under these standards does not relieve an EIDT of complying with any other applicable reporting or disclosure requirements under state or federal laws, rules, or regulations.

703. Notification to Guardians and Legal Custodians.

(a) An EIDT must notify the guardian or legal custodian of a beneficiary of any reportable incident involving a beneficiary, as well as any injury or accident involving a beneficiary even if the injury or accident is not otherwise required to be reported in this Section.

(b) An EIDT should maintain documentation evidencing notification required in subdivision (a).

Subchapter 8. Enforcement.

801. Monitoring.

(a) (1) DPSQA shall monitor an EIDT to ensure compliance with these standards.

(2) (A) An EIDT must cooperate and comply with all monitoring, enforcement, and any other regulatory or law enforcement activities performed or requested by DPSQA or law enforcement.

(B) Cooperation required under these standards includes without limitation cooperation and compliance with respect to investigations surveys, site visits, reviews, and other regulatory actions taken by DPSQA or any third-party contracted by DHS to monitor, enforce, or take other regulatory action on behalf of DHS, DPSQA, or DDS.

(b) Monitoring includes without limitation:

(1) On-site surveys and other visits including without limitation complaint surveys and initial site visits;

(2) On-site or remote file reviews;

(3) Written requests for documentation and records required under these standards;

(4) Written requests for information; and

(5) Investigations related to complaints received.

(c) DHS may contract with a third-party to monitor, enforce, or take other regulatory action on behalf of DHS, DPSQA, or DDS.

802. Written Notice of Enforcement Action.

(a) DPSQA shall provide written notice to the EIDT of all enforcement actions taken against the EIDT.

(b) DPSQA shall provide written notice to the EIDT by mailing the imposition of the enforcement action to the manager appointed by the EIDT pursuant to Section 301.

803. <u>Remedies</u>.

(a) (1) DPSQA shall not impose any remedies imposed by an enforcement action unless:

(A) The EIDT is given notice and an opportunity to be heard pursuant to this Section 802 and Subchapter 10; or

(B) DPSQA determines that public health, safety, or welfare imperatively requires emergency action;

(2) If DPSQA imposes a remedy as an emergency action before the EIDT has notice and an opportunity to be heard pursuant to subdivision (a)(1), DPSQA shall:

(A) Provide immediate notice to the EIDT of the enforcement action; and

(B) Provide the EIDT with an opportunity to be heard pursuant to Subchapter 10.

(b) DPSQA may impose on an EIDT any of the following enforcement actions for the EIDT's failure to comply with these standards:

(1) Plan of correction;

(2) Directed in-service training plan;

(3) Moratorium on new admissions;

(4) Transfer of beneficiaries;

(5) Monetary penalties;

(6) Suspension of EIDT license;

(7) Revocation of EIDT license; and

(8) Any remedy authorized by law or rule including without limitation section 25-15-217 of the Arkansas Code.

(c) DPSQA shall determine the imposition and severity of these enforcement remedies on a case-by-case basis using the following factors:

(1) Frequency of non-compliance;

(2) Number of non-compliance issues;

(3) Impact of non-compliance on a beneficiary's health, safety, or well-being;

(4) Responsiveness in correcting non-compliance;

(5) Repeated non-compliance in the same or similar areas;

(6) Non-compliance with previously or currently imposed enforcement remedies;

(7) Non-compliance involving intentional fraud or dishonesty; and

(8) Non-compliance involving violation of any law, rule, or other legal requirement.

(d) (1) DPSQA shall report any noncompliance, action, or inaction by the EIDT to appropriate agencies for investigation and further action.

(2) DPSQA shall refer non-compliance involving Medicaid billing requirements to the Division of Medical Services and the Arkansas Attorney General's Medicaid Fraud Control Unit.

(e) These enforcement remedies are not mutually exclusive and DPSQA may apply multiple remedies simultaneously to a failure to comply with these standards.

(f) The failure to comply with an enforcement remedy imposed by DPSQA constitutes a separate violation of these standards.

804. <u>Moratorium</u>.

(a) DPSQA may prohibit an EIDT from accepting new beneficiaries.

(b) An EIDT prohibited from accepting new admissions may continue to provide services to existing beneficiaries.

805. <u>Transfer of Beneficiaries</u>.

(a) DPSQA may require an EIDT to transfer a beneficiary to another EIDT if DPSQA finds that the EIDT cannot adequately provide services to the beneficiary.

(b) If directed by DPSQA, an EIDT must continue providing services until the beneficiary is transferred to his or her new service provider of choice.

(c) A transfer of a beneficiary may be permanent or for a specific term depending on the circumstances.

806. <u>Monetary Penalties</u>.

(a) DPSQA may impose on an EIDT a civil monetary penalty not to exceed five hundred dollars ($500) for each violation of these standards.

(b) (1) DPSQA may file suit to collect a civil monetary penalty assessed pursuant to these standards if the EIDT does not pay the civil monetary penalty within sixty (60) days from the date DPSQA provides written notice to the EIDT of the imposition of the civil monetary penalty.

(2) DPSQA may file suit in Pulaski County Circuit Court or the circuit court of any county in which the EIDT is located.

807. <u>Suspension and Revocation of EIDT License</u>.

(a) (1) DPSQA may temporarily suspend an EIDT license if the EIDT fails to comply with these standards.

(2) If an EIDT's license is suspended, the EIDT must immediately stop providing EIDT services until DPSQA reinstates its license.

(b) (1) DPSQA may permanently revoke an EIDT license if the EIDT fails to comply with these standards.

(2) If an EIDT's license is revoked, the EIDT must immediately stop providing EIDT services and comply with the permanent closure requirements in Section 901(a).

Subchapter 9. Closure.

901. Closure.

(a) (1) An EIDT license ends if an EIDT permanently closes, whether voluntarily or involuntarily, and is effective the date of the permanent closure as determined by DPSQA.

(2) An EIDT that intends to permanently close, or does permanently close without warning, whether voluntarily or involuntarily, must immediately:

(A) Provide the custodian or legal guardian of each beneficiary with written notice of the closure;

(B) Provide the custodian or legal guardian of each beneficiary with written referrals to at least three (3) other appropriate service providers;

(C) Assist each beneficiary and his or her custodian or legal guardian in transferring services and copies of beneficiary records to any new service providers;

(D) Assist each beneficiary and his or her custodian or legal guardian in transitioning to new service providers; and

(E) Arrange for the storage of beneficiary service records to satisfy the requirements of Section 305.

(b) (1) An EIDT that intends to voluntarily close temporarily due to natural disaster, pandemic, completion of needed repairs or renovations, or for similar circumstances may request to temporarily close its facility while maintaining its EIDT license for up to one (1) year from the date of the request.

(2) An EIDT must comply with subdivision (a)(2)'s requirements for notice, referrals, assistance, and storage of beneficiary records if DPSQA grants an EIDT's request for a temporary closure.

(3) (A) DPSQA may grant a temporary closure if the EIDT demonstrates that it is reasonably likely that it will be able to reopen after the temporary closure.

(B) DPSQA shall end an EIDT's temporary closure and direct that the EIDT permanently close if the EIDT fails to demonstrate that it is reasonably likely that it will be able to reopen after the temporary closure.

(4) (A) DPSQA may end an EIDT's temporary closure if the EIDT demonstrates that it is in full compliance with these standards.

(B) DPSQA shall end an EIDT's temporary closure and direct that the EIDT permanently close if the EIDT fails to become fully compliant with these standards within one (1) year from the date of the request.

Subchapter 10. Appeals.

1001. Reconsideration of Adverse Regulatory Actions.

(a) (1) An EIDT may ask for reconsideration of any adverse regulatory action taken by DPSQA by submitting a written request for reconsideration to: Division of Provider Services and Quality Assurance, Office of the Director: Requests for Reconsideration of Adverse Regulatory Actions, P.O. Box 1437, Slot 427, Little Rock, Arkansas 72203.

(2) The written request for reconsideration of an adverse regulatory action taken by DPSQA must be submitted by the EIDT and received by DPSQA within thirty (30) calendar days of the date the EIDT received written notice of the adverse regulatory action.

(3) The written request for reconsideration of an adverse regulatory action taken by DPSQA must include without limitation the specific adverse regulatory action taken, the date of the adverse regulatory action, the name of the EIDT against whom the adverse regulatory action was taken, the address and contact information for the EIDT against whom the adverse regulatory action was taken, and the legal and factual basis for reconsideration of the adverse regulatory action.

(b) (1) DPSQA shall review each timely received written request for reconsideration and determine whether to affirm or reverse the adverse regulatory action taken based on these standards.

(2) DPSQA may request, at its discretion, additional information as needed to review the adverse regulatory action and determine whether the adverse regulatory action taken should be affirmed or reversed based on these standards.

(c) (1) DPSQA shall issue in writing its determination on reconsideration within thirty (30) days of receiving the written request for reconsideration or within thirty (30) days of receiving all information requested by DPSQA under subdivision (b)(2), whichever is later.

(2) DPSQA shall issue its determination to the EIDT using the address and contact information provided in the request for reconsideration.

(d) (1) An applicant may ask for reconsideration of a determination by DDS that a county is not underserved by submitting a written request for reconsideration pursuant to DDS Policy 1076.

(2) If a determination that a county is not underserved is reversed on reconsideration by DDS or on appeal by an agency or court with jurisdiction:

(i) The applicant shall notify DPSQA of the reversal and submit a written request for reconsideration to DPSQA as provided in this section for any adverse regulatory action taken by DPSQA based on the initial determination; and

(ii) DPSQA shall review the written request for reconsideration as provided in this section.

(e) DPSQA may also decide to reconsider any adverse regulatory action on its own accord any time it determines, in its discretion, that an adverse regulatory action is not consistent with these standards.

1002. <u>Appeal of Regulatory Actions</u>.

(a) (1) An EIDT may administratively appeal any adverse regulatory action to the DHS Office of Appeals and Hearings (OAH) except for provider appeals related to the payment for Medicaid claims and services governed by the Medicaid Fairness Act, Ark. Code Ann. § 20-77-1701 to -1718, which shall be governed by that Act.

(2) OAH shall conduct administrative appeals of adverse regulatory actions pursuant to DHS Policy 1098 and other applicable laws and rules.

(b) An EIDT may appeal any adverse regulatory action or other adverse agency action to circuit court as allowed by the Administrative Procedures Act, Ark. Code Ann. § 25-15-201 to -220.

State of Arkansas
91st General Assembly
Regular Session, 2017

A Bill

HOUSE BILL 1919

By: Representative Boyd
By: Senator Files

For An Act To Be Entitled

AN ACT TO CODIFY THE PROCESS FOR THE REVIEW OF RULES IMPACTING STATE MEDICAID COSTS; TO EXEMPT MEDICAL CODES FROM THE RULE-MAKING PROCESS AND LEGISLATIVE REVIEW AND APPROVAL; AND FOR OTHER PURPOSES.

Subtitle

TO CODIFY THE PROCESS FOR THE REVIEW OF RULES IMPACTING STATE MEDICAID COSTS; AND TO EXEMPT MEDICAL CODES FROM THE RULE-MAKING PROCESS AND LEGISLATIVE REVIEW AND APPROVAL.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code § 10-3-309(b)(1)(B), concerning the definition of "rule" within the legislative review and approval of state agency rules procedure, is amended to read as follows:

(B) "Rule" does not mean:

(i) A statement that concerns the internal management of a state agency and that does not affect the private rights or procedures available to the public;

(ii) A declaratory order or ruling issued under § 25-15-206 or other provision of law applicable to the state agency issuing the declaratory order or ruling; ~~or~~

(iii) Intraagency memoranda; or

(iv) A medical code within the Arkansas Medicaid

Program that is issued by the Centers for Medicare and Medicaid Services, including without limitation:

(a) Current Procedural Terminology codes;

(b) Healthcare Common Procedure Coding System codes;

(c) International Classification of Diseases codes;

(d) National Uniform Billing Committee Official UB-04 Specifications Manual codes; and

(e) National Correct Coding Initiative codes;

SECTION 2. Arkansas Code § 25-15-202(9)(B), concerning the definition of "rule" within the Administrative Procedure Act, is amended to read as follows:

(B) "Rule" does not mean:

(i) ~~Statements concerning~~ A statement that concerns the internal management of ~~an~~ a state agency and that ~~do~~ does not affect the private rights or procedures available to the public;

(ii) ~~Declaratory rulings~~ A declaratory order or ruling issued ~~pursuant to~~ under § 25-15-206 or other provision of law applicable to the state agency issuing the declaratory order or ruling; ~~or~~

(iii) ~~Intra-agency~~ Intraagency memoranda; or

(iv) A medical code within the Arkansas Medicaid Program that is issued by the Centers for Medicare and Medicaid Services, including without limitation:

(a) Current Procedural Terminology codes;

(b) Healthcare Common Procedure Coding System codes;

(c) International Classification of Diseases codes;

(d) National Uniform Billing Committee Official UB-04 Specifications Manual codes; and

(e) National Correct Coding Initiative codes;

SECTION 3. Arkansas Code Title 25, Chapter 15, is amended to add an additional subchapter to read as follows:

Subchapter 4 — Rules Impacting Medicaid Costs

25-15-401. Legislative finding.

In light of the potential for rapidly rising costs to the state attributable to the Arkansas Medicaid Program and the importance of Medicaid expenditures to the health and welfare of the citizens of this state, the General Assembly finds that it is desirable to exercise a more thorough review of future proposed changes to any rule impacting state Medicaid costs.

25-15-402. Definition.

(a) As used in this section, "rule impacting state Medicaid costs" means a proposed rule as defined by § 25-15-202(9), or a proposed amendment to an existing rule as defined by § 25-15-202(9), that would, if adopted, adjust Medicaid reimbursement rates, Medicaid eligibility criteria, or Medicaid benefits, including without limitation a proposed rule or a proposed amendment to an existing rule seeking to:

(1) Reduce the number of individuals covered by the Arkansas Medicaid Program;

(2) Limit the types of services covered by the program;

(3) Reduce the utilization of services covered by the program;

(4) Reduce provider reimbursement;

(5) Increase consumer cost sharing;

(6) Reduce the cost of administering the program;

(7) Increase the program revenues;

(8) Reduce fraud and abuse in the program;

(9) Change any of the methodologies used for reimbursement of providers;

(10) Seek a new waiver or modification of an existing waiver of any provision under Title XIX of the Social Security Act, 42 U.S.C. § 1396-1 et seq., including a waiver that would allow a demonstration project;

(11) Participate or seek to participate in the waiver authority of Section 1115(a)(1) of the Social Security Act, 42 U.S.C. § 1315(a)(1), that would allow operation of a demonstration project or program;

(12) Participate or seek to participate in a request under Section 1115(a)(2) of the Social Security Act, 42 U.S.C. § 1315(a)(2), for the United States Secretary of the Department of Health and Human Services to

provide federal financial participation for costs associated with a demonstration project or program;

(13) Implement managed care provisions under Section 1932 of the Social Security Act, 42 U.S.C. § 1396u-2; or

(14) Participate or seek to participate in the projects or programs of the Centers for Medicare and Medicaid Services Innovation.

(b) "Rule impacting state Medicaid costs" does not include a modification, addition, or elimination of the medical codes used within the Arkansas Medicaid Program that are issued by the Centers for Medicare and Medicaid Services, including without limitation:

(1) Current Procedural Terminology codes;

(2) Healthcare Common Procedure Coding System codes;

(3) International Classification of Diseases codes;

(4) National Uniform Billing Committee Official UB-04 Specifications Manual codes; and

(5) National Correct Coding Initiative codes.

25-15-403. Additional rule procedure.

(a)(1) In addition to filing requirements under the Arkansas Administrative Procedure Act, § 25-15-201 et seq., and § 10-3-309, the Department of Human Services shall, at least thirty (30) days before the expiration of the period for public comment, file a proposed rule impacting state Medicaid costs or a proposed amendment to an existing rule impacting state Medicaid costs with the Senate Committee on Public Health, Welfare, and Labor and the House Committee on Public Health, Welfare, and Labor.

(2) A review of the proposed rule or proposed amendment to an existing rule by the Senate Committee on Public Health, Welfare, and Labor and the House Committee on Public Health, Welfare, and Labor shall occur within forty-five (45) days of the date the proposed rule or proposed amendment to an existing rule is filed with the Senate Committee on Public Health, Welfare, and Labor and the House Committee on Public Health, Welfare, and Labor.

(b)(1) If adopting an emergency rule impacting state Medicaid costs, in addition to the filing requirements under the Arkansas Administrative Procedure Act, § 25-15-201 et seq., and § 10-3-309, the Department of Human Services shall notify the following individuals of the emergency rule and

provide each individual with a copy of the rule within five (5) business days of adopting the rule:

(A) The Speaker of the House of Representatives;

(B) The President Pro Tempore of the Senate;

(C) The Chair of the Senate Committee on Public Health, Welfare, and Labor; and

(D) The Chair of the House Committee on Public Health, Welfare, and Labor.

(2) A review of the emergency rule by the Senate Committee on Public Health, Welfare, and Labor and the House Committee on Public Health, Welfare, and Labor shall occur within forty-five (45) days of the date that the emergency rule is provided to the chairs.

APPROVED: 03/23/2017