SUMMARY OF EARLY INTERVENTION DAY TREATMENT

Pursuant to Ark. Code Ann. § 20-48-1101 et seq., DDS is combining the current Developmental Day Treatment Clinic Services (DDTCS) for children and Child Health Management Services (CHMS) into one successor program, now called Early Intervention Day Treatment (EIDT).

This new program combines eligibility criteria for both programs, specifically (1) a developmental assessment; and (2) the medical (nursing) or therapeutic needs of the beneficiary. The EIDT program will:

(1) Ensure children with the highest needs can access the full array of core services;
(2) Expand family choice of providers, instead of dividing clinics between programs;
(3) Tighten child-staff ratios to increase success, quality and monitoring for high-need children; and
(4) Streamline billable codes whereby eliminating the need for prior authorization process and implementing a retrospective process.

Current DDTCS and CHMS centers will be grandfathered in as EIDT licensed programs under the licensing standards until June 30, 2019, at which time they will have to renew their license as an EIDT.

Children receiving services in DDTCS or CHMS centers as of July 1, 2018, and meet the eligibility criteria promulgated on October 1, 2017, for either a DDTCS children's program or a 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.

EARLY INTERVENTION DAY TREATMENT (EIDT) PROGRAM SUMMARY

EIDT Generally

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, or a medical condition that puts them at risk for a developmental delay.

Early Intervention Day Treatment (EIDT) includes diagnostic, screening, evaluation, preventative, therapeutic, palliative, rehabilitative, and habilitative services. This includes speech, occupational, 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 function level. EIDT is available year-round to children aged 0-6; and in the summer months for children aged 6-21.

EIDT Core Services

Habilitative services and Evaluation
Physical Evaluation and Therapy
Occupational Evaluation and Therapy
Speech Evaluation and Therapy
Day Habilitative Services in Summer for aged 6-21
Nursing Services are available for the medically fragile, those with complex health needs or both, if prescribed by PCP.

Eligibility

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:

Hawaii Early Learning Profile (HELP)
Learning Accomplishment Profile (LAP)
Early Learning Accomplishment Profile (E-LAP)
Brigance Inventory of Early Development (IED)

A. Evaluation that shows:

1. For ages 0-36 months, a score of greater than 25% 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 a greater than 25% 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 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.

Licensing Requirements

A. EIDT providers 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.

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

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

EFFECTIVE DATE: **July 1, 2018**

SUBJECT: **Provider Manual Update Transmittal EIDT-New-18**

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

Explanation of Updates

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

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

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

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

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

Thank you for your participation in the Arkansas Medicaid Program.

Rose M. Naff
Director

Updated section received By BLR 5-17-18

TOC required

200.000 GENERAL INFORMATION

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

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

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

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

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

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

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

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

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

Determination of underserved status for expansion of services

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

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

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

201.100 Licensing Requirements 7-1-18

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

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

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

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

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

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

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

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

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

A. Is located in the state of Arkansas;

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

C. Specializes in developmental pediatrics;

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

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

F. Does not provide treatment services to children.

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

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

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

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

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

202.100 EIDT Record Requirements 7-1-18

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

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

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

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

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

202.200 Electronic Signatures 7-1-18

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

210.000 PROGRAM COVERAGE

211.000 Introduction 7-1-18

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

212.000 Establishing Eligibility 7-1-18

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

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

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

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

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

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

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

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

212.100 Eligibility Criteria 7-1-18

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

A. Hawaii Early Learning Profile (HELP)

B. Learning Accomplishment Profile (LAP)

C. Early Learning Accomplishment Profile (E-LAP)

D. Brigance Inventory of Early Development (IED)

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

A. Evaluation that shows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

213.100 Nursing Services 7-1-18

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

213.200 Non-covered Services 7-1-18

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

214.000 Description of EIDT Core Services

214.100 Evaluation 7-1-18

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

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

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

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

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

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

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

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

1. Is a licensed Speech Therapist, Occupational Therapist, Physical Therapist, or Developmental Therapist; or

2. Has a Bachelor's Degree, plus one of the following:

(a) Current Arkansas state certification in Early Childhood or Early Childhood Special Education;

(b) A current Child Development Associate Certificate;

(c) A current Birth to pre-K credential; or

(d Documented experience working with children with special needs and twelve (12) hours of completed college courses in any of the following areas:

(i) Early Childhood;

(ii) Child Development;

(iii) Special Education/Elementary Education; or

(iv) Child and Family Studies.

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

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

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

1. During naptime:

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

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

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

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

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

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

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

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

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

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

AND

B. Receive at least one of the following services:

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

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

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

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

~~**215.000 Description of Optional Medical Services**~~

215.0100 Nursing Services 7-1-18

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

A. Assisting ventilator-dependent beneficiaries;

B. Tracheostomy: suctioning and care

C. Feeding tube: feeding, care and maintenance

D. Catheterizations

E. Breathing treatments

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

G. Administration of medication

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

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

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

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

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

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

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

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

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

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

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

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

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

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

220.000 REIMBURSEMENT AND RECOUPMENT

221.000 Method of Reimbursement 7-1-18

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

221.100 Fee Schedules 7-1-18

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

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

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

222.000 Retrospective Reviews 7-1-18

Arkansas Medicaid conducts retrospective review of the core EIDT services:

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

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

223.000 Recoupment 7-1-18

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

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

224.000 Administrative Reconsideration 7-1-18

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

224.100 Appeal Process 7-1-18

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

230.000 BILLING PROCEDURES

231.000 Introduction to Billing 7-1-18

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

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

232.000 CMS-1500 Billing Procedures

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

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

Procedure Code	Required Modifier	Description
T1015	U6, UB	Habilitative Services Aged 0-6 (1unit equals 1 hour, maximum of 5 units per day)
T1015	U6, UC	Habilitative Services in the Summer Aged 6-21 (1 unit equals 1 hour, maximum of five units per day)
99211	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)
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.

Field Name and Number	Instructions for Completion
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	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. RESERVED	Reserved for NUCC use.
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT?	Required when an auto accident is related to the services. Check YES or NO.
PLACE (State)	If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.

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

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

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

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

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

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

232.400 Special Billing Procedures

7-1-18

Not applicable to this program.

ARKANSAS MEDICAID EARLY INTERVENTION DAY TREATMENT (EIDT) FEE SCHEDULE

This fee schedule does not address the various coverage limitations routinely applied by Arkansas Medicaid before final payment is determined (e.g., beneficiary and provider eligibility, benefit limits, billing instructions, frequency of services, third party liability, age restrictions, prior authorization, co-payments/coinsurance where applicable). Procedure codes and/or fee schedule amounts listed do not guarantee payment, coverage or amount allowed.

Although every effort is made to ensure the accuracy of this information, discrepancies may occur. This fee schedule may be changed or updated at any time to correct such discrepancies. The reimbursement rates reflected in this fee schedule are in effect as of the date of this report. The reimbursement rate applied to a claim depends on the claim's date of service because Arkansas Medicaid's reimbursement rates are date-of-service effective. This fee schedule reflects only procedure codes that are currently payable. Any procedure code reflecting a Medicaid maximum of $0.00 is manually priced.

Please note that Arkansas Medicaid will reimburse the lesser of the amount billed or the Medicaid maximum. For a full explanation of the procedure codes and modifiers listed here, refer to your Arkansas Medicaid provider manual.

Run Date

Procedure Code	Mod 1	Mod 2	Mod 3	Mod 4	Medicaid Maximum Allowed Amount
T1015	U6	UB	00	00	$16.46
T1015	U6	UC	00	00	$16.46
T1023	U6	UC	00	00	$108.00
92507	00	00	00	00	$21.76
92507	UB	00	00	00	$17.40
92508	00	00	00	00	$5.94
92508	UB	00	00	00	$4.75
92521	UA	00	00	00	$49.44
92522	UA	00	00	00	$49.44
92523	UA	00	00	00	$49.44
92524	UA	00	00	00	$49.44
97001	00	00	00	00	$49.44
97003	00	00	00	00	$49.44
97110	00	00	00	00	$21.76
97110	UB	00	00	00	$17.40
97150	00	00	00	00	$5.94
97150	U1	UB	00	00	$4.75
97150	U2	00	00	00	$5.94
97150	UB	00	00	00	$4.75
97530	00	00	00	00	$21.76
97530	UB	00	00	00	$17.40
99211	U6	00	00	00	$14.30
99367	UA	00	00	00	$22.50

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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

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

EFFECTIVE DATE: **July 1, 2018**

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

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

Explanation of Updates

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

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

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

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

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

Thank you for your participation in the Arkansas Medicaid Program.

Rose M. Naff
Director

SECTION II - CHILD HEALTH MANAGEMENT SERVICES

CONTENTS

200.000 CHILD HEALTH MANAGEMENT SERVICES PROGRAM GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Child Health Management Services (CHMS) Providers 10-1-17

Child Health Management Services (CHMS) 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. CHMS must be provided by an organization that is certified by the Arkansas Medicaid Quality Improvement Organization (QIO) to be in full compliance with one of the two conditions described below:

1. An academic medical center program specializing in Developmental Pediatrics that is administratively staffed and operated by an academic medical center and under the direction of a boarded or board-eligible developmental pediatrician. An academic medical center consists of a medical school and its primary teaching hospitals and clinical programs. In order to be eligible for CHMS reimbursement, the academic medical center must:

a. Be located in the state of Arkansas;

b. Provide multi-disciplinary diagnostic, evaluation and treatment services to children throughout Arkansas;

c. Serve as a large multi-referral program as well as a referral source for other non-academic CHMS providers with the state and

d. Be staffed to provide training of pediatric residents and other professionals in the multi-disciplinary diagnostics, evaluation and treatment of children with special health care needs.

For an academic medical center CHMS program, services may be provided at different sites operated by the academic medical center as long as the CHMS program falls under one administrative structure within the academic medical center.

OR

2. A program housed under one roof and one administrative structure.

B. An organization seeking to provide CHMS must complete a certification and licensure process for each CHMS service delivery site. A certification or a license is not transferable from one holder to another or from one location to another.

A request for certification/licensure must be directed in writing to each of the following organizations:

1. The Arkansas Department of Health (certification). **View or print the Department of Health contact information.**

2. The Arkansas Medicaid Quality Improvement Organization (certification). **View or print QIO contact information.**

3. The Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit (licensure). **View or print the Arkansas Department of Human Services, Division of Child Care and Early Childhood Education, Child Care Licensing Unit contact information.**

C. The provider application and Medicaid contract must have accompanying copies of:

1. Current certification from the Department of Health

2. Current certification from the QIO and

3. Verification of current Child Care Center licensure from the Division of Child Care and Early Childhood Education.

201.100 CHMS Certification Requirement Reviews: Arkansas Department of Health , Office of Quality Assurance and Arkansas Foundation for Medical Care, Inc. 10-1-17

The Department of Health or its designees shall conduct an annual CHMS Certification Review to substantiate continued compliance with these regulations and standards.

A formal report, listing any cited deficiencies, shall be forwarded by the reviewer to the CHMS clinic within fifteen (15) working days of the certification review.

201.110 CHMS Corrective Action Plan (CAP) 8-1-05

The CHMS clinic shall have thirty (30) calendar days from the receipt date of the report to develop and submit a written corrective action plan to remedy the deficiencies noted in the certification review report. The clinic may formally request an extension of up to thirty (30) days by submitting sufficient written justification to the Department of Health and Human Services or its designee, as appropriate, within the first thirty (30) day time frame.

Within five (5) working days of receipt of the plan the reviewing entity shall inform the CHMS clinic in writing of any recommended modification to the corrective action plan. The notification shall include a time frame for the CHMS clinic to respond to a request for CAP modification.

Failure to file a corrective action plan and/or subsequent revisions to the plan within the required time frames shall result in the CHMS clinic being placed in a non-certified status. Written notice of non-certification will be forwarded to the CHMS clinic and the Arkansas Medicaid Provider Enrollment Unit. **Enrollment in the Arkansas Medicaid Child Health Management Program is contingent upon the CHMS clinic's certification status.** Clinics holding a non-certification status are not eligible to receive reimbursement from the Arkansas Medicaid Program. A clinic's non-certification status will remain in effect until the clinic is found to be in compliance with the certification requirements.

The Director of the Division of Medical Services will be apprised of the site visit results. The Director must approve or disapprove recommendations for renewal or non-renewal of certification.

All certification review reports, corrective action plans and progress reports will be filed with and maintained by the Department of Health and Human Services or its designees.

201.120 Certification Appeal Process 10-13-03

The CHMS clinic may appeal any cited deficiency or assigned timetable for corrective action resulting from a CHMS certification review.

The Division of Medical Services shall be responsible for the appeals process for CHMS clinics.

The clinic must submit a written request for appeal to the Division of Medical Services Director within thirty (30) days of receiving the formal written report of deficiencies. **View or print the Division of Medical Services Director contact information.** The clinic must specify which deficiencies and/or time frames are being appealed and clearly demonstrate why the cited deficiencies are incorrect or the assigned time frames for correction are unreasonable.

Within ten (10) working days of receipt of the appeal request, a three (3) person committee will be appointed by the Division of Medical Services to review the site report, documentation supporting the certification reviewer's recommendations and the appeal information submitted by the CHMS clinic. The committee may request additional documentation if necessary.

The committee will submit a written report of its finding to the Division of Medical Services Director, within ten (10) working days from the date the appeal request is received.

The final decision of the appeal rests with the Director. The CHMS clinic will be notified in writing of the Director's decision within five (5) working days of the receipt of the committee's report.

201.200 CHMS Licensing Requirement Reviews and Appeal Process: Division of Child Care and Early Childhood Education, Child Care Licensing Unit 8-1-05

The "Child Care Facility Licensing Act" Ark. Code Annotated §20-78-201-220, as amended, authorizes the Department of Health and Human Services, Division of Child Care and Early Childhood Education to establish rules and regulations governing the granting, denial, suspension and revocation of the licenses for child care facilities and their operation in Arkansas. Section 102, **Licensing Procedures**, of the *Minimum Licensing Requirements for Child Care Centers* manual, outlines the process for licensure and for maintaining licensed status. The process for licensing reviews, deficiency reports, corrective action plans and hearings and appeals administered by the Division of Child Care and Early Childhood Education shall be followed.

Enrollment in the Arkansas Medicaid CHMS Program is contingent upon the CHMS clinic's licensure status.

The Director of the Division of Medical Services will be apprised of the site visit results. All certification review reports, corrective action plans and progress reports will be filed with and maintained by the Department of Health and Human Services, Division of Child Care and Early Childhood Education.

202.000 Arkansas Medicaid Participation Requirements for Providers of Comprehensive Health Assessments for Foster Children 8-1-05

Providers of comprehensive health assessments for foster children must meet the following criteria in order to be eligible to participate in the Arkansas Medicaid Program:

A. An organization seeking to provide comprehensive health assessments for foster children must be certified by the Division of Children and Family Services (DCFS). The request for certification should be directed in writing to the Department of Health and Human Services, Division of Children and Family Services, Contracts Management Unit. **View or print the Contracts Management Unit contact information.**

B. A provider of comprehensive health assessments for foster children must complete and submit to the Medicaid Provider Enrollment Unit a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). A copy of the certification as a provider of comprehensive health assessments for foster children must accompany the application and contract. **View or print a provider application (DMS-652), a Medicaid contract (DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9).**

The Arkansas Medicaid Program must approve the provider application and the Medicaid contract.

203.000 Documentation Required of All Medicaid Providers 10-15-09

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

203.100 Required CHMS Medical/Clinical Records 10-1-17

CHMS providers are required to maintain the following medical/clinical records.

A. A daily log of patient visits shall be maintained by the CHMS clinic. The clinic staff will record the entry and exit time of day of each client.

B. All CHMS services provided must be recorded in the patient's record, dated and signed by the person performing the service. The beginning and ending time of day of each service must be recorded.

C. For CHMS Diagnosis/Evaluation Services:

Complete and accurate clinical records must be maintained for any patient who receives direct services from the CHMS clinic. Each record must contain, at a minimum, the following information:

1. Identifying data and demographic information
2. Consent for service and release of information forms required by law or local policy
3. Referral source(s) as documented by a PCP referral
4. Reason(s) for referral as documented on the PCP referral
5. Results of the annual developmental screen performed by the Department of Human Services' Third Party Vendor, or an approved medical diagnosis exemption of the

developmental screen, in accordance with the Provider Manual Governing Independent Assessments and Developmental Screens that shows diagnostic/evaluation services are needed.

If the physician or CHMS provider believes that the child has a significant developmental diagnosis, disability, or delay such that he or she does not need a developmental screen, the physician or CHMS provider may send relevant documentation for review by the Third Party Vendor's clinician. The Third Party Vendor's Clinician will determine the necessity of a developmental screen.

6. Content and results of all diagnostic work-ups and/or problem assessments, including the source documents, e.g., social history, test protocols, mental status examination, history of complaints, etc.

7. Treatment plan signed by a CHMS clinic physician

8. Medication record of all prescribed and/or administered medications

9. Progress notes and/or other documentation of:

   a. Treatment received

   b. Referral for treatment

   c. Changes in the patient's situation or condition

   d. Significant events in the patient's life relevant to treatment

   e. Response to treatment

10. Submittal of prior authorization request (including intervention/treatment needed) to CHMS prior authorization contractor when appropriate.

D. For CHMS Day Treatment Services:

The following additional records must be maintained for patients receiving day treatment in pediatric day programs.

1. Documentation of completion of intake process.

2. Documentation of interdisciplinary evaluation to address presenting diagnosis and establish base line of functioning and subsequent submission of prior authorization request.

3. Physician's prescription, form DMS-201, signed treatment plan and 6 month records review completed and signed by a CHMS physician.

4. PCP initial referral and 6 month pediatric day treatment referral.

5. Daily treatment records documenting services provided, relation of service to treatment plan and level of completion of treatment goal. Services must be provided in accordance with the treatment plan, with clear documentation of the services rendered.

   a. If a child does not receive all services as outlined in the treatment plan, there must be clear documentation regarding the reason the prescribed services were not provided (e.g., child absent, therapist unavailable, etc.)

   b. If a child does not receive the prescribed amount of therapy due to the unavailability of CHMS therapy staff for a period of more than two (2) weeks, the primary care physician and the child's parent/guardian must be notified of the missed therapy and given an estimated time frame in which therapy services should resume at the prescribed rate.

6. Weekly progress notes that document the progress toward the goals and objectives lined out in the treatment plan.

7. Revisions of treatment plan including treatment goals will be documented at a minimum of each six months, or more often if warranted by the patient's progress or lack of progress.

203.200 Electronic Signatures 10-8-10

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

204.000 The Child Health Management Services (CHMS) Provider's Role in the Child Health Services (EPSDT) Program 1-1-07

The Arkansas Medical Assistance Program includes a Child Health Services (Early and Periodic Screening, Diagnosis and Treatment) Program for Medicaid beneficiaries under 21 years of age. The purpose of this program is to detect and treat health problems in their early stages.

The Arkansas Medical Assistance Program operates under a primary care case management (PCCM) system. A primary care physician (PCP) referral is required for all services not performed by the PCP, including an EPSDT Screen. A CHMS provider who is also a Child Health Services provider may perform an EPSDT Screen, with a PCP referral. The screen must be allowable within the periodicity schedule. However, if the EPSDT Screen is medically necessary but non-allowable due to the periodicity schedule it still may be performed with a PCP referral.

If a condition is diagnosed through a Child Health Services (EPSDT) Screen that requires treatment services not normally covered under the Arkansas Medicaid Program, those treatment services may be considered for coverage if they are medically necessary and permitted under federal Medicaid regulations. The PCP must prescribe and request consideration of coverage for services not otherwise covered in the Arkansas Medicaid State Plan by completing form DMS-693. This form must be submitted to the Utilization Review Section of the Division of Medical Services. **View or print form DMS-693. View or print Utilization Review Section contact information.**

CHMS providers interested in enrolling in the Child Health Services (EPSDT) Program should contact the Central Child Health Services Office. **View or print the Central Child Health Services Office contact information.**

If you are a Child Health Services (EPSDT) provider, please refer to the Child Health Services (EPSDT) manual for additional information.

205.000 Referral to First Connections Program Pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) 10-1-17

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.

Each CHMS must, within two (2) working days of receipt of referral of an infant or toddler thirty-six (36) months of age or younger, present the family with DDS-approved information about the Part C program, First Connections, so that the parent/guardian can make an informed choice regarding early intervention options. Each CHMS must maintain appropriate documentation of parent choice in the child record.

206.000 Election to Provide Special Education Services in Accordance with Part B of the Individuals with Disabilities Education Act (IDEA) 10-1-17

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 CHMS with the option of participating in Part B as a LEA. Participation as a LEA requires a CHMS 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 CHMS 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 CHMS 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 as follows:

A. Opt in: A CHMS that elects to provide Special Education Services to all children with disabilities it is serving aged three (3) until entry into Kindergarten must follow Arkansas Department of Education Procedural Requirements and Program Standards for Special Education and comply with Part B at all times. Failure by a CHMS to provide all required Special Education Services in compliance with the above will result in a loss of Part B funds.

B. Opt-out: A CHMS that elects not to provide Special Education Services to all children with disabilities it is serving aged three (3) until entry into kindergarten must perform the following:

1. Prior to delivering any services to a child age three (3) or older who has or is suspected of having a disability under Part B, the CHMS must complete a Special Education Referral Form (or any successor form), and submit it to the appropriate LEA. The CHMS will be responsible for maintaining documentation evidencing that a timely and properly completed referral was provided to the appropriate LEA.

2. The CHMS must complete a Special Education Referral Form (or any successor form), and submit it to the appropriate LEA at least ninety (90) days prior to the third (3rd) birthday of any child who has or may have a disability under Part B that is being served by the CHMS. The CHMS will be responsible for maintaining documentation evidencing that a timely and properly completed referral was provided to the appropriate LEA.

3. For any child who has a disability under Part B served by the CHMS that will be entering kindergarten in a calendar year, the CHMS must complete a referral form and submit it to the LEA where the child will attend kindergarten by February 1 of that year. The CHMS will be responsible for maintaining documentation evidencing that a timely and properly completed referral was provided to the appropriate LEA.

A CHMS may change its election at any time; however, a decision to change will only be effective as of July 1st. A CHMS must inform DDS of its intent to change its election no later than March 1st for its election to be effective as of July 1st of the same calendar year. Any decision to change an election received by DDS after March 1st will not be effective until July 1st of the next calendar year. Any time a CHMS elects to cease providing Special Education Services, the CHMS must complete a Special Education Referral Form (or any successor form) for each child age three (3) or older it is currently serving, and submit each one to the appropriate LEA.

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

210.000 PROGRAM COVERAGE

211.000 Introduction 10-1-17

Medicaid (Medical Assistance) is designed to assist Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. Reimbursement may be made for Child Health Management Services (CHMS) provided to eligible Medicaid beneficiaries at qualified provider facilities.

212.000 Scope 1-1-07

Child Health Management Services (CHMS) comprises an array of clinic services intended to provide full medical multi-discipline diagnosis, evaluation and treatment for the purpose of intervention, treatment and prevention of long term disability for Medicaid beneficiaries.

Beneficiaries of Child Health Management Services must have a diagnosis of developmental disability or delay. These services are not designed to be used as a well-child check-up.

Entry into the CHMS clinic system will begin with a referral from the patient's primary care physician (PCP) after review of the results of the developmental screen. The PCP's approval of the plan for treatment must be in place to initiate care.

212.100 Child Health Management Services 10-1-17

Services are limited to the following components:

Audiology	Neuropsychology	Psychological
Behavior	Nutrition	Social work
Day Treatment Services	Occupational/Physical Therapy	Speech/Language Pathology
Medical (to include nursing)	Psychiatry	Therapy

Services are outpatient only and are available to eligible Medicaid patients under age 21. The CHMS provider will provide services in one or more of the above components. The CHMS provider will bill only for those services that are medically necessary. Prior authorization is required to admit a child into Child Health Management Services. See Section 240.000 of this manual for prior authorization procedures.

All services provided to a child must be included in an individual treatment plan signed by the CHMS pediatrician and include follow-up to ensure treatment has been done. (See Section 218.200.)

The CHMS clinic must establish a patient referral system within the clinic, to hospitals and other health care providers. (See Section 221.000).

Beneficiaries that are enrolled in a program that is dually certified as a DDTCS and CHMS cannot be billed under both programs during the same enrollment period. An enrollment period is defined as the twelve (12) months of allowed billing after the developmental screen is administered and a prescription is written for CHMS or DDTCS services for the beneficiary.

Beneficiaries that continue to qualify for either DDTCS or CHMS during the enrollment period can transfer to another CHMS or DDTCS program based on parent choice. These beneficiaries do not have to undergo another developmental screen.

Beneficiaries that graduate or no longer qualify for DDTCS or CHMS before the end of the enrollment period must be referred to the third party vendor for a developmental screen and obtain a new prescription before they can be reenrolled in a DDTCS or CHMS program.

212.200 CHMS Service Delivery Professionals 8-15-08

CHMS service delivery professionals must include the following:

Audiologist	Neuropsychologist	Psychological Examiner
Child and Adolescent Psychiatrist	Nutritionist	Registered Nurse
Developmental Pediatrician	Occupational Therapist	Social Worker
Early Childhood Developmental Specialist	Pediatric Psychologist	Speech/Language Pathologist
Licensed Counselor	Physical Therapist	

Services of a pediatric registered nurse practitioner and a licensed practical nurse are not required but may be used for activities within the scope of practice under state license. All personnel shall be licensed or certified to perform the services they render when such services require licensure or certification under the laws of the State of Arkansas.

The CHMS clinic shall develop written policies and job descriptions which clearly document the authority, responsibility and function of each staff member.

Effective for dates of service on and after October 1, 2008, when a CHMS clinic files a claim with Arkansas Medicaid, the clinic staff member who actually performed the service on behalf of the clinic must be identified on the claim as the performing provider. CHMS staff members who are eligible to enroll in the Arkansas Medicaid program have the option of either enrolling or requesting a Practitioner Identification Number (View or print form DMS-7708) so that they can be identified on claims. For example, an LCSW may choose to enroll in the Licensed Mental Health Practitioners program or choose to obtain a Practitioner Identification Number.

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).

Certain types of practitioners who perform services on behalf of a CHMS clinic are not allowed to enroll in the Arkansas Medicaid program. These practitioners must request a Practitioner Identification Number so that they can be identified on claims:

- Nutritionists
- Early Childhood Developmental Specialists
- Registered Nurses
- Licensed Practical Nurses

212.300 Supervising Physician Requirements and Duties 1-1-07

Medical personnel and health service delivery in a CHMS clinic must be under the medical supervision, control and responsibility of a physician currently licensed in the state of Arkansas. The physician must possess documentable skills in a specific CHMS sub-specialty area as documented by annual continuing medical education (CMEs) in areas relevant to developmental

pediatrics, or a practice population composed of 25% patients that have developmental concerns/delays/disabilities/risks.

The supervising physician must direct the development of individualized treatment plans.

The supervising physician shall ensure that the CHMS provider has written procedures which include an outline of the medical tasks involved in patient care and specify to whom such tasks may be delegated as well as the criteria and procedures for patient referral.

The physician must make certain the procedures conform to good medical practices of the community, and must review and update the procedures at least annually. The procedures must be on file at the clinic and made available for review at all times.

212.400 Other Personnel Requirements and Duties 10-13-03

A physician or registered nurse must be present in the CHMS clinic at any time specialized medical services occur. Medications must be administered only by licensed medical personnel.

Nursing services shall be provided only by licensed registered nurses; with the exception of nursing services that may be furnished by a certified physician's assistant under the supervision, control and responsibility of a licensed physician. Other CHMS personnel may provide care required in the course of a day long program that would be performed by the parent if the child were home.

213.000 Definitions 10-1-17

A. CHMS Clinic

A facility used for the provision of Child Health Management Services. Each facility must be enrolled with Medicaid to obtain a unique Medicaid Provider Number for identification purposes. Administrative, financial, clinical and managerial responsibility for the clinic may rest with a provider organization.

B. Clinic Services

Clinic services are defined as preventive, diagnostic, therapeutic, rehabilitative or palliative items or services that are:

1. Provided to outpatients;
2. Furnished at the clinic by or under the direction of a physician and
3. Provided at the clinic by a facility that is not a part of a hospital but is organized and operated to provide medical care (42 Code of Federal Regulations 440.90.)

C. Department

The Arkansas Department of Human Services and its designated representatives.

D. Provider Organization

The entity responsible for the operation of a CHMS clinic.

213.100 Definitions of Service Components 10-1-17

A. Audiology

Assessment of hearing problems or other chronic ear problems.

B. Behavior

Provision of counseling and therapy for behavior related problems identified by psychological, social and developmental medical evaluations.

C. Day Treatment Services

Assessment, treatment planning and provision of an integrated developmentally based program of services to strengthen and enhance appropriate developmental outcomes.

D. Medical

A complete medical evaluation that will identify developmental problems and/or coexisting medical problems and provide a plan of treatment or referral for the remediation or management of medical problems.

E. Neuropsychology

Psychological testing in such areas as intelligence, achievement, emotional/behavioral, academic and social development; assessment of visual motor integration skills and adaptive behavior; assessment of psychomotor speed and strength, memory executive functioning including attention, problem solving and mental flexibility, verbal fluency and word finding.

F. Nutrition

Assessment of a child's nutritional deficiencies or special needs to include a plan of treatment to prevent, improve or resolve a developmental or other medical condition.

G. Occupational/Physical Therapy

Evaluation, therapy and programming recommendations for motor dysfunction patients; coordination with medical and speech pathology assessments to maximize muscle function and coordination.

H. Psychiatry

Psychiatric evaluation that will identify psychological and/or behavioral problems and provide a plan of treatment or referral to appropriate treatment. Provision of counseling and therapy may be included.

I. Psychology

Psychological testing/assessment in such areas as development, intelligence, achievement, emotional, behavioral, academic and social development and assessment of visual motor integration skills and adaptive behavior.

J. Social Work

Assessment of social/emotional risks or problems through the gathering of information from patient, family and others related to the treatment planning of the patient. A social history is used to describe all pertinent facts including assessment of family dynamics and need for intervention by CHMS staff.

K. Speech and Language Pathology

Assessment of language development, oral-motor functions, articulation problems, strengths and weaknesses in auditory processing capabilities and the provision of therapy for problems identified.

L. Therapy

Provision of counseling and therapy for problems identified by psychological, social and medical evaluations.

213.200 Definitions of Staff 10-1-17

A. Early Childhood Development Specialist (ECDS)

This professional must possess at a minimum a Bachelor's Degree plus one of the following:

1. Current Arkansas state certification in Early Childhood Special Education

or

2. A current Child Development Associate Certificate

or

3. 12 hours of completed college courses in one of the following areas – early childhood, child development, special education/elementary education or child and family studies and documented experience in working with children with special needs.

There must be one (1) ECDS for every fifty (50) beneficiaries enrolled at a CHMS site.

B. Licensed Practical Nurse

Licensed in the State of Arkansas as a practical nurse.

C. Neuropsychologist

Licensed in the State of Arkansas as a Psychologist (Ph.D. or PsyD) and has completed postdoctoral training in neuropsychology (including neurophysiology, clinical neuropsychology and neuropsychological assessment).

D. Nutritionist/Dietitian

Dietitian licensed or registered by the State of Arkansas who has special training in the nutritional needs of children.

E. Pediatric Nurse Practitioner

Licensed in the State of Arkansas as a registered nurse practitioner or advanced practice nurse with documented expertise in pediatrics.

F. Physician

Licensed in the State of Arkansas to practice surgery and/or medicine and has documentable skills in the required CHMS specified subspecialty area.

G. Psychiatrist

Licensed in the State of Arkansas and completed an accepted residency in child and adolescent psychiatry.

H. Psychological Examiner

Licensed in the State of Arkansas as a psychological examiner.

I. Psychologist

Licensed in the State of Arkansas to provide evaluation, screening and therapeutic services.

J. Registered Nurse

Licensed in the State of Arkansas as a registered nurse.

K. Social Worker

Licensed in the State of Arkansas as an LSW, LCSW holding, at a minimum, a B.A. in Social Work or a Master's Degree in Social Work.

L. Related Professionals

Speech therapist, physical therapist, licensed counselor and occupational therapist, etc. shall be considered as professional clinical personnel provided that they meet the requirements for registration or licensing in their respective professions within the State of Arkansas.

214.000 Staff Records/Credentialing 10-13-03

The CHMS clinic must maintain accurate and complete records for all employees and other health professionals who provide services at the clinic.

214.100 Record Requirements for Full-time Employees 10-13-03

Records for full-time employees shall, at a minimum, contain:

A. An initial resume and any other background information needed to justify the initial and/or continuing employment of an individual;

B. For an individual whose position requires licensure, documentation that the individual has or has applied for, within the time period and under the conditions prescribed by the appropriate licensing board, a current valid license;

C. Documentation verifying academic records and references required by the job description and

D. Current information relevant to work performance.

E. For those individuals who have direct patient contact, criteria set forth in Section 107 of Arkansas Minimum Licensing Requirements for Child Care Centers manual must be followed. Child abuse registry and criminal records checks must be obtained in a timely fashion and eligibility for hire restrictions as listed in 107.3 of Arkansas Minimum Licensing Requirements for Child Care Centers manual will be used.

R. Also, documentation of completion of continuing education hours (as required by specific licensing standards) that relate to the responsibilities and functions of the individuals' position shall be maintained.

214.200 Record Requirements for Part-time Employees 10-13-03

Records for part-time employees must, at a minimum, contain:

A. An initial resume;

B. Verification of references and

C. A current valid license or application for licensure, if appropriate.

D. For those individuals who have direct patient contact, criteria set forth in Section 107 of Arkansas Minimum Licensing Requirements for Child Care Centers must be followed.

Child abuse registry and criminal records checks must be obtained in a timely fashion and eligibility for hire restrictions as listed in 107.3 will be used.

215.000 General Standards 10-1-17

The following standards must be met or exceeded by all Child Health Management Services clinics in the state of Arkansas.

A. The CHMS clinic must be in compliance with all applicable federal and state statutes, rules and regulations.

B. All clinic services must be performed by licensed professional personnel as identified herein, when such services require licensure under the laws of the State of Arkansas.

C. Medical records must be established and maintained for each patient by the CHMS clinic. Records must include documentation of all services provided and the signature and title of the individuals who provided the services.

D. The CHMS clinic must utilize professionals with the qualifications necessary to perform Child Health Management Services. There must be sufficient health professionals available to ensure close and adequate supervision of all CHMS clinical activities.

Specifically, in the classroom setting, the following staff-to-beneficiary ratios** must be observed:

1. For children 0-3 years: one (1) staff for every four (4) beneficiaries
2. For children 3-6 years: one (1) staff for every seven (7) beneficiaries
3. For children six (6) and up: one (1) staff for every then (10) beneficiaries.

**These ratios will become effective on July 1, 2018.

E. The CHMS clinic must have adequate and appropriate general liability insurance for the protection of its patients, staff, physical facilities and the general public.

F. Medical supervisory responsibility must be vested in a physician who is licensed to practice medicine in the state of Arkansas. The physician must possess skills documented and defined by annual continuing medical education (CME units) in areas relevant to developmental pediatrics or a practice population of which 25% of the patients have developmental concerns/delays/disabilities/ risks) in the required CHMS specified sub-specialty areas. The CHMS clinic must issue policies formulated by the responsible physician, setting forth the procedures CHMS staff are to follow in the event a patient has or develops an emergency condition.

G. In the event a patient is hospitalized for a condition related to his or her CHMS outpatient treatment, the CHMS clinic will obtain written consent from the child's parent or legal guardian to release medical information; then, provide the admitting hospital with a written summary presenting the patient's history, diagnosis and significant outpatient treatment. Such information may not be provided without written consent.

H. The physician, vested with medical responsibility for the clinic, must report infectious and/or communicable diseases according to the regulations set forth by the Arkansas Division of Health. The physician must appoint a registered nurse to fulfill this requirement in his or her absence.

I. CHMS clinic staff, including a physician, must institute a quality assurance program to include a regularly scheduled examination of patient records to ensure adequate and appropriate care. Annual peer reviews must be conducted to determine that each patient is receiving appropriate diagnosis, evaluation and treatment services.

J. All policies and procedures must be reviewed annually by the supervising CHMS physician and by the clinic Administrator, signed and dated.

K. Patient Rights

The CHMS clinic must adopt policies and procedures which safeguard patient legal, civil and human rights including, but not limited to:

1. Non-discrimination in treatment as provided in Title VI of the Civil Rights Act of 1964; as amended; Section 504 of the Rehabilitation Act of 1973, as amended and the Americans with Disabilities Act of 1990;
2. Assignment to treatment solely on the basis of clinical need;
3. Maintenance of the confidentiality of clinical information;
4. Receipt of treatment in an atmosphere that enhances the dignity, self-respect and individuality of each patient;
5. Provisions to safeguard against hazardous treatment and against any risk entailed as a result of informed consent participation in research conducted in the CHMS clinic;
6. Maintenance of the right to communicate with family, friends, legal representatives and significant others and
7. Assurances that these rights are communicated to the patient prior to receipt of services.

216.000 Service Settings 10-13-03

Child Health Management Services are typically provided in either of two settings. The first is a multi-disciplinary clinical setting, where diagnostic services and/or treatment for individual children/families are provided. The second is a pediatric day program/intervention setting where many children are treated on a daily basis. Diagnostic services, though infrequently provided in this setting, will be provided as needed to serve the purpose of the developmental treatment planning for the children attending the center.

216.100 Physical Facility Requirements 10-13-03

The CHMS clinic administration shall be responsible for providing physical facilities that, at a minimum:

A. Are structurally sound and meet all applicable federal, state and local regulations for adequacy of construction, safety, sanitation and health;

B. Are conducive to effective patient care and comply with the appropriate state and local building fire safety and zoning codes;

C. Have separate areas that are functionally appropriate for providing patient privacy;

D. Meet the requirements of the service element involved for space and accessories, e.g., storage space, electrical outlets, etc.;

E. Are in compliance with Section 504 of the Rehabilitation Act of 1973, as amended and the Americans with Disabilities Act of 1990 with consideration for safety and age appropriateness for patients;

F. Are easily accessible for patients and staff and

G. Meet the same facility guidelines required for licensed childcare centers, in CHMS facilities where daily treatment programs are provided for pre-school children.

217.000 Establishing Need for CHMS Services 10-1-17

Referral to a CHMS clinic may be made for any medically indicated reason as identified by the primary care physician (PCP). This referral can be made for diagnosis and/or treatment. The population typically served by CHMS providers is defined as follows:

"Children with Special Health Care Needs (CSHCN) are those who have or are at increased risk of chronic physical, developmental, behavioral, or emotional conditions and who require health and related services of a type or amount beyond that required by children generally," as defined by the Bureau of Maternal and Child Health.

CHMS are a combination of diagnostic and daily trans-disciplinary treatment programs and are a melding of developmental, medical, health and therapeutic services, some of which might be considered only educational or social. The medical aspect of these children's special needs and their needs for care by specially trained personnel makes these services health care.

Child Health Management Services are delivered to those children with the most significant medical and/or developmental diagnoses and those presenting with multiple/complex conditions. These children may require one of the following services:

A. Frequent nursing services

B. Close physician monitoring (availability for consultation in addition to frequent face-to-face contact)

C. Special nutritional services requiring consultation with parents and staff and/or possible special menu planning and adapted feeding regimen

D. Constant coordination of care (in communication with the PCP) within the interdisciplinary team to maximize provision of individual services and appropriate therapy services

E. Additional family contact for education and support

F. Therapy services from more than one discipline (occupational, physical, speech)

217.100 Definition of Developmental Diagnosis 10-1-17

A. A developmental disability:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. The disability has continued or is expected to continue indefinitely.

C. The disability constitutes a substantial handicap to the beneficiary's ability to function without appropriate support services.

217.200 Cognition Testing 10-1-17

Patients referred for developmental concerns are eligible for CHMS if they qualify on two or more developmental evaluations administered by appropriate CHMS professionals:

A. For ages 0-36 months:

1. A developmental evaluation that reflects a score of 25% or greater delay in at least two of the five domains (motor, social, cognitive, self-help/adaptive, or communication); or

2. A psychological evaluation that reflects a score of 75 or less; and

3. A physical therapy, occupational therapy or speech therapy evaluation that meets qualifying scores as set out in § 245.100 of this Manual.

B. For ages 3-5:

1. A developmental evaluation that reflects a score of at least two (2) standard deviations below the mean in at least two of the five domains (motor, social, cognitive, self-help/adaptive, or communication); or

2. A psychological evaluation that reflects a score of 70 or less; and

3. A physical therapy, occupational therapy, or speech therapy evaluation that meets qualifying scores as set out in § 245.100 of this Manual..

The developmental evaluation must be comprehensive and include a norm referenced (standardized) evaluation and a criterion referenced evaluation. For all evaluations, the evaluator must document that the test protocols for each instrument were followed and that the evaluator met the qualifications to administer the instrument.

218.000 Groupings of Services 10-13-03

The following is a discussion of methods of care delivery characterized by a particular grouping of services and the general referral, approval and service route involved with each care method.

218.200 Individual Treatment Planning 10-1-17

Under the direction of a CHMS physician and with input from the diagnostic evaluation team, an individualized treatment plan will be developed. This plan will include physician orders/prescription for services to be provided. A PCP referral/approval/prescription will be obtained. This includes occupational, physical and speech therapy services.

A DMS-640 form is required for a PCP, or attending physician if the beneficiary is exempt from PCP managed care program requirements, referral and a separate DMS-640 form is required for a prescription for occupational, physical and speech therapy services. The PCP or attending physician must use form DMS-640 when making referrals and prescribing occupational, physical or speech therapy services. **View or print form DMS-640.** A copy of the prescription must be maintained in the child's CHMS record; the PCP or attending physician retains the original prescription. If occupational, physical and speech therapy sessions are missed; make-up therapy services must not exceed the prescribed number of minutes per week without an additional PCP/attending physician prescription on form DMS-640.

The CHMS physician will determine the appropriate treatment to address the diagnosis, treatment needs and family concerns identified for the beneficiary.

For those children receiving day treatment services on a daily or weekly basis, the individualized treatment plan will be written for a period of 12 months and will be updated as needed.

Prior authorization is required for admission into the CHMS program and for treatment procedures. Intervention/treatment services must be included in the individual treatment plan to be considered for coverage. Refer to Section 262.120 for a listing of the treatment procedure codes that require prior authorization.

218.300 Day Treatment Services 10-1-17

Intervention/Treatment Services are defined as assessment and provision of an integrated developmentally based program of services (such as therapy treatment) to strengthen and enhance appropriate developmental outcomes. This treatment service is typically provided multiple times per week based on the orders/treatment plan signed by the CHMS physician.

Therapy Treatment Services may include psychotherapy, speech/language therapy, occupational therapy, physical therapy, behavioral therapy, family counseling, individual and group counseling, pediatric medical treatment and diagnostic services, nutrition and cognitive services. These treatment services are available for children from birth to age 21 and are provided based on the physician's prescription, which authorizes the amount of day treatment needed.

218.400 Transition/Follow-Up 2-1-10

When it is determined that the patient no longer has a medical need for therapy services, the treatment plan will be updated accordingly and services will be discontinued. Releases to provide copies of testing results and treatment records will be obtained, if appropriate. Follow-up with the parent/patient will be made no more than 180 days following discontinuation of therapy to determine the status of the patient. Follow up may be as soon and as frequent as the CHMS physician determines is necessary.

When it is determined that the patient no longer has a medical need for intervention/treatment services, a transition conference will be held with the relevant CHMS providers and the patient/parents. Releases to provide copies of testing results and treatment records will be obtained, if appropriate. Follow-up with the parent will be made no more than 180 days following transition to determine the status of the patient. Follow up may be as soon and as frequent as the CHMS physician determines is necessary.

When CHMS multidisciplinary treatment services are no longer medically necessary, or if CHMS services are discontinued for other reasons (e.g., child is moving, parental/guardian request, etc.), the CHMS Discharge Notification (DMS-202) must be completed and a copy submitted to AFMC within thirty (30) days of service termination.

219.000 Evaluation of Clinical Care/Internal Quality Assurance 10-13-03

The CHMS clinic must maintain and document an ongoing evaluation of the quality of care given to each patient. This shall be done through Individual Case Review and Clinical Evaluation studies.

219.100 Individual Case Review 10-13-03

Each case shall be reviewed periodically by the relevant CHMS staff physician, evaluation team and/or relevant others in order to monitor the course of treatment, assess the quality of care provided and make any necessary changes in the individualized treatment plan. Each case shall be reviewed within two (2) weeks of the patient's initial visit and at least every ninety (90) days during the course of treatment, unless otherwise specified and justified in the patient's individualized treatment plan.

Each case review must be documented and include a description of the review results.

219.200 Clinical Care Evaluation 10-13-03

The CHMS clinic must annually conduct and document analysis and evaluation of patient care occurring within the clinic.

220.000 BENEFIT LIMITS

221.000 Referral Process for Non-Child Health Management Services 10-13-03

In certain circumstances it may be determined that the patient is in need of services that are not available through the CHMS clinic. In those situations the CHMS clinic may make referrals for other services.

The CHMS clinic must establish policies and procedures for making referrals and for the follow-up of these referrals. These policies shall provide for:

A. Consultation with PCP;

B. Appropriate transfer of relevant information;

C. Joint discussion of the role of the referral in the overall treatment process;

D. Preparation of the patient for referral and

E. Follow-up reports subsequent to the referral.

These policies and procedures must be reviewed annually, signed and dated by appropriate clinical staff.

222.000 Inspection of Care 10-1-17

Inspection of care will be performed in conjunction with the certification site visits. A team of healthcare professionals will assess the care needed by and provided to a sampling of CHMS patients.

For each inspection of care visit, the QIO will select patients currently being served by the CHMS clinic. The QIO team will review medical records, and may interview patients, parents and staff and observe treatment in progress.

A. The medical record review will include assessment of the patient's continued eligibility for and the medical necessity of Child Health Management Services (CHMS), determining if the treatment plan is being followed and if the therapy services are being provided as prescribed by the primary care physician (subject to applicable authorizations and utilization controls.

B. A QIO team member (determined by the patient's diagnosis and treatment program) may interview staff and, if available, parents to assess the patient's needs, goals and progress with treatment. The same team member may also meet, assess and observe the patient in treatment.

C. In addition to focusing on selected patients, the QIO team will observe the activities at the CHMS clinic for therapeutic function.

Any child determined to not meet the requirements for enrollment in a CHMS clinic will be decertified from the program. A written notification will be given to the clinic with a copy mailed to the parents of the patient. The clinic/parents will be allowed thirty (30) calendar days to request reconsideration of the patient decertification to the QIO. A reconsideration of the decertification will be completed with notification to the clinic and parents within fifteen (15) working days from receipt of the appeal.

A written report of the inspection of care finding will be mailed to the Division of Medical Services.

240.000 PRIOR AUTHORIZATION FOR CHILD HEALTH MANAGEMENT SERVICES

241.000 Intake Process 10-1-17

A. A prescription from the primary care physician (PCP) must be received by the CHMS clinic for a beneficiary to receive CHMS services.

B. The CHMS clinic must conduct an intake and assessment once the prescription is received.

The steps in the intake process are as follows:

1. The intake process begins with the family or referral source to identify the needs of the patient.
2. The CHMS clinic will schedule an appointment with the child's family for the intake assessment.
3. The CHMS professional staff will assess the need of the patient for the services available. History and concerns of the family will be collected and the intake process will be completed.
4. If no concerns are found, the family will be provided other service information.
5. When developmental or medical concerns are found, a CHMS pediatrician visit will be scheduled.
6. After the visit is completed and the developmental screen results, as well as all other evaluation results are reviewed, admission for treatment services will be prescribed or not prescribed by the CHMS physician.

242.000 Prior Authorization Request to Determine and Verify the Patient's Need for Child Health Management Services 10-1-17

Day treatment services for Medicaid beneficiaries must be prior authorized in accordance with the following procedures.

A. When a recommendation is made for day treatment services, the CHMS Request for Prior Authorization form DMS-102 must be completed by the CHMS clinic and submitted via mail, electronically, or by fax to the QIO. Fax transmission will be limited to 25 pages. For those clinics wishing to utilize electronic submission, contact the QIO and request specifics. **View or print CHMS Request for Prior Authorization form DMS-102 and instructions for completion. View or print QIO contact information.**

The request must include a report of the findings from the developmental screen, the diagnostic evaluation and a current plan for treatment. Review for medical necessity will be performed on the information sent by the provider. This information must substantiate the need for the child to receive services in a multidisciplinary CHMS clinic, including that the child meets the eligibility criteria laid out in Section 217.000.

B. Prior Authorization Review Process

1. Prior authorization requests are initially screened by a CHMS review coordinator (a registered nurse). When complete documents are received, a prior authorization review of the requested services is performed. If the CHMS review coordinator cannot approve all of the services requested, the review is sent to a pediatric physician advisor for determination.
2. When the request is approved, a prior authorization number is issued along with a preliminary length of service, procedure codes and units approved. Approval notifications are mailed to the CHMS provider and the Medicaid beneficiary.

C. For any request that is denied or approved at a reduced level, a letter containing case specific rationale that explains why the request was not approved is mailed to the beneficiary and to the Medicaid provider. These notification letters also contain information regarding the beneficiary and provider's due process rights.

D. Providers may request reconsideration. Requests must be received within thirty-five (35) days from the date of the determination. Requests must be made in writing and include additional information to substantiate the medical necessity of the requested services. Reconsideration review will be performed by a different physician advisor.

E. The prior authorization/reconsideration process will be completed within thirty (30) working days of receipt of all required documentation. Intervention/Treatment Services may begin prior to the receipt of prior authorization only at the financial risk of the CHMS organization.

F. The Medicaid beneficiary, the CHMS provider, or both may request a fair hearing of a denied review determination made by the QIO. The fair hearing request must be in writing and received by the Office of Appeals and Hearings section of The Department of Human Services (DHS) within thirty-five (35) calendar days of the date on the denial letter.

Refer to the flow chart in Section 244.000 of this manual for the process outlined above.

243.000 Mechanisms for Record Transfer and Reporting 10-13-03

All prior authorization requests will be shared via mail, fax or electronic submission.

All reports, records and documents will be available to Medicaid and other authorized entities concerning the prior authorization requests, approvals/denials, appeal process, patient information, etc., upon request with advance notice of 5 working days. Periodic set reports can be established and provided.

244.000 Flow Chart of Intake and Prior Authorization Process for Intervention/Treatment 2-1-10

View or print Flow Chart of Intake and Prior Authorization Process for Intervention/Treatment.

View or print AFMC CHMS Request for Prior Authorization Form and instructions for completion.

245.000 Guidelines for Retrospective Review of Occupational, Physical and Speech Therapy Services 10-1-17

Arkansas Medicaid conducts retrospective review of the first 90 minutes per week of occupational, physical and speech therapy 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. **View or print QIO contact information.**

For the provider's information specific guidelines have been developed for occupational, physical and speech therapy retrospective reviews. These guidelines may be found in Sections 245.100 through 245.220.

245.100 Occupational and Physical Therapy Guidelines 10-1-17

A. Medical Necessity

Occupational and physical therapy services must be medically necessary to the treatment of the individual's illness or injury. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The service must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The service must be of such a level of complexity or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical or occupational therapist.
3. There must be reasonable expectation that therapy will result in a meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See the medical necessity definition in the Glossary of this manual.)

B. Evaluation and Report Components

To establish medical necessity, a comprehensive assessment in the suspected area of deficit must be performed. A comprehensive assessment must include:

1. Date of evaluation.
2. Child's name and date of birth.
3. Diagnosis specific to therapy.
4. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's deminant language; if not, an explanation must be provided in the evaluation.

   NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

   7 months - [(40 weeks) - 28 weeks) / 4 weeks]

   7 months - [(12) / 4 weeks]

   7 months - [3]

   4 months

5. Standardized test results, including all subtest scores, if applicable. Test results must be reported as standard scores, Z scores, T scores or percentiles. Age-equivalent scores and percentage of delay cannot be used to qualify for services.
6. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.
7. Objective information describing the child's gross/fine motor abilities/deficits, e.g., range of motion measurements, manual muscle testing, muscle tone or a narrative description of the child's functional mobility skills (strengths and weaknesses).
8. An interpretation of the results of the evaluation, including recommendations for therapy/minutes per week.
9. A description of functional strengths and limitations, a suggested treatment plan and potential goals that address each identified problem.
10. Signature and credentials of the therapist performing the evaluation.

C. Interpretation and Eligibility: Ages Birth to 21

1. Tests used must be norm-referenced, standardized and specific to the therapy provided.

2. Tests must be age-appropriate for the child being tested.

3. All subtests, components and scores must be reported for all tests used for eligibility purposes.

4. Eligibility for therapy will be based upon a score of -1.50 standard deviations (SD) below the mean or greater in at least one subtest area or composite score on a norm-referenced, standardized test. When a -1.5 SD or greater is not indicated by the test, a criterion-referenced test along with informed clinical opinion must be included to support the medical necessity of services.

5. If the child cannot be tested with a norm-referenced, standardized test, criterion-based testing or a functional description of the child's gross/fine motor deficits may be used. Documentation of the reason why a standardized test could not be used must be included in the evaluation.

6. The *Mental Measurement Yearbook (MMY)* is the standard reference to determine reliability and validity. Refer to "Accepted Tests" sections for a list of standardized tests accepted by the Arkansas Medicaid program for retrospective review.

7. Range of Motion: A limitation of greater than ten degrees and/or documentation of how deficit limits function.

8. Muscle Tone: Modified Ashworth Scale.

9. Manual Muscle Test: A deficit is a muscle strength grade of fair (3/5) or below that impedes functional skills. With increased muscle tone, as in cerebral palsy, testing is unreliable.

10. Transfer Skills: Documented as the amount of assistance required to perform transfer, e.g., maximum, moderate, minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.

11. Children (birth to age 21) receiving services outside of the public schools must be evaluated annually.

12. Children (birth to age 2) in the Child Health Management Services (CHMS) program must be evaluated every 6 months.

13. Children (age three to 21) receiving services within public schools, as a part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP), must have a full evaluation every three years; however, an annual update of progress is required.

D. Frequency, Intensity and Duration of Physical and/or Occupational Therapy Services

The frequency, intensity and duration of therapy services should always be medically necessary and realistic for the age of the child and the severity of the deficit or disorder. Therapy is indicated if improvement will occur as a direct result of these services and if there is a potential for improvement in the form of functional gain.

1. Monitoring: May be used to ensure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment such as orthotics and other durable medical equipment. Monitoring frequency should be based on a time interval that is reasonable for the complexity of the problem being addressed.

2. Maintenance Therapy: Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical or occupational therapy services. These services can be provided to the child as part of a home program that can be implemented by the child's caregivers and do not necessarily require the skilled services of a physical or occupational therapist to be performed safely and effectively.

3. Duration of Services: Therapy services should be provided as long as reasonable progress is made toward established goals. If reasonable functional progress cannot be expected with continued therapy, then services should be discontinued and monitoring or establishment of a home program should be implemented.

E. Progress Notes

1. Child's name.
2. Date of service.
3. Time in and time out of each therapy session.
4. Objectives addressed (should coincide with the plan of care).
5. A description of specific therapy services provided daily and the activities rendered during each therapy session, along with a form measurement.
6. Progress notes must be legible.
7. Therapists must sign each date of entry with a full signature and credentials.
8. Graduate students must have the supervising physical therapist or occupational therapist co-sign progress notes.

245.110 Accepted Tests for Occupational Therapy 3-15-12

To view the current list of Accepted Tests for Occupational Therapy, refer to Section 214.310 of the Occupational, Physical, Speech Therapy Services manual.

245.120 Accepted Tests for Physical Therapy 3-15-12

To view the current list of Accepted Tests for Physical Therapy, refer to Section 214.320 of the Occupational, Physical, Speech Therapy Services manual.

245.200 Speech-Language Therapy Guidelines 10-1-17

A. Medical Necessity

Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The services must be of such a level of complexity, or the patient's condition must be such, that the services required can be safely and effectively performed only by or under the supervision of a qualified speech and language pathologist.
3. There must be reasonable expectation that therapy will result in meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition. (See the medical necessity definition in the Glossary of this manual.)

B. Types of Communication Disorders

1. Language Disorders — Impaired comprehension and/or use of spoken, written and/or other symbol systems. This disorder may involve the following components: forms of language (phonology, morphology, syntax), content and meaning of language (semantics, prosody), function of language (pragmatics) and/or the perception/processing of language. Language disorders may involve one, all or a combination of the above components.

2. Speech Production Disorders — Impairment of the articulation of speech sounds, voice and/or fluency. Speech Production disorders may involve one, all or combination of these components of the speech production system.

An articulation disorder may manifest as an individual sound deficiency, i.e., traditional articulation disorder, incomplete or deviant use of the phonological system, i.e. phonological disorder or poor coordination of the oral-motor mechanism for purposes of speech production, i.e. verbal and/or oral apraxia, dysarthria.

3. Oral Motor/Swallowing/Feeding Disorders — Impairment of the muscles, structures and/or functions of the mouth (physiological or sensory-based) involved with the entire act of deglutition from placement and manipulation of food in the mouth through the oral and pharyngeal phases of the swallow. These disorders may or may not result in deficits to speech production.

C. Evaluation and Report Components

1. STANDARDIZED SCORING KEY:

Mild: Scores between 84-78; -1.0 standard deviation

Moderate: Scores between 77-71; -1.5 standard deviations

Severe: Scores between 70-64; -2.0 standard deviations

Profound: Scores of 63 or lower; -2.0+ standard deviations

2. LANGUAGE: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 245.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Language disorder must include:

a. Date of evaluation.

b. Child's name and date of birth.

c. Diagnosis specific to therapy.

d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in his or her dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of language disorder, including all relevant scores, quotients and/or indexes, if applicable. A comprehensive measure of language must be included for initial evaluations. Use of one-word vocabulary tests alone will not be accepted. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

f. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should

be noted in the evaluation.

g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of the orofacial structures.

h. Formal or informal assessment of hearing, articulation, voice and fluency skills.

i. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

j. A description of functional strengths and limitations, a suggested treatment plan and potential goals that address each identified problem.

k. Signature and credentials of the therapist performing the evaluation.

3. SPEECH PRODUCTION (Articulation, Phonological, Apraxia): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 245.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Articulation, Phonological, Apraxia) disorder must include:

a. Date of evaluation.

b. Child's name and date of birth.

c. Diagnosis specific to therapy.

d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in his or her dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. All errors specific to the type of speech production disorder must be reported (e.g., positions, processes, motor patterns). (To view a current list of Accepted Tests for Speech Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

f. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.

g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures.

h. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen or TTFC.

i. Formal or informal assessment of hearing, voice and fluency skills.

j. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

k. A description of functional strengths and limitations, a suggested treatment

plan and potential goals that address each identified problem.

l. Signature and credentials of the therapist performing the evaluation.

4. SPEECH PRODUCTION (Voice): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 245.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Voice) disorder must include:

a. A medical evaluation to determine the presence or absence of a physical etiology as a prerequisite for evaluation of voice disorder.

b. Date of evaluation.

c. Child's name and date of birth.

d. Diagnosis specific to therapy.

e. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in his or her dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

f. Results from an assessment relevant to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

g. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is12 months of age or younger, and this should be noted in the evaluation.

h. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures.

i. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen or TTFC.

j. Formal or informal assessment of hearing, articulation and fluency skills.

k. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

l. A description of functional strengths and limitations, a suggested treatment plan and potential goals that address each identified problem.

m. Signature and credentials of the therapist performing the evaluation.

5. SPEECH PRODUCTION (Fluency): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 245.200, part D, paragraphs 9-12 for required frequency of re-

evaluations.) A comprehensive assessment for Speech Production (Fluency) disorder must include:

a. Date of evaluation.

b. Child's name and date of birth.

c. Diagnosis specific to therapy.

d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in his or her dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. (To view a current list of Accepted Tests for Speech Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

f. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is12 months of age or younger, and this should be noted in the evaluation.

g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures.

h. Formal screening of language skills. Examples include, but are not limited to, the Fluharty 2, KLST-2, CELF-4 Screen or TTFC.

i. Formal or informal assessment of hearing, articulation and voice skills.

j. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

k. A description of functional strengths and limitations, a suggested treatment plan and potential goals that address each identified problem.

l. Signature and credentials of the therapist performing the evaluation.

6. ORAL MOTOR/SWALLOWING/FEEDING: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 245.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Oral Motor/Swallowing/Feeding disorder must include:

a. Date of evaluation.

b. Child's name and date of birth.

c. Diagnosis specific to therapy.

d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in his or her dominant language; if not, an explanation must be provided in the

evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of oral motor/swallowing/feeding disorder, including all relevant scores, quotients and/or indexes, if applicable. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

f. If swallowing problems and/or signs of aspiration are noted, then include a statement indicating that a referral for a videofluoroscopic swallow study has been made.

g. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.

h. Formal or informal assessment of hearing, language, articulation, voice and fluency skills.

i. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

j. A description of functional strengths and limitations, a suggested treatment plan and potential goals that address each identified problem.

k. Signature and credentials of the therapist performing the evaluation.

D. Interpretation and Eligibility: Ages Birth to 21

1. LANGUAGE: Two language composite or quotient scores (i.e., normed or standalone) in the area of suspected deficit must be reported, with at least one being a norm-referenced, standardized test with good reliability and validity. (Use of two one-word vocabulary tests alone will not be accepted.)

a. For children age birth to three: criterion-referenced tests will be accepted as a second measure for determining eligibility for language therapy.

b. For children age three to 21: criterion-referenced tests will not be accepted as a second measure when determining eligibility for language therapy. (When use of standardized instruments is not appropriate, see Section 245.200, part D, paragraph 8).

c. Age birth to three: Eligibility for language therapy will be based upon a composite or quotient score that is -1.5 standard deviations (SD) below the mean or greater from a norm-referenced, standardized test, with corroborating data from a criterion-referenced measure. When these two measures do not agree, results from a third measure that corroborate the identified deficits are required to support the medical necessity of services.

d. Age three to 21: Eligibility for language therapy will be based upon 2 composite or quotient scores that are -1.5 standard deviations (SD) below the mean or greater. When -1.5 SD or greater is not indicated by both of these

scores, a third standardized score indicating a -1.5 SD or greater is required to support the medical necessity of services.

2. ARTICULATION AND/OR PHONOLOGY: Two tests and/or procedures must be administered, with at least one being from a norm-referenced, standardized test with good reliability and validity.

Eligibility for articulation and/or phonological therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two tests. When -1.5 SD or greater is not indicated by both of these tests, corroborating data from accepted procedures can be used to support the medical necessity of services. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

3. APRAXIA: Two tests and/or procedures must be administered, with at least one being a norm-referenced, standardized test with good reliability and validity.

Eligibility for apraxia therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two tests. When -1.5 SD or greater is not indicated by both of these tests, corroborating data from a criterion-referenced test and/or accepted procedures can be used to support the medical necessity of services. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

4. VOICE: Due to the high incidence of medical factors that contribute to voice deviations, a medical evaluation is a requirement for eligibility for voice therapy.

Eligibility for voice therapy will be based upon a medical referral for therapy and a functional profile of voice parameters that indicates a moderate or severe deficit/disorder.

5. FLUENCY: At least one norm-referenced, standardized test with good reliability and validity and at least one supplemental tool to address affective components.

Eligibility for fluency therapy will be based upon an SS of -1.5 SD below the mean or greater on the standardized test.

6. ORAL MOTOR/SWALLOWING/FEEDING: An in-depth, functional profile of oral motor structures and function.

Eligibility for oral motor/swallowing/feeding therapy will be based upon an in-depth functional profile of oral motor structures and function using a thorough protocol (e.g., checklist, profile) that indicates a moderate or severe deficit or disorder. When moderate or severe aspiration has been confirmed by videofluoroscopic swallow study, the patient can be treated for pharyngeal dysphagia via the recommendations set forth in the swallow study report.

7. All subtests, components and scores must be reported for all tests used for eligibility purposes.

8. When administration of standardized, norm-referenced instruments is inappropriate, the provider must submit an in-depth functional profile of the child's communication abilities. An in-depth functional profile is a detailed narrative or description of a child's communication behaviors that specifically explains and justifies the following:

a. The reason standardized testing is inappropriate for this child.

b. The communication impairment, including specific skills and deficits.

c. The medical necessity of therapy.

d. Supplemental instruments from Accepted Tests for Speech-Language Therapy may be useful in developing an in-depth functional profile.

9. Children (birth to age 21) receiving services outside of the schools must be evaluated annually.

10. Children (birth to 24 months) in the Child Health Management Services (CHMS) Program must be evaluated every 6 months.

11. Children (age three to 21) receiving services within schools as part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP) must have a full evaluation every three years; however, an annual update of progress is required.

12. Children (age three to 21) receiving privately contracted services, apart from or in addition to those within the schools, must have a full evaluation annually.

13. IQ scores are required for all children who are school age and receiving language therapy. Exception: IQ scores are not required for children under ten (10) years of age.

E. Progress Notes

1. Child's name.

2. Date of service.

3. Time in and time out of each therapy session.

4. Objectives addressed (should coincide with the plan of care).

5. A description of specific therapy services provided daily and the activities rendered during each therapy session, along with a form of measurement.

6. Progress notes must be legible.

7. Therapists must sign each date of entry with a full signature and credentials.

8. Graduate students must have the supervising speech-language pathologist co-sign progress notes.

245.210 Accepted Tests for Speech-Language Therapy 3-15-12

To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services manual.

245.220 Intelligence Quotient (IQ) Testing 11-1-10

Children receiving language intervention therapy must have cognitive testing once they reach ten (10) years of age. This also applies to home-schooled children. If the IQ score is higher than the qualifying language scores, then the child qualifies for language therapy; if the IQ score is lower than the qualifying language test scores, the child would appear to be functioning at or above expected level. In this case, the child may be denied for language therapy. If a provider determines that therapy is warranted, an in-depth functional profile must be submitted. However, IQ scores are not required for children under ten (10) years of age.

A. IQ Tests — Traditional

Test	Abbreviation
Stanford-Binet	S-B
The Wechsler Preschool & Primary Scales of Intelligence, Revised	WPPSI-R
Slosson	
Wechsler Intelligence Scale for Children, Third Edition	WISC-III
Kauffman Adolescent & Adult Intelligence Test	KAIT
Wechsler Adult Intelligence Scale, Third Edition	WAIS-III

Test	Abbreviation
Differential Ability Scales	DAS
Reynolds Intellectual Assessment Scales	RAIS

B. Severe and Profound IQ Test/Non-Traditional – Supplemental – Norm-Reference

Test	Abbreviation
Comprehensive Test of Nonverbal Intelligence	CTONI
Test of Nonverbal Intelligence – 1997	TONI-3
Functional Linguistic Communication Inventory	FLCI

245.300 Recoupment Process 7-1-15

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

Medicaid 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.

246.000 Appeal Process for Medicaid Beneficiaries 1-1-07

When an adverse decision for prior authorization of services is received from AFMC, the beneficiary may request a fair hearing of the reconsideration decision of the denial of services from the Department of Health and Human Services.

The appeal request must be in writing and received by the Appeals and Hearings Section of the Department of Health and Human Services within thirty days of the date on the letter from AFMC explaining the denial.

Submit appeal requests to the Department of Health and Human Services (DHHS), Appeals and Hearings Section. **View or print Appeals and Hearings Section contact information.**

250.000 REIMBURSEMENT

251.000 Method of Reimbursement 10-13-03

The reimbursement methodology for some Child Health Management Services (CHMS) 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 Child Health Management Services providers.

251.010 Fee Schedules 12-1-12

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at **https://www.medicaid.state.ar.us** 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.

252.000 Rate Appeal Process 1-1-07

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the decision of the Division of Medical Services Assistant Director is unsatisfactory, the provider may appeal to the standing Rate Review Panel established by the Director of the Division of Medical Services. This panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Health and Human Services Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

260.000 BILLING PROCEDURES

261.000 Introduction to Billing 7-1-07

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

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

262.000 CMS-1500 Billing Procedures

262.100 Child Health Management Services Procedure Codes

262.110 Diagnosis and Evaluation Procedure Codes 9-15-14

The following diagnosis and evaluation procedure codes are limited to two (2) diagnosis and evaluation encounters per state fiscal year (July 1 through June 30). If additional diagnosis and evaluation procedures are required, the CHMS provider must request an extension of benefits.

Procedure Codes							
92550	92551	92552	92553	92555	92557	92558	92567
92570	92582	92585	92586	92587	92588	96105	96111
96118*	99201	99202	99203	99204	99205		

*Effective for dates of service on and after March 1, 2006, procedure code 96117 was made non-payable and was replaced with procedure code 96118.

**(...)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.

Procedure Code	Required Modifier(s)	Description
90791	U9	**(Diagnostic evaluation/review of records (1 unit = 15 minutes), maximum of 3 units; limited to 6 units per state fiscal year)
90833	U9	**(Individual psychotherapy, insight oriented, behavior-modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes, face-to-face with the patient with medical evaluation and management services)
90836	U9	**(Individual psychotherapy, insight oriented, behavior-modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes, face-to-face with the patient with medical evaluation and management services)
90838	U9	**(Individual psychotherapy, insight oriented, behavior-modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes, face-to-face with the patient with medical evaluation and management services)
90887		Interpretation of diagnosis (1 unit = 15 minutes), maximum of 3 units; limited to 6 units per state fiscal year
92521	UA	**(Evaluation of speech fluency (e.g., stuttering, cluttering) (30-minute unit; maximum of 4 units per state fiscal year. July 1 through June 30)
92522	UA	**(Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthia) (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30)
92523	UA	**(Evaluation of speech production (e.g., articulation, phonological process, apraxia, dysarthia) with evaluation of language comprehension and expression (e.g., receptive and expressive language) (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30)
92524	UA	**(Behavioral and qualitative analysis of voice and resonance) (30-minute unit; maximum of 4 units per state fiscal year, July 1 through June 30)

Procedure Code	Required Modifier(s)	Description
96101	UA, UB	Psychological testing battery (1 unit = 15 minutes), maximum of 4 units; limited to 8 units per state fiscal year Effective for dates of service on and after March 1, 2006, procedure code 96100 was replaced with procedure code 96101.
97001		Evaluation for physical therapy (1 unit = 30 minutes), maximum of 4 units per state fiscal year
97003		Evaluation for occupational therapy (1 unit = 30 minutes), maximum of 4 units per state fiscal year
97802		Nutrition Screening: Review of recent nutrition history, medical record, current laboratory and anthropometric data and conference with patient, caregiver or other CHMS professional (1 unit = 15 minutes). Maximum of 2 units; limited to 4 units per state fiscal year
97802	U1	Nutrition Assessment: Assessment/evaluation of current nutritional status through history of nutrition, activity habits and current laboratory data, weight and growth history and drug profile; determination of nutrition needs; formulation of medical nutrition therapy plan and goals of treatment; a conference will be held with parents and/or other CHMS professionals or a written plan for medical nutrition therapy management will be provided (1 unit = 15 minutes). Maximum of 2 units; limited to 4 units per state fiscal year
97802	U2	Comprehensive Nutrition Assessment: Assessment/ evaluation of current nutritional status through initial history of nutrition, activity and behavioral habits; review of medical records; current laboratory data, weight and growth history, nutrient analysis and current anthropometric data (when available); determination of energy, protein, fat, carbohydrate and macronutrient needs; formulation of medical nutrition therapy plan and goals of treatment. May conference with parent(s)/guardian or caregivers and/or physician for implementation of medical nutrition therapy management or provide a written plan for implementation (1 unit = 15 minutes). Maximum of 4 units; limited to 8 units per state fiscal year

262.120 Treatment Procedure Codes 7-1-17

The following treatment procedures are payable for services included in the child's treatment plan. Prior authorization is required for *all* CHMS treatment procedures. See Section 240.000 of this manual for prior authorization requirements. See Glossary - Section IV - for definitions of "individual" and "group" as they relate to therapy services.

Procedure Codes				
90847	90849	97762*	99211	99212
99213	99214	99215		

*Effective for dates of service on and after March 1, 2006, procedure code 97703 was made non-payable and was replaced with procedure code 97762.

Procedure Code	Required Modifier(s)	Description
T1024		Brief Consultation, on site — A direct service contact by a CHMS professional on-site with a patient for the purpose of: obtaining the full range of needed services; monitoring and supervising the patient's functioning; establishing support for the patient and gathering information relevant to the patient's individual treatment plan.
T1024	U1	Collateral Services, on site — Face-to-face contact on site by a CHMS professional with other professionals, caregivers or other parties on behalf of an identified patient to obtain or provide relevant information necessary to the patient's assessment, evaluation or treatment.
90846	U4	Family therapy, on-site, for therapy as part of the treatment plan, without the patient present (1 unit = 15 minutes)
90847	U4	Family therapy, on site, for therapy as part of the treatment plan, with the patient present (1 unit = 15 minutes)
99367	UA	Treatment Plan — Plan of treatment developed by CHMS professionals and the patient'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 = 15 minutes).
H2011	—	Crisis Management Visit, on site — An unscheduled/ unplanned direct service contact on site with the identified patient for the purpose of preventing physical injury, inappropriate behavior or placement in a more restrictive service delivery system (1 unit = 15 minutes)
S9470	—	Nutrition Counseling/Consultation — Conference with parent/guardian and/or PCP to provide results of evaluation, discuss medical nutrition therapy plan and goals of treatment and education. May provide detailed menus for home use and information on sources of special nutrition products (1 unit = 30 minutes)
90832	U9	**(Individual psychotherapy, insight-oriented, behavior-modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes, face-to-face with the patient)
90834	U9	**(Individual psychotherapy, insight-oriented, behavior-modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes, face-to-face with the patient)
90837	U9	**(Individual psychotherapy, insight-oriented, behavior-modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes, face-to-face with the patient)
90853	—	Group Psychotherapy/counseling (1 unit = 5 minutes)
92507	—	Individual Speech Session by Speech-Language Pathology Therapist (1 unit = 15 minutes), maximum of 6 units per week

Procedure Code	Required Modifier(s)	Description
92507	UB	Individual Speech Therapy by Speech-Language Pathology Assistant (1 unit = 15 minutes), maximum of 6 units per week
92508	—	Group Speech Session by Speech-Language Pathology Therapist (1 unit = 15 minutes), maximum of 6 units per week, maximum of 4 clients per group
92508	UB	Group Speech Therapy by Speech-Language Pathology Assistant (1 unit = 15 minutes), maximum of 6 units per week, maximum of 4 clients per group
97110	—	Individual Physical Therapy by Physical Therapist (1 unit = 15 minutes), maximum of 6 units per week
97110	UB	Individual Physical Therapy by Physical Therapy Assistant (1 unit = 15 minutes), maximum of 6 units per week
97150	—	Group Physical Therapy by Physical Therapist (1 unit = 15 minutes), maximum of 6 units per week, maximum of 4 clients per group
97150	U2	Group Occupational Therapy by Occupational Therapist (1 unit = 15 minutes), maximum of 6 units per week, maximum of 4 clients per group
97150	U1, UB	Group Occupational Therapy by Occupational Therapy Assistant (1 unit = 15 minutes), maximum of 6 units per week, maximum of 4 clients per group
97150	UB	Group Physical Therapy by Physical Therapy Assistant (1 unit = 15 minutes), maximum of 6 units per week, maximum of 4 clients per group
97530	—	Individual Occupational Therapy by Occupational Therapist (1 unit = 15 minutes), maximum of 6 units per week
97530	UB	Individual Occupational Therapy by Occupational Therapy Assistant (1 unit = 15 minutes), maximum of 6 units per week
97530	U1	Developmental Motor Activity Services — Individualized activities provided by, or under the direction of, an Early Childhood Developmental Specialist to improve general motor skills by increasing coordination, strength and/or range of motion. Activities will be directed toward accomplishment of a motor goal identified in the patient's individualized treatment plan as authorized by the responsible CHMS physician (1 unit = 15 minutes)
97532	—	Cognitive Development Services — Individualized activities to increase the patient's intellectual development and competency. Activities will be those appropriate to carry out the treatment plan for the patient as authorized by the responsible CHMS physician. Cognitive Development Services will be provided by or under the direction of an Early Childhood Developmental Specialist. Activities will address goals of cognitive and communication skills development: (1 unit = 15 minutes).

Procedure Code	Required Modifier(s)	Description
97535	UB	Self Care and Social/Emotional Developmental Services — Individualized activities provided by or under the direction of an Early Childhood Developmental Specialist to increase the patient's self-care skills and/or ability to interact with peers or adults in a daily life setting/situation. Activities will be those appropriate to carry out the treatment plan for the patient as authorized by the responsible CHMS physician. (1 unit = 15 minutes).
97803	—	Nutrition follow-up: Reassess recent nutrition history, new anthropometer and laboratory data to evaluate progress toward meeting medical nutritional goals. May include a conference with parent or other CHMS professional (1 unit = 15 minutes).

Medicaid will reimburse up to six (6) occupational, physical and speech therapy units (1 unit = 15 minutes) weekly, per discipline, without authorization. Additional daily therapy units will require an extended therapy request for beneficiaries under age 21.

Please refer to the Occupational, Physical, Speech Therapy Services Manual for further instructions regarding prior authorization protocol.

262.130 CHMS Procedure Codes – Foster Care Program 7-1-17

Refer to Section 202.000 of this manual for Arkansas Medicaid Participation Requirements for Providers of Comprehensive Health Assessments for Foster Children.

The following procedure codes are to be used for the mandatory comprehensive health assessments of children entering the Foster Care Program. These procedures *do not* require prior authorization.

**(...)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.

Procedure Code	Required Modifier(s)	Description
T1016		Informing (1 unit = 15 minutes), maximum of 4 units
T1023		Staffing (1 unit = 15 minutes), maximum of 4 units
T1025		Developmental Testing
90791	U1, U9	Diagnostic Interview, includes evaluation and reports (1 unit = 15 minutes), maximum of 8 units
92521	U1, UA	**(Evaluation of speech fluency (e.g., stuttering, cluttering) (1 unit = 15 minutes; maximum of 4 units)
92522	U1, UA	**(Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthia) (1 unit = 15 minutes; maximum of 4 units)

Procedure Code	Required Modifier(s)	Description
92523	U1, UA	**(Evaluation of speech production (e.g., articulation, phonological process, apraxia, dysarthia) with evaluation of language comprehension and expression (e.g. receptive and expressive language) (1 unit = 15 minutes; maximum of 4 units)
92524	U1, UA	**(Behavioral and qualitative analysis of voice and resonance) (1 unit = 15 minutes; maximum of 4 units)
92551	U1	Audio Screen
92567	U1	Tympanometry
92587**	U1	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)
95961	UA	Cortical Function Testing
96101*	U1, UA	Psychological Testing, 2 or more (1 unit = 15 minutes), maximum of 8 units
96101*	UA	Interpretation (1 unit = 15 minutes), maximum of 8 units
99173		Visual Screen
99205 99215	U1 U1	High Complex medical exam

*Effective for dates of service on and after March 1, 2006, procedure code 96100 was made non-payable and was replaced with procedure code 96101.

**Effective for dates of service on and after January 1, 2007, procedure code 92587 is payable.

262.200 National Place of Service (POS) Codes 7-1-07

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

Place of Service	POS Codes
Doctor's Office	11

262.300 Billing Instructions – Paper Only 11-1-17

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 the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. **View or print the 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.

262.310 Completion of CMS-1500 Claim Form 9-1-14

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	
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.

Field Name and Number	Instructions for Completion
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.
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.

Field Name and Number	Instructions for Completion
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 CHMS services. If services are the result of a Child Health Services (EPSDT) screening/referral, enter the referral source, including name and title.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. ADDITIONAL CLAIM INFORMATION	For tracking purposes, occupational, physical and speech therapy providers are required to enter one of the following therapy codes: Code — Category A — Individuals from birth through 2 years who are receiving therapy services under an Individualized Family Services Plan (IFSP) through the Division of Developmental Disabilities Services.

Field Name and Number	Instructions for Completion
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.**
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).

Field Name and Number	Instructions for Completion
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.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	

Field Name and Number	Instructions for Completion
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 #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.
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)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

252.400 Special Billing Procedures 10-13-03

Not applicable to this program.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

P.O. Box 1437, Slot S295 · Little Rock, AR 72203-1437
501-320-6428 · Fax: 501-404-4619
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TO: **Arkansas Medicaid Health Care Providers – Developmental Day Treatment Clinic Services**

EFFECTIVE DATE: **July 1, 2018**

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

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

Explanation of Updates

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

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

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

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

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

Thank you for your participation in the Arkansas Medicaid Program.

Rose M. Naff
Director

SECTION II - DEVELOPMENTAL DAY TREATMENT CLINIC SERVICES (DDTCS)

CONTENTS

200.000 DEVELOPMENTAL DAY TREATMENT CLINIC SERVICES (DDTCS) GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Developmental Day Treatment Clinic Services (DDTCS) Providers 11-1-09

DDTCS 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 DDTCS must be licensed as a Developmental Day Treatment clinic by the Division of Developmental Disabilities Services (DDS), Arkansas Department of Human Services.

B. A copy of the current license must accompany the provider application and the Medicaid contract.

201.100 Providers of DDTCS Services in Arkansas and Bordering States 10-13-03

Developmental day treatment clinic services (DDTCS) providers in Arkansas and the six bordering states (Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas) may be enrolled as routine services providers if they meet all Arkansas Medicaid participation requirements outlined above.

DDTCS providers may furnish and claim reimbursement for covered services in the Arkansas Medicaid Program subject to benefit limits and coverage restrictions set forth in this manual. Claims must be filed according to the specifications in this manual.

201.200 DDTCS Providing Occupational, Physical, or Speech Therapy 8-15-08

Optional services available through DDTCS include occupational, physical and speech therapy and evaluation as an essential component of the plan of care for an individual accepted for developmental disabilities services. Therapy services are not included in the core services and are provided in addition to the core services (see Sections 214.210 and 215.200 of this manual for additional requirements for provision of therapy services).

A DDTCS facility may contract with or employ qualified therapy practitioners. Effective for dates of service on and after October 1, 2008, the individual therapy practitioner who actually performs a service on behalf of the DDTCS facility must be identified on the claim as the performing provider when the DDTCS 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.

202.000 Documentation Requirements

202.100 Documentation Requirements for All Medicaid Providers 11-1-09

See Section 141.000 for the documentation that is required for all Medicaid providers.

202.200 Clinical Records DDTCS Providers Must Keep 10-1-17

A. Providers must establish and maintain medical records for each beneficiary that include documentation of medical necessity for DDTCS services and a plan of care.

B. For each beneficiary who is under 18, the record must include the result of the annual developmental screen performed by the Department of Human Services' Third-Party Vendor or an approved medical diagnosis exemption of the developmental screen in accordance with the Provider Manual Governing Independent Assessments and Developmental Screens.

C. Sufficient written documentation for each beneficiary record must support the medical or remedial therapy services provided. This requirement applies to core services and optional services. Refer to Sections 214.000 through 214.210 of this manual for description of services.

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

1. The specific services furnished daily,
2. The date and actual beginning and ending time of day the services were performed daily,
3. Name(s) and title(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 individualized plan of care, and
5. At a minimum, weekly progress notes, signed or initialed by the person providing the service(s), describing each beneficiary's status with respect to his or her goals and objectives.

202.300 Electronic Signatures 10-8-10

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

203.000 Referral to First Connections Program Pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) 10-1-17

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.

Each DDTCS must, within two (2) working days of receipt of referral of an infant or toddler thirty-six (36) months of age or younger, present the family with DDS approved information about the Part C program, First Connections, so that the parent/guardian can make an informed choice regarding early intervention options. Each DDTCS must maintain appropriate documentation of parent choice in the child record.

204.000 Election to Provide Special Education Services in Accordance with Part B of the Individuals with Disabilities Education Act (IDEA) 10-1-17

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 DDTCS with the option of participating in Part B as a LEA. Participation as a LEA requires a DDTCS 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 DDTCS 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 DDTCS 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 as follows:

A. Opt in: A DDTCS that elects to provide Special Education Services to all children with disabilities it is serving aged three (3) until entry into Kindergarten must follow Arkansas Department of Education Procedural Requirements and Program Standards for Special Education and comply with Part B at all times. Failure by a DDTCS to provide all required Special Education Services in compliance with the above will result in a loss of Part B funds.

B. Opt out: A DDTCS that elects not to provide Special Education Services to all children with disabilities it is serving aged three (3) until entry into kindergarten must perform the following:

1. Prior to delivering any services to a child age three (3) or older who has or is suspected of having a disability under Part B, the DDTCS must complete a Special Education Referral Form (or any successor form), and submit it to the appropriate LEA. The DDTCS will be responsible for maintaining documentation evidencing that a timely and properly completed referral was provided to the appropriate LEA.

2. The DDTCS must complete a Special Education Referral Form (or any successor form), and submit it to the appropriate LEA at least ninety (90) days prior to the third (3^{rd}) birthday of any child who has or may have a disability under Part B that is being served by the DDTCS. The DDTCS will be responsible for maintaining documentation evidencing that a timely and properly completed referral was provided to the appropriate LEA.

3. For any child who has a disability under Part B served by the DDTCS that will be entering kindergarten in a calendar year, the DDTCS must complete a referral form and submit it to the LEA where the child will attend kindergarten by February 1 of that year. The DDTCS will be responsible for maintaining documentation evidencing that a timely and properly completed referral was provided to the appropriate LEA.

A DDTCS may change its election at any time; however, a decision to change will only be effective as of July 1st. A DDTCS must inform DDS of its intent to change its election no later than March 1st for its election to be effective as of July 1st of the same calendar year. Any decision to change an election received by DDS after March 1st will not be effective until July 1st of the next calendar year. Any time a DDTCS elects to cease providing Special Education Services, the DDTCS must complete a Special Education Referral Form (or any successor form) for each child age three (3) or older it is currently serving, and submit each one to the appropriate LEA.

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

210.000 PROGRAM COVERAGE

211.000 Introduction 11-1-06

Medicaid assists eligible individuals to obtain medical care in accordance with the guidelines specified in Section I of this manual. Reimbursement may be made for covered developmental day treatment clinic services provided to Medicaid beneficiaries at qualified provider facilities.

212.000 Scope 10-1-17

A. Developmental day treatment clinic services in qualified facilities may be covered only when they are:

1. Provided to outpatients
2. Determined medically necessary for the beneficiary
3. Provided pursuant to a written prescription by a physician
4. Provided in accordance with an individualized written plan of care

B. Outpatients are individuals who travel to and from a treatment site on the same day, who do not reside in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) and who are not inpatients of a hospital.

C. Please refer to Sections 215.000 through 216.100 of this manual for details regarding medical necessity and plans of care.

D. Beneficiaries who are enrolled in a program that is dually certified as a DDTCS and CHMS cannot be billed under both programs during the same enrollment period. An enrollment period is defined as the twelve (12) months of allowed billing after the developmental screen is administered and a prescription is written for CHMS or DDTCS services for the beneficiary.

Beneficiaries who continue to qualify for either DDTCS or CHMS during the enrollment period can transfer to another CHMS or DDTCS program based on parent choice. These beneficiaries do not have to undergo another developmental screen.

Beneficiaries who graduate or no longer qualify for DDTCS or CHMS before the end of the enrollment period must be referred to the third party vendor for a developmental screen and obtain a new prescription before they can be reenrolled in a DDTCS or CHMS program.

213.000 Non-Covered Services 10-13-03

Non-covered services include, but are not limited to:

A. Diagnosis and evaluation services, pre-school services and adult development services less than 1 hour in length,

B. Early intervention services less than 2 hours in length,

C. Supervised living services,

D. Educational services and

E. Services to inpatients.

A developmental day treatment clinic must provide only those services that the Division of Developmental Disabilities Services licenses the DDTCS clinic to provide.

214.000 Coverage of DDTCS Services

214.100 DDTCS Core Services 10-13-03

A. Developmental Day Treatment Clinic Services (DDTCS) may be furnished only by DDS licensed comprehensive day treatment centers offering as core services:

1. Diagnosis and Evaluation and
2. Habilitation.

B. DDTCS core services are provided at three levels of care. The levels of care are:

1. Early Intervention,
2. Pre-School and
3. Adult Development.

214.110 Diagnosis and Evaluation (D&E) 10-1-17

Diagnosis and evaluation services (D&E) constitute the process of determining a person's eligibility for habilitation services in one of the three levels of care.

D&E services are covered separately from DDTCS habilitation training services. D&E services are reimbursed on a per unit basis with one unit equal to one hour of service. 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.

D&E services are covered once each calendar year if the service is deemed medically necessary by a physician. For children in the early intervention and pre school levels of care, the child must be determined to need D&E services by the developmental screen conducted in accordance with the Manual Governing Independent Assessments and Developmental Screens.

If the physician or DDTCS provider believes that the child has a significant developmental diagnosis, disability, or delay such that he or she does not need a developmental screen, the physician or DDTCS provider may send relevant documentation for review by the Third Party Assessor's clinician. The Clinician will determine the necessity of a developmental screen.

214.120 Habilitation 10-1-17

A. Habilitation is instruction in areas of self help, socialization, communication, or cognitive development; or to reinforce skills learned and practiced in occupational, physical, or speech therapy. Habilitation activities must be designed to teach habilitation goals and objectives specified in the client's individualized plan of care. (Refer to Section 216.000 of this manual.)

B. Medicaid covers habilitation services only in clinical settings licensed by DDS and enrolled in Medicaid.

C. DDTCS providers must ensure that a noon meal is available to each Medicaid beneficiary who receives at least four hours of DDTCS core services in a day and who is unable to provide his or her own meal on the date of the core services.

1. When being responsible for providing his or her own meal is a component of a beneficiary's plan of care, the provider may request the beneficiary furnish the meal.

2. A beneficiary may not be charged for a meal the facility provides, whether or not providing his or her own meal is included in the client's individualized plan of care.

214.130 Levels of Care

214.131 Early Intervention 7-15-12

Early intervention is a facility-based program designed to provide one-on-one direct training to the child *and* the parent or caregiver. The intent of early intervention is to work with parents and caregivers to assist them with training the child. The parent or caregiver of the child must participate in the programming to learn how to work with the child in the home.

A. To be eligible for early intervention services, the child must be an individual with a developmental disability or developmental delay and must not be school age. School age is defined as having reached the age of five years on or before the date set by the Arkansas Department of Education. A child reaching age five after that date is not considered school age until the next school year.

B. Early intervention services must include training the parent or caregiver in meeting the needs of the child and in meeting the goals of the care plan.

C. Coverage is limited to one encounter per day. An early intervention encounter includes the time spent on preparation and service documentation as well as the direct training. Each early intervention encounter must be two hours or more in duration. At each encounter, a minimum of one hour of direct training with the child and the parent or caregiver is required.

214.132 Pre-School 7-15-12

Pre-school service is a facility-based program designed to provide specialized services to children who have been diagnosed with a developmental disability or developmental delay and who are not school age. School age is defined as having reached the age of five years on or before the date set by the Arkansas Department of Education. A child reaching age five after that date is not considered school age until the next school year.

Services must be provided for the purpose of teaching habilitation goals as set forth in the plan of care. Services are established on a unit-of-service basis. Each unit of service equals one hour. A maximum of five units per day is allowed.

Time spent in transit from the person's place of residence to the provider facility and from the facility back to the person's place of residence is not included in the unit of service calculation.

214.133 Adult Development 7-15-12

Adult development is a facility-based program providing specialized habilitation services to adults who have been diagnosed with a developmental disability. Qualifying individuals must be between ages 18 and 21 with a diploma or certificate of completion, or age 21 and older.

A. Adult development services may include prevocational services that prepare a person for employment. Prevocational services:

1. May *not* be job-task oriented, but

2. May include such *habilitation* goals as compliance, attending, task completion, problem solving and safety, and

3. May be provided only to persons who are not expected to be able to join the general work force or to participate in a transitional sheltered workshop within one year (excluding supported employment programs).

B. Prevocational services may not be primarily directed at teaching specific job skills. All prevocational services must be listed in the plan of care as habilitation and may not address explicit employment objectives. The person's compensation must be less than 50% of minimum wage in order for the training to qualify as prevocational services. Commensurate wage must be paid under a current Wage and Hour Sheltered Workshop Certificate.

C. Documentation must be maintained in each person's file showing that the services are not available under a program funded under Section 110 of the Rehabilitation Act of 1973, as amended, or the Individuals with Disabilities Education Act of 1997.

Adult development services are established on a unit-of-service basis. Each unit of service equals one hour in the facility with a maximum of five units reimbursable per day.

Time spent in transit from the person's place of residence to the provider facility and from the facility back to the person's place of residence is not included in the unit of service calculation.

214.200 DDTCS Optional Services

214.210 Occupational, Physical and Speech Therapy 7-1-17

Optional services available through DDTCS include occupational, physical and speech therapy and evaluation as an essential component of the plan of care for an individual accepted for developmental disabilities services. Therapy services are not included in the core services and are provided in addition to the core services. Procedural and benefit differences are based on the beneficiaries age (under age 21 and over age 21 yrs).

A. The DDTCS client's primary care physician (PCP) or attending physician must refer a client for evaluation for occupational, physical or speech therapy services. For clients under the age of 21, the use of form DMS-640 is required. **View or print form DMS-640.** The DDTCS client's primary care physician (PCP) or attending physician must also prescribe occupational, physical and/or speech therapy services and again, for clients under the age of 21, the use of an additional form DMS-640 is required for the prescription. The prescribed therapy must be included in the individual's DDTCS plan of care. A copy of the prescription must be maintained in the beneficiary's records. The original prescription is to be maintained by the physician. After the initial referral and initial prescription, subsequent referrals and prescriptions for continued therapy may be made at the same time using the same DMS-640 for clients under age 21. Instructions for completion of form DMS-640 are located on the back of the form. Medicaid will accept an electronic signature provided it is compliance with Arkansas Code 25-31-103.

B. Therapies in the DDTCS Program may be provided only to individuals whose plan of care includes one of the three levels of care (early intervention, pre-school or adult development). Medicaid does not cover optional therapy services furnished by a DDTCS provider as "stand-alone" services. To ensure quality care, group therapy sessions are limited to no more than four persons in a group.

1. When a DDTCS provider renders therapy services in conjunction with a DDTCS core service, therapy services must be billed by the DDTCS provider according to billing instructions in Section II of this manual.

2. DDTCS providers may not bill under the Medicaid Occupational, Physical and Speech Therapy Program for therapy services available in the DDTCS Program and provided to DDTCS clients.

3. Therapy services may not be provided during the same time period DDTCS core services are provided.

C. Arkansas Medicaid applies the following therapy benefits to all therapy services provided in the DDTCS program:

1. Medicaid will reimburse up to four (4) occupational, physical and speech therapy evaluation units (1 unit = 30 minutes) per discipline, per state fiscal year (July 1 through June 30) without authorization. Additional evaluation units for beneficiaries under age 21 will require an extended therapy request.

2. Medicaid will reimburse up to six (6) occupational, physical and speech therapy units (1 unit = 15 minutes) weekly, per discipline, without authorization. Additional daily therapy units will require an extended therapy request for beneficiaries under age 21.

3. All requests for extended therapy services must comply with Sections 217.000 through 217.100 for beneficiaries under age 21.

4. All requests for benefit extensions for therapy services provided in the DDTCS program to beneficiaries age 21 years and over must comply with Sections 217.700 through 217.800.

D. Make-up therapy sessions are covered for beneficiaries under age 21 in the event a therapy session is canceled or missed, if determined medically necessary and prescribed by the beneficiary's PCP. A make-up therapy session requires a separate prescription from the original previously received. Form DMS-640 must be used by the PCP for make-up therapy session prescriptions for beneficiaries under age 21.

E. Therapy services carried out by an unlicensed therapy student may be covered only when the following criteria are met:

1. Therapies performed by an unlicensed student must be under the direction of a licensed therapist and the direction is such that the licensed therapist is considered to be providing the medical assistance.

2. The licensed therapist must be present and engaged in student oversight during the entirety of any encounter.

214.500 Occupational, Physical and Speech Therapies Provided in the DDTCS Program For Beneficiaries 21 Years of Age and Older 7-1-17

A. Medicaid will reimburse up to four (4) occupational, physical and speech therapy evaluation units (1 unit = 30 minutes) per discipline, for an eligible beneficiary, per state fiscal year (July 1 through June 30).

B. Medicaid will reimburse up to six (6) occupational, physical and speech therapy units (1 unit = 15 minutes) weekly, per discipline, for an eligible beneficiary.

C. All requests for benefit extensions for therapy services for beneficiaries over age 21 must comply with Sections 217.700 through 217.800.

215.000 Establishing Medical Necessity for DDTCS

215.100 Establishing Medical Necessity for Core Services 10-1-17

Reimbursement for covered services will be approved only when the individual's attending physician has determined DDTCS core services are medically necessary.

A. The physician must identify the individual's medical needs that habilitation training can address.

B. To initiate DDTCS services the individual's physician must issue a written prescription. The prescription for DDTCS is valid for one year unless the prescribing physician specifies a shorter period of time. The prescription must be renewed at least once a year for services to continue.

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

D. For beneficiaries under age 18, the prescription must be based on the result of the developmental screen performed by DHS' Third-Party Assessor, as well as the results of the D&E.

215.290 Establishing Medical Necessity for Optional Services 3-1-10

A. Occupational, physical and speech therapy services for Medicaid beneficiaries under age 21 require a *referral* from the client's primary care physician (PCP) or attending physician if the individual is exempt from mandatory PCP referral requirements. The *referral* for occupational, physical and speech therapy services must be renewed every six months. The PCP or attending physician is responsible for determining medical necessity for therapy treatment.

B. A written *prescription* for therapy services is required and is valid for one year unless the prescribing physician specifies a shorter period.

215.300 Definition of Developmental Diagnosis 10-1-17

A. A developmental disability:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. The disability has continued or is expected to continue indefinitely.

C. The disability constitutes a substantial handicap to the beneficiary's ability to function without appropriate support services.

216.000 Plan of Care 11-1-06

For each beneficiary who enters the DDTCS Program, an individualized plan of care must be developed. This consists of a written, individualized plan to improve the beneficiary's condition. The plan of care must contain a written description of the treatment objectives for the beneficiary. It also must describe:

A. The treatment regimen—the specific medical and remedial services, therapies and activities that will be used to achieve the treatment objectives.

B. A schedule for service delivery—this includes the frequency and duration of each type of therapeutic session or encounter.

C. The job titles or credentials of personnel that will furnish each service.

D. A schedule for completing reevaluations of the beneficiary's condition and updating the plan of care.

The plan of care may be authorized only by the physician determining that DDTCS services are medically necessary. The physician's original personal signature and the date signed must be recorded on the plan of care. Delegation of this function or a stamped signature is not allowed.

~~216.100 Periodic Review of Plan of Care~~ ~~11-1-06~~

~~DDTCS staff must periodically review the plan of care to assess the appropriateness of services, the beneficiary's status with respect to treatment objectives and his or her need for continued participation in the program. The reviews must be performed at least every 90 days and documented in detail in the individual's case file.~~

~~The beneficiary's physician must authorize (by dated original signature) any revisions to the plan of care for any reason.~~

~~217.000 Procedures for Requesting Extension of Benefits/Prior Approval for Therapy Services for Occupational, Physical and Speech Therapy (Evaluation or Treatment)~~ ~~10-1-17~~

~~A. Requests for extension of benefits/prior approval of therapy services for beneficiaries must be submitted to the Quality Improvement Organization (QIO) under the contract to the Arkansas Medicaid Program via mail, fax or electronically. View or print the QIO contact information. The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.~~

~~1. Requests will be considered when the initial prescription is written, with documentation that extended benefits are medically necessary and that outcomes can be achieved.~~

~~2. The request must be received by the QIO and processed before the provider may bill for extended benefits.~~

~~B. Form DMS-671, Request for Extension of Benefits for Clinical, Outpatient, Laboratory, and X-Ray Services, must be utilized for requests for extended therapy services. View or print form DMS-671. Consideration of requests requires correct completion of all fields on this form. The instructions for completion of this form are located on the back of the form. The provider must sign, include credentials and date the request. An electronic signature is accepted provided it is in compliance with Arkansas Code 25-31-103. All applicable records that support the medical necessity of the request should be attached.~~

~~C. The QIO will approve, deny, or ask for additional information, within 3 business days of receiving a completed request. QIO reviewers will simultaneously advise the provider and the beneficiary when a request is denied. Approved requests will be returned to the provider with an authorization number that is required to be submitted with the billing for the approved services in order to obtain Medicaid payment.~~

~~217.100 Documentation Requirements for Extension of Benefits/Prior Approval of Therapy Benefits~~ ~~10-1-17~~

~~A. To request extension of benefits/prior approval of therapy services, all applicable documentation that support the medical necessity of extended benefits are required.~~

~~B. Documentation requirements are as follows. Clinical records must:~~

~~1. Be legible and include documentation supporting the medical necessity of the specific request and include expected outcomes.~~

~~2. Be signed (with credentials) by the performing provider.~~

~~3. Include the physician referral and prescription for additional therapy based on clinical records and progress reports furnished by the performing provider.~~

~~218.000 Administrative Reconsideration of Extension of Benefits/Prior Approval of Therapy Services Denial~~ ~~10-1-17~~

A. A request for administrative reconsideration of a denial of a request for extension of benefits/prior approval of therapy must be in writing and sent to the QIO within 30 calendar days of the denial. The request must include a copy of the denial letter and additional supporting documentation.

B. The deadline for receipt of the reconsideration request will be enforced pursuant to Sections 190.012 and 190.013 of this manual. A request received by the QIO with 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days of a denial will be considered on an individual basis. Reconsideration requests must be mailed and will not be accepted via facsimile or email.

218.100 Appeal Process 10-1-17

When the Division of Medical Services (DMS) denies coverage of services, the beneficiary may request a fair hearing to appeal the denial of services from the Department of Human Services. (See DDS Policy 1076.)

The appeal request must be in writing and received by the appropriate office within thirty (30) days of the date of the denial notification. (See Sections 160.000 and 190.000.)

219.000 Utilization Review 11-1-06

A. The Utilization Review Section of the Arkansas Medicaid Program has the responsibility for assuring quality medical care for Medicaid beneficiaries and for protecting the integrity of state and federal funds supporting the Medical Assistance Program. These responsibilities are mandated by federal regulations.

B. The Utilization Review team shall:

1. Conduct on-site medical audits for the purpose of verifying the nature and extent of services paid for by the Medicaid Program,
2. Research all inquiries from beneficiaries in response to the Explanation of Medicaid Benefits and
3. Retrospectively evaluate medical practice patterns and providers' patterns by comparing each provider's pattern to norms and limits set by all the providers of the same specialty. Prior authorization is not required for DDTCS core service or for occupational, physical and speech therapy services.

220.000 Guidelines for Retrospective Review of Occupational, Physical and Speech Therapy Services 10-1-17

Arkansas Medicaid conducts retrospective review of the first 90 minutes per week of occupational, physical and speech therapy 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. **View or print QIO contact information.**

Specific guidelines have been developed for occupational, physical and speech therapy retrospective reviews. These guidelines may be found in Sections 220.100 through 220.220.

220.100 Occupational and Physical Therapy Guidelines 10-1-17

A. Medical Necessity

Occupational and physical therapy services must be medically necessary to the treatment of the individual's illness or injury. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The services must be of such a level of complexity or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified physical or occupational therapist.
3. There must be reasonable expectation that therapy will result in a meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition (See the medical necessity definition in the Glossary of this manual).

B. Evaluation and Report Components

To establish medical necessity, a comprehensive assessment in the suspected area of deficit must be performed. A comprehensive assessment must include:

1. Date of evaluation.
2. Child's name and date of birth.
3. Diagnosis specific to therapy.
4. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

   NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

   7 months - [(40 weeks) - 28 weeks) / 4 weeks]

   7 months - [(12) / 4 weeks]

   7 months - [3]

   4 months

5. Standardized test results, including all subtest scores, if applicable. Test results must be reported as standard scores, Z scores, T scores or percentiles. Age-equivalent scores and percentage of delay cannot be used to qualify for services.
6. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.
7. Objective information describing the child's gross/fine motor abilities/deficits, e.g., range of motion measurements, manual muscle testing, muscle tone or a narrative description of the child's functional mobility skills (strengths and weaknesses).
8. An interpretation of the results of the evaluation, including recommendations for therapy/minutes per week.
9. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.
10. Signature and credentials of the therapist performing the evaluation.

C. Interpretation and Eligibility: Ages Birth to 21

1. Tests used must be norm-referenced, standardized and specific to the therapy provided.
2. Tests must be age appropriate for the child being tested.
3. All subtests, components and scores must be reported for all tests used for eligibility purposes.
4. Eligibility for therapy will be based upon a score of -1.5 standard deviations (SD) below the mean or greater in at least one subtest area or composite score on a norm-referenced, standardized test. When a -1.5 SD or greater is not indicated by the test, a criterion-referenced test along with informed clinical opinion must be included to support the medical necessity of services.
5. If the child cannot be tested with a norm-referenced standardized test, criterion-based testing or a functional description of the child's gross/fine motor deficits may be used. Documentation of the reason why a standardized test could not be used must be included in the evaluation.
6. The *Mental Measurement Yearbook (MMY)* is the standard reference to determine reliability and validity. Refer to "Accepted Tests" sections for a list of standardized tests accepted by the Arkansas Medicaid program.
7. Range of Motion: A limitation of greater than ten degrees and/or documentation of how deficit limits function.
8. Muscle Tone: Modified Ashworth Scale.
9. Manual Muscle Test: A deficit is a muscle strength grade of fair (3/5) or below that impedes functional skills. With increased muscle tone, as in cerebral palsy, testing is unreliable.
10. Transfer Skills: Documented as amount of assistance required to perform transfer, e.g., maximum, moderate or minimal assistance. A deficit is defined as the inability to perform a transfer safely and independently.
11. Children (birth to age 21) receiving services outside of the public schools must be evaluated annually.
12. Children (birth to age 2) in the Child Health Management Services (CHMS) program must be evaluated every 6 months.
13. Children (age three to 21) receiving services within public schools, as a part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP), must have a full evaluation every three years; however, an annual update of progress is required.

D. Frequency, Intensity and Duration of Physical and/or Occupational Therapy Services

The frequency, intensity and duration of therapy services should always be medically necessary and realistic for the age of the child and the severity of the deficit or disorder. Therapy is indicated if improvement will occur as a direct result of these services and if there is a potential for improvement in the form of functional gain.

1. Monitoring: May be used to ensure that the child is maintaining a desired skill level or to assess the effectiveness and fit of equipment such as orthotics and other durable medical equipment. Monitoring frequency should be based on a time interval that is reasonable for the complexity of the problem being addressed.
2. Maintenance Therapy: Services that are performed primarily to maintain range of motion or to provide positioning services for the patient do not qualify for physical or occupational therapy services. These services can be provided to the child as part of a home program implemented by the child's caregivers and do not necessarily require the skilled services of a physical or occupational therapist to be performed safely and effectively.

3. Duration of Services: Therapy services should be provided as long as reasonable progress is made toward established goals. If reasonable functional progress cannot be expected with continued therapy, then services should be discontinued and monitoring or establishment of a home program should be implemented.

E. Progress Notes

1. Child's name.
2. Date of service.
3. Time in and time out of each therapy session.
4. Objectives addressed (should coincide with the plan of care).
5. A description of specific therapy services provided daily and the activities rendered during each therapy session, along with a form measurement.
6. Progress notes must be legible.
7. Therapists must sign each date of entry with a full signature and credentials.
8. Graduate students must have the supervising physical therapist or occupational therapist co-sign progress notes.

220.110 Accepted Tests for Occupational Therapy 3-15-12

To view the current list of accepted tests for Occupational Therapy, refer to Section 214.310 of the Occupational, Physical, Speech Therapy Services manual.

220.120 Accepted Tests for Physical Therapy 3-15-12

To view the current list of accepted tests for Physical Therapy, refer to Section 214.320 of the Occupational, Physical, Speech Therapy Services manual.

220.200 Speech-Language Therapy Guidelines 10-1-17

A. Medical Necessity

Speech-language therapy services must be medically necessary to the treatment of the individual's illness or injury. A diagnosis alone is not sufficient documentation to support the medical necessity of therapy. To be considered medically necessary, the following conditions must be met:

1. The services must be considered under accepted standards of practice to be a specific and effective treatment for the patient's condition.
2. The services must be of such a level of complexity, or the patient's condition must be such that the services required can be safely and effectively performed only by or under the supervision of a qualified speech and language pathologist.
3. There must be reasonable expectation that therapy will result in meaningful improvement or a reasonable expectation that therapy will prevent a worsening of the condition (See the medical necessity definition in the Glossary of this manual).

B. Types of Communication Disorders

1. Language Disorders — Impaired comprehension and/or use of spoken, written and/or other symbol systems. This disorder may involve the following components: forms of language (phonology, morphology, syntax), content and meaning of language (semantics, prosody), function of language (pragmatics) and/or the perception/processing of language. Language disorders may involve one, all or a combination of the above components.

2. Speech Production Disorders — Impairment of the articulation of speech sounds, voice and/or fluency. Speech Production disorders may involve one, all or combination of these components of the speech production system.

An articulation disorder may manifest as an individual sound deficiency, i.e., traditional articulation disorder, incomplete or deviant use of the phonological system, i.e. phonological disorder, or poor coordination of the oral-motor mechanism for purposes of speech production, i.e. verbal and/or oral apraxia, dysarthria.

3. Oral Motor/Swallowing/Feeding Disorders — Impairment of the muscles, structures and/or functions of the mouth (physiological or sensory-based) involved with the entire act of deglutition from placement and manipulation of food in the mouth through the oral and pharyngeal phases of the swallow. These disorders may or may not result in deficits to speech production.

C. Evaluation and Report Components

1. STANDARDIZED SCORING KEY:

Mild: Scores between 84-78; -1.0 standard deviation

Moderate: Scores between 77-71; -1.5 standard deviations

Severe: Scores between 70-64; -2.0 standard deviations

Profound: Scores of 63 or lower; -2.0+ standard deviations

2. LANGUAGE: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 220.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for language disorder must include:

a. Date of evaluation.

b. Child's name and date of birth.

c. Diagnosis specific to therapy.

d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of language disorder, including all relevant scores, quotients and/or indexes, if applicable. A comprehensive measure of language must be included for initial evaluations. Use of one-word vocabulary tests alone will not be accepted. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

f. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.

g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of the orofacial structures.

h. Formal or informal assessment of hearing, articulation, voice and fluency skills.

i. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

j. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.

k. Signature and credentials of the therapist performing the evaluation.

3. SPEECH PRODUCTION (Articulation, Phonological, Apraxia): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 220.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Articulation, Phonological, Apraxia) disorder must include:

a. Date of evaluation.

b. Child's name and date of birth.

c. Diagnosis specific to therapy.

d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28-week gestational age infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. All errors specific to the type of speech production disorder must be reported (e.g., positions, processes, motor patterns). (To view a current list of Accepted Tests for Speech Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

f. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.

g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures.

h. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen or TTFC.

i. Formal or informal assessment of hearing, voice and fluency skills.

j. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

k. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.

l. Signature and credentials of the therapist performing the evaluation.

4. SPEECH PRODUCTION (Voice): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 220.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Voice) disorder must include:

   a. A medical evaluation to determine the presence or absence of a physical etiology as a prerequisite for evaluation of voice disorder.

   b. Date of evaluation.

   c. Child's name and date of birth.

   d. Diagnosis specific to therapy.

   e. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

      NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

      7 months - [(40 weeks) - 28 weeks) / 4 weeks]

      7 months - [(12) / 4 weeks]

      7 months - [3]

      4 months

   f. Results from an assessment relevant to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

   g. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is12 months of age or younger, and this should be noted in the evaluation.

   h. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures.

   i. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen or TTFC.

   j. Formal or informal assessment of hearing, articulation and fluency skills.

   k. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

   l. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.

   m. Signature and credentials of the therapist performing the evaluation.

5. SPEECH PRODUCTION (Fluency): To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 220.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Speech Production (Fluency) disorder must include:

   a. Date of evaluation.

   b. Child's name and date of birth.

c. Diagnosis specific to therapy.

d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of speech production disorder, including all relevant scores, quotients and/or indexes, if applicable. (To view a current list of Accepted Tests for Speech Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

f. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is12 months of age or younger, and this should be noted in the evaluation.

g. Oral-peripheral speech mechanism examination, which includes a description of the structure and function of orofacial structures.

h. Formal screening of language skills. Examples include, but are not limited to, the Fluharty-2, KLST-2, CELF-4 Screen or TTFC.

i. Formal or informal assessment of hearing, articulation and voice skills.

j. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

k. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.

l. Signature and credentials of the therapist performing the evaluation.

6. ORAL MOTOR/SWALLOWING/FEEDING: To establish medical necessity, results from a comprehensive assessment in the suspected area of deficit must be reported. (Refer to Section 220.200, part D, paragraphs 9-12 for required frequency of re-evaluations.) A comprehensive assessment for Oral Motor/Swallowing/Feeding disorder must include:

a. Date of evaluation.

b. Child's name and date of birth.

c. Diagnosis specific to therapy.

d. Background information including pertinent medical history; and, if the child is 12 months of age or younger, gestational age. The child should be tested in the child's dominant language; if not, an explanation must be provided in the evaluation.

NOTE: To calculate a child's gestational age, subtract the number of weeks born before 40 weeks of gestation from the chronological age. Therefore, a 7-month-old, former 28 week gestational age

infant has a corrected age of 4 months according to the following equation:

7 months - [(40 weeks) - 28 weeks) / 4 weeks]

7 months - [(12) / 4 weeks]

7 months - [3]

4 months

e. Results from an assessment specific to the suspected type of oral motor/swallowing/feeding disorder, including all relevant scores, quotients and/or indexes, if applicable. . (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

f. f swallowing problems and/or signs of aspiration are noted, then include a statement indicating that a referral for a videofluoroscopic swallow study has been made.

g. If applicable, test results should be adjusted for prematurity (less than 37 weeks gestation) if the child is 12 months of age or younger, and this should be noted in the evaluation.

h. Formal or informal assessment of hearing, language, articulation, voice and fluency skills.

i. An interpretation of the results of the evaluation including recommendations for frequency and intensity of treatment.

j. A description of functional strengths and limitations, a suggested treatment plan and potential goals to address each identified problem.

k. Signature and credentials of the therapist performing the evaluation.

D. Interpretation and Eligibility: Ages Birth to 21

1. LANGUAGE: Two language composite or quotient scores (i.e., normed or standalone) in the area of suspected deficit must be reported, with at least one being a norm-referenced, standardized test with good reliability and validity. (Use of two one-word vocabulary tests alone will not be accepted.)

a. For children age birth to three: criterion-referenced tests will be accepted as a second measure for determining eligibility for language therapy.

b. For children age three to 21, criterion-referenced tests will not be accepted as a second measure when determining eligibility for language therapy. (When use of standardized instruments is not appropriate, see Section 220.200, part D, paragraph 8).

c. Age birth to three: Eligibility for language therapy will be based upon a composite or quotient score that is -1.5 standard deviations (SD) below the mean or greater from a norm-referenced, standardized test, with corroborating data from a criterion-referenced measure. When these two measures do not agree, results from a third measure that corroborate the identified deficits are required to support the medical necessity of services.

d. Age three to 21: Eligibility for language therapy will be based upon 2 composite or quotient scores that are -1.5 standard deviations (SD) below the mean or greater. When -1.5 SD or greater is not indicated by both of these scores, a third standardized score indicating a -1.5 SD or greater is required to support the medical necessity of services.

2. ARTICULATION AND/OR PHONOLOGY: Two tests and/or procedures must be administered, with at least one being from a norm-referenced, standardized test with good reliability and validity.

Eligibility for articulation and/or phonological therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two tests. When -1.5 SD or greater is not indicated by both of these tests, corroborating data from accepted procedures can be used to support the medical necessity of services. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual).

3. APRAXIA: Two tests and/or procedures must be administered, with at least one being a norm-referenced, standardized test with good reliability and validity.

Eligibility for apraxia therapy will be based upon standard scores (SS) of -1.5 SD or greater below the mean from two tests. When -1.5 SD or greater is not indicated by both of these tests, corroborating data from a criterion-referenced test and/or accepted procedures can be used to support the medical necessity of services. (To view a current list of Accepted Tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services Manual.)

4. VOICE: Due to the high incidence of medical factors that contribute to voice deviations, a medical evaluation is a requirement for eligibility for voice therapy.

Eligibility for voice therapy will be based upon a medical referral for therapy and a functional profile of voice parameters that indicates a moderate or severe deficit/disorder.

5. FLUENCY: At least one norm-referenced, standardized test with good reliability and validity, and at least one supplemental tool to address affective components.

Eligibility for fluency therapy will be based upon an SS of -1.5 SD below the mean or greater on the standardized test.

6. ORAL MOTOR/SWALLOWING/FEEDING: An in-depth, functional profile of oral motor structures and function.

Eligibility for oral motor/swallowing/feeding therapy will be based upon an in-depth functional profile of oral motor structures and function using a thorough protocol (e.g., checklist, profile) that indicates a moderate or severe deficit or disorder. When moderate or severe aspiration has been confirmed by videofluoroscopic swallow study, the patient can be treated for pharyngeal dysphagia via the recommendations set forth in the swallow study report.

7. All subtests, components and scores must be reported for all tests used for eligibility purposes.

8. When administration of standardized, norm-referenced instruments is inappropriate, the provider must submit an in-depth functional profile of the child's communication abilities. An in-depth functional profile is a detailed narrative or description of a child's communication behaviors that specifically explains and justifies the following:

   a. The reason standardized testing is inappropriate for this child,

   b. The communication impairment, including specific skills and deficits, and

   c. The medical necessity of therapy.

   d. Supplemental instruments from Accepted Tests for Speech-Language Therapy may be useful in developing an in-depth functional profile.

9. Children (birth to age 21) receiving services outside of the schools must be evaluated annually.

10. Children (birth to 24 months) in the Child Health Management Services (CHMS) Program must be evaluated every 6 months.

11. Children (age three to 21) receiving services within schools as part of an Individual Program Plan (IPP) or an Individual Education Plan (IEP) must have a full evaluation every three years; however, an annual update of progress is required.

12. Children (age three to 21) receiving privately contracted services, apart from or in addition to those within the schools, must have a full evaluation annually.

13. IQ scores are required for all children who are school age and receiving language therapy. Exception: IQ scores are not required for children under ten (10) years of age.

E. Progress Notes

1. Child's name.

2. Date of service.

3. Time in and time out of each therapy session.

4. Objectives addressed (should coincide with the plan of care).

5. A description of specific therapy services provided daily and the activities rendered during each therapy session, along with a form of measurement.

6. Progress notes must be legible.

7. Therapists must sign each date of entry with a full signature and credentials.

8. Graduate students must have the supervising speech-language pathologist co-sign progress notes.

220.210 Accepted Tests for Speech-Language Therapy 3-15-12

To view a current list of accepted tests for Speech-Language Therapy, refer to Section 214.410 of the Occupational, Physical, Speech Therapy Services manual.

220.220 Intelligence Quotient (IQ) Testing 11-1-10

Children receiving language intervention therapy must have cognitive testing once they reach ten (10) years of age. This also applies to home-schooled children. If the IQ score is higher than the qualifying language scores, the child qualifies for language therapy; if the IQ score is lower than the qualifying language test scores, the child would appear to be functioning at or above the expected level. In this case, the child may be denied for language therapy. If a provider determines that therapy is warranted, an in-depth functional profile must be submitted. **However, IQ scores are not required for children under ten (10) years of age.**

A. IQ Tests — Traditional

Test	Abbreviation
Stanford-Binet	S-B
The Wechsler Preschool & Primary Scales of Intelligence, Revised	WPPSI-R
Slosson	
Wechsler Intelligence Scale for Children, Third Edition	WISC-III
Kauffman Adolescent & Adult Intelligence Test	KAIT
Wechsler Adult Intelligence Scale, Third Edition	WAIS-III
Differential Ability Scales	DAS
Reynolds Intellectual Assessment Scales	RIAS

B. Severe and Profound IQ Test/Non-Traditional — Supplemental — Norm-Reference

Test	Abbreviation
Comprehensive Test of Nonverbal Intelligence	CTONI
Test of Nonverbal Intelligence – 1997	TONI-3
Functional Linguistic Communication Inventory	FLCI

221.000 Recoupment Process 7-1-15

The Division of Medical Services (DMS), Utilization Review Section (UR) is required to initiate the recoupment process for all services denied by the Arkansas Medicaid programs' contracted Quality Improvement Organization (QIO) for retrospective therapy reviews for not meeting the medical necessity requirement. Based on QIO findings during retrospective reviews, UR will initiate recoupment as appropriate.

Medicaid 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.

240.000 PRIOR AUTHORIZATION 10-1-17

Prior authorization is not required for DDTCS core service or for the first 90 minutes per week of occupational, physical and speech therapy services.

250.000 REIMBURSEMENT

251.000 Method of Reimbursement 10-13-03

The reimbursement methodology for DDTCS services is a "fee schedule" methodology. Under the fee schedule methodology, reimbursement is made at the lower of the billed charge for each procedure or the maximum allowable for each procedure. The maximum allowable fee for a procedure is the same for all DDTCS providers.

251.010 Fee Schedules 12-1-12

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at https://www.medicaid.state.ar.us 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.

252.000 Rate Appeal Process 11-1-06

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate.

Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity of a conference, for a full explanation of the factors involved and the Program decision.

Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the provider disagrees with the decision made by the Assistant Director, the provider may appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services. The Rate Review Panel will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Health and Human Services (DHHS) management staff, who will serve as chairperson.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The panel will hear the question(s) and will submit a recommendation to the Director.

200.000 BILLING PROCEDURES

262.000 CMS-1500 Billing Procedures

262.100 DDTCS Core Services Procedure Codes 12-5-05

DDTCS 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.

Procedure Code	Required Modifier	Description
T1015	U4	Early Intervention Services (1 unit equals 1 encounter of two hours or more; maximum of 1 unit per day.)
T1015	—	Adult Development Services (1 unit equals 1 hour of service; maximum of 5 cumulative units per day.)
T1015	U1	Pre-School Services (1 unit equals 1 hour of service; maximum of 5 cumulative units per day.)
T1023	UB	Diagnosis and Evaluation Services (not to be billed for therapy evaluations) (1 unit equals 1 hour of service; maximum of 1 unit per date of service.)

262.110 Occupational, Physical and Speech Therapy Procedure Codes 7-1-17

DDTCS therapy services may be provided only outside the time DDTCS core services are furnished. The following procedure codes must be used for therapy services in the DDTCS Program for Medicaid beneficiaries of all ages.

A. 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)

Procedure Code	Required Modifier(s)	Description
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)

B. 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)

C. Speech Therapy Procedure Codes

Procedure Code	Required Modifier(s)	Description
92521	UA	**Evaluation of speech fluency (e.g. stuttering, cluttering) (maximum of four 30-minute units per state fiscal year, July 1 through June 30)
92522	UA	**Evaluation of speech sound production (e.g. articulation, phonological process, apraxia, dysarthric) (maximum of four 30-minute units per state fiscal year, July 1 through June 30)

Procedure Code	Required Modifier(s)	Description
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.

262.200 National Place of Service (POS) Codes 7-1-07

Listed below is the National Place of Service (POS) Code for DDTCS procedures.

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

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

262.300 Billing Instructions – Paper Only 11-1-17

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 the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. **View or print the 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.

262.310 Completion of the CMS-1500 Claim Form 9-1-14

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	
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.

Field Name and Number	Instructions for Completion
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. CLAIMS CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at **www.nucc.org** under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.

Field Name and Number	Instructions for Completion
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	Referring physician's name and title. DDTCS optional therapy services require primary care physician (PCP) referral.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
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/DDYY.
19. ADDITIONAL CLAIM INFORMATION Code A	For tracking purposes, DDTCS providers are required to enter one of the following therapy codes: Category 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.

Field Name and Number	Instructions for Completion
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 and 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 and 3) the Individualized Education Plan is through an education service cooperative.**
D (and 4-digit LEA code)	Individuals aged 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 and 3) the Individualized Education Plan is through a school district.**
E	Individuals aged 18 years and up who are receiving therapy services through the Division of Developmental Disabilities Services.
F	Individuals aged 18 years and up who are receiving therapy services through individual or group providers not included in any of the previous categories (A-E).

Field Name and Number	Instructions for Completion
G	Individuals aged 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).
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 ICD codes is being reported. Use "9" for ICD-9-CM. Use "0" for ICD-10-CM. Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field. Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.
22. RESUBMISSION CODE	Reserved for future use.
ORIGINAL REF. NO.	Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. 1. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month. 2. Providers may bill on the same claim detail for two or more sequential dates of service within the same calendar month when the provider furnished equal amounts of the service on each day of the date sequence.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 262.200 for codes.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from Sections 262.100 through 262.110.
MODIFIER	Enter the applicable modifier from Section 262.110.

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

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

262.400 Special Billing Procedures 11-1-06

Special billing procedures are not applicable to this program.

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

(2) Apnea (Cardiorespiratory) Monitors

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

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

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

Core services provided by EIDT are:

a. **Comprehensive Evaluation for ages 0-20, 1 unit per year**
b. **Habilitative Services for ages 0-6—5 units per day, 1 hour each**
c. **Habilitative Services in the Summer for ages 6-20, 5 units per day, 1 hour each**
d. **Physical Therapy as prescribed by a physician and provided under the supervision of a qualified physical therapist**
e. **Speech Therapy as prescribed by a physician, and provided under the supervision of a qualified speech pathologist**
f. **Occupational Therapy as prescribed by a physician, and provided under the supervision of a qualified occupational therapist**
g. **Nursing Services as prescribed by a physician, and provided by a registered nurse or a licensed nurse practitioner, 4 units per day, 15 minutes each**

Individual and group therapy are limited to six (6) units per week. One unit equal 15 minutes. Evaluations are limited to four (4) units per State Fiscal Year (July 1 through July 30). One unit equals 30 minutes.

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

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

(2) Apnea (Cardiorespiratory) Monitors

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

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

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

Core services provided by EIDT are:

h. **Comprehensive Evaluation for ages 0-20, 1 unit per year**
i. **Habilitative Services for ages 0-6—5 units per day, 1 hour each**
j. **Habilitative Services in the Summer for ages 6-20, 5 units per day, 1 hour each**
k. **Physical Therapy as prescribed by a physician and provided under the supervision of a qualified physical therapist**
l. **Speech Therapy as prescribed by a physician, and provided under the supervision of a qualified speech pathologist**
m. **Occupational Therapy as prescribed by a physician, and provided under the supervision of a qualified occupational therapist**
n. **Nursing Services as prescribed by a physician, and provided by a registered nurse or a licensed nurse practitioner, 4 units per day, 15 minutes each**

Individual and group therapy are limited to six (6) units per week. One unit equal 15 minutes. Evaluations are limited to four (4) units per State Fiscal Year (July 1 through July 30). One unit equals 30 minutes.

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Apnea (Cardiorespiratory) Monitors

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

(3) ~~Child Health Management Services (CHMS)~~**Early Intervention Day Treatment (EIDT) Services**

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

Core services provided by EIDT are:

a. **Comprehensive Evaluation for ages 0-20, 1 unit per year**
b. **Habilitative Services for ages 0-6—5 units per day, 1 hour each**
c. **Habilitative Services in the Summer for ages 6-20, 5 units per day, 1 hour each**
d. **Physical Therapy as prescribed by a physician and provided under the supervision of a qualified physical therapist**
e. **Speech Therapy as prescribed by a physician, and provided under the supervision of a qualified speech pathologist**
f. **Occupational Therapy as prescribed by a physician, and provided under the supervision of a qualified occupational therapist**
g. **Nursing Services as prescribed by a physician, and provided by a registered nurse or a licensed nurse practitioner, 4 units per day, 15 minutes each**

Individual and group therapy are limited to six (6) units per week. One unit equal 15 minutes. Evaluations are limited to four (4) units per State Fiscal Year (July 1 through July 30). One unit equals 30 minutes.

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

~~**CHMS treatment requires prior authorization to determine and verify the patient's need for CHMS services. Effective March 1, 2000, all CHMS treatment services will require prior authorization. Two of the CHMS treatment procedure codes, Z1573 and Z1574, are limited to four (4) per State Fiscal Year (July 1 through June 30). Extension of the benefit limit will be provided if medically necessary**~~.

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

(2) Apnea (Cardiorespiratory) Monitors

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

(3) ~~Child Health Management Services (CHMS)~~**Early Childhood Intervention Day Treatment (EIDT) Services**

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

Core services provided by EIDT are:

h. **Comprehensive Evaluation for ages 0-20, 1 unit per year**
i. **Habilitative Services for ages 0-6—5 units per day, 1 hour each**
j. **Habilitative Services in the Summer for ages 6-20, 5 units per day, 1 hour each**
k. **Physical Therapy as prescribed by a physician and provided under the supervision of a qualified physical therapist**
l. **Speech Therapy as prescribed by a physician, and provided under the supervision of a qualified speech pathologist**
m. **Occupational Therapy as prescribed by a physician, and provided under the supervision of a qualified occupational therapist**
n. **Nursing Services as prescribed by a physician, and provided by a registered nurse or a licensed nurse practitioner, 4 units per day, 15 minutes each**

Individual and group therapy are limited to six (6) units per week. One unit equal 15 minutes. Evaluations are limited to four (4) units per State Fiscal Year (July 1 through July 30). One unit equals 30 minutes.

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

~~CHMS treatment requires prior authorization to determine and verify the patient's need for CHMS services. Effective March 1, 2000, all CHMS treatment services will require prior authorization. Two of the CHMS treatment procedure codes, Z1573 and Z1574, are limited to four (4) per State Fiscal Year (July 1 through June 30). Extension of the benefit limit will be provided if medically necessary.~~

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: ~~January 1, 2003~~July 1, 2018

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

(3) ~~Child Health Management Services (CHMS)~~**Early Intervention Day Treatment (EDIT)**

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

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

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

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

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

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

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

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

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

Arkansas Department of Human Services

Division of Developmental Disabilities Services

DDS STANDARDS for Certification, Investigation and Monitoring

FOR CENTER-BASED COMMUNITY SERVICES

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

PHILOSOPHY & MISSION STATEMENT

The Division of Developmental Disabilities Services (DDS), the DDS Board, and its providers are dedicated to the pursuit of the following goals:

- Advocating for adequate funding, staffing, and services to address the needs of persons with developmental disabilities.
- Encouraging an interdisciplinary service system to be utilized in the delivery of appropriate individualized and quality services.
- Protecting the constitutional rights of individuals with disabilities and their rights to personal dignity, respect and freedom from harm.
- Assuring that individuals with developmental disabilities who receive services from DDS are provided uninterrupted essential services until such time a person no longer needs to depend on these services.
- Encouraging family, parent/guardian, individual, and public/community involvement in program development, delivery, and evaluation.
- Engaging in statewide planning that ensures optimal and innovative growth of the Arkansas service system to meet the needs of persons with developmental disabilities and to assist such persons to achieve independence, productivity, and integration into the community.

To accomplish its mission, DDS, the DDS Board, and its providers are committed to the principle and practices of: normalization; least restrictive alternatives; affirmation of individuals' constitutional rights; provision of quality services; the interdisciplinary service delivery model; and the positive management of challenging behaviors.

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INTRODUCTION

The licensing standards for DDS Community Programs have been developed to accomplish: normalization, least restrictive alternatives, affirmation of individuals' constitutional rights, provision of quality services, the interdisciplinary service delivery model, and the positive management of challenging behaviors.

These Standards shall apply to any day treatment program in Arkansas for children and adults, including a "successor programs," as defined in Ark. Code Ann. § 20-48-1101 et seq. The Department of Human Services and its Divisions and Agents shall have the authority to enforce these regulations.

Individual program plans shall be developed with the participation of the individual (18 years and older), as appropriate, the family, and representatives of the services required. The team is responsible for assessing needs, developing a plan to meet them, and contributing to its implementation.

NOTE: It is imperative that all Medicaid providers be enrolled with the Division of Medical Services and meet all enrollment requirements for the specific Medicaid Program for which they are enrolling as an Arkansas Medicaid Provider.

All standards are applicable to all services provided, unless otherwise specified.

Administrative Rules and Regulation Sub-Committee of the
Arkansas Legislative Council:

Effective Date:	July 1, 2018
Implementation Date:	July 1, 2018
Grandfathering Period:	July 1, 2018—June 30, 2019

100 GOVERNING BOARD/ORGANIZATION / LEADERSHIP

Guiding Principles: The Governing Board/organization/Leadership is that body of people who have been chosen by the corporation and vested with legal authority to be responsible for directing the business and affairs of the corporation. The responsibilities assured by each Board/organization member by their acceptance of membership are to provide effective and ethical governance leadership on behalf of its owners'/stakeholders' interest to ensure that the organization focuses on its purpose and outcomes for persons served, resulting in the organization's long-term success and stability.

The mission statement of the organization is based on the Board/organization's philosophical motivations, the services provided, and values of the members. The mission statement should identify the population to be served and the services to be provided. This description shall be nondiscriminatory by reason of sex, age, disability, creed, marital status, ethnic, or national membership.

NOTE: See Arkansas Code Ann. §§ 20-48-201 - 20-48-211 for examples of Board/organization responsibilities.

NOTE: All information regarding your organization shall be readily available to staff, consumers, referral and funding sources, and the interested public pursuant to the Freedom of Information Act.

101 The organization shall be legally incorporated under the appropriate federal, state or local statues as defined by its official Articles of Incorporation and registered to do business in the State of Arkansas.

A. The governing body should periodically review the appropriateness of its governing documents. (Ark. Code Ann. §§ 20-48-201 – 20-48-211). This shall include the organizations mission statement as filed with the Secretary of State, and the Articles of Incorporation.

B. Any changes in the Articles of Incorporation must be filed with the Secretary of State. This includes name changes, amendments, or any reconstitution of the Governing Board/organization. The organization shall provide copies of any changes to DDS upon filing.

102 Bylaws shall be established which govern the internal affairs of the organization and will address each of the following areas as applicable:

A. Composition of Board

1. This shall include the number of Board members and the eligibility criteria (i.e. citizenship and residency).
2. Selection of Board/ members

a. Twenty percent (20%) consumer and advocate representation on the Board is required. *(Note: defined as a consumer, immediate family member or guardian of a consumer receiving services or has received services at the organization or person in a qualified position that advocates on behalf of the population served)*

B. Term of membership:
   1. Number of years as dictated by the organization's Articles of Incorporation.
      Note: It is recommended that membership on the governing body be rotated periodically.

C. Replacement/removal of directors:
   1. Refers to written criteria for Board membership. Shall include any contingency to include but not be limited to resignation of Board/organization members and removal for non-attendance or other reasons.

D. Election of officers and directors:
   1. Describe the election process

E. Duties and responsibilities of Board officers are described in writing
   1. Must document each position's purpose, structure, responsibilities, authority, if any, and the relationship of the advisory committee of Board members to other entities involved with the organization.

F. Appointment of committees, if applicable;
   1. Duties and functions of standing committees are described in writing, if applicable.

G. Meetings of the Board/organization and its committees. All meetings shall be planned, organized, and conducted in accordance with the organization's by-laws, policies, procedures, applicable statutes, or other appropriate regulations. In no event shall the full Board/organization meet less than four times per year.

   Note: The Board/organization and its committees should meet with a frequency sufficient to discharge their responsibilities effectively.

H. The Board/organization shall adopt written procedures to guide the conduct of its meetings (i.e. Parliamentary Procedure, Robert's Rules of Order, etc.);

I. The Board/organization shall maintain minutes of all actions taken by the Board/organization for review by DDS. Minutes shall accurately document all members present and any action taken at the committee meetings to include any committee recommendations to the Board/organization.
   1. Written minutes of previous Board/organization meetings should be made available by posting the adopted minutes in a location convenient to the staff and individuals served, and made available to members of the public upon request, as required under the Freedom of Information Act.

103 The Board/organization shall establish a procedural statement addressing nepotism as it relates to Board/organization and staff positions.

103.1 The Board shall establish a procedural statement addressing conflict of interest

Note: The intent of the standard does not rule out a business relationship, but does call for the governing body to decide in advance what relationships are in the best interest of the organization.

A. Paid employees may not serve as Board members. (Note: This DOES NOT include individuals receiving services.)

Note: Paid employees serving on the Board as of 11/01/07 may continue to serve for the remainder of their current term at which time they must rotate off the Board.

B. Directors of organizations may serve as non-voting ex officio Board members.

104 Board/organization meetings and public meetings as defined by Ark. Code Ann. §§ 25-19-106 shall be conducted at a time and place which make the meetings accessible to the public. Specifically, except as otherwise specifically provided by law, all meetings, formal or informal, special or regular, of the governing bodies of all municipalities, counties, townships, and school districts and all boards, bureaus, commissions, or organizations of the State of Arkansas, except grand juries, supported wholly or in part by public funds or expending public funds, shall be public meetings.

A. Board/organization meetings and Executive sessions shall be announced to be in compliance with Ark. Code Ann. §§ 25-19-101 – 25-19-107 "Freedom of Information Act"

B. All local media are to be notified one week in advance and a notice posted in a prominent place by the organization. Called meetings shall be announced to the local media and others who have requested notification at least two hours in advance of meeting. Documentation of Notification may include newspaper clippings, copy of item posted on bulletin Board/organization, radio contact forms, etc.

D. If the meetings are held each month at the same time and location, one notification and posting shall be sufficient.

105 The Board/organization of Directors shall adopt a mission statement to guide its activities and to establish goals for the organization. The plan shall show evidence of participation by stakeholders (evidence of open meeting, letters of input, survey, questionnaire, etc.).

105.1 The Board/organization of Directors shall review the mission statement annually and shall make changes as necessary to ensure the overall goals and objectives of the organization are reflected in its mission.

106 The Board/organization maintains a plan which shall identify annual and long range goals; the plan should address community needs and target populations and should be reviewed and updated annually.

A. Each Board/organization will develop and implement a long-range plan of action for that organization. Examples include, but are not limited to starting a new component, accessing individualized services in the community, etc.

B. Development and implementation of the plan shall include stakeholder input. The organization shall maintain evidence of this input (i.e., letters of input, minutes of open meetings, questionnaires, surveys, etc.)

C. The plan shall be reviewed annually and updated as needed. The Board/organization shall approve the initiation, expansion, or modification of the organization's program based on the needs of the community and the capability of the organization to have an effect upon those needs within its established goals and objectives.
Note: The Board/organization of Directors, at its discretion, may assign this responsibility to staff.

107 The Board/organization shall demonstrate corporate social responsibility while maintaining overall accountability for the administration and direction of the organization, and shall delegate authority and responsibility to executive leadership as deemed appropriate by the organization.

A. The organization shall identify:
   1. Its leadership structure.
   2. The roles and responsibilities of each level of leadership.

B. The identified leadership shall guide the following:
   1. Establishment of the mission and direction of the organization.
   2. Promotion of value/achievement of outcomes in the programs and services offered.
   3. Balancing the expectations of both the persons served and other stakeholders, as defined by the organization's policies.
   4. Financial solvency.
   5. Compliance with insurance and risk management requirements.
   6. Ongoing performance improvement.
   7. Development and implementation of corporate responsibilities.
   8. Compliance with all legal and regulatory requirements.

C. The organization shall respond to the diversity of its stakeholders with respect to:
   1. Culture.
   2. Age.
   3. Gender.
   4. Sexual orientation.
   5. Spiritual beliefs.
   6. Socioeconomic status.
   7. Language.

108 The Board/organization shall create a mechanism for monitoring the decisions and operations of the organization's programs which includes provisions for the periodic review and evaluation of its program in relation to the program goals. Documentation of the review must be maintained on file for review. Documentation may include but not be limited to Board/organization minutes, reports, etc.

Guiding Principle: An organized training program for Board/organization Members prepares them for their responsibilities and assures that they are kept up-to-date on issues concerning services offered to individuals with a developmental disability.

109 The Board shall maintain a general plan for Board/organization training and will ensure that all items listed as required topics are covered in the required three-hour training.

A. Training shall be provided for all Board/organization members. Where the Board, because of its size, lacks sufficient resources to conduct a training program, it will make arrangements with another Board, organization, agency, appropriate community resource, or training organization to provide such training.

109.1 New Board Members must participate in a minimum of three hours of training.

A. The following topics shall be required during the first year of service
1. Functions and Responsibilities of the Board
2. Composition and Size of the Board

3. Legal Responsibilities
4. Funding Sources and Responsibilities,
5. Equal Employment Opportunity/Affirmative Action,
6. Due Process
7. Ark. Code Ann. §§ 25-19-101 – 25-19-107 "Freedom of Information Act of 1967"
8. U. S. C. § 12101 et. seq. "Title 42 THE PUBLIC HEALTH AND WELFARE--CHAPTER126—EQUAL OPPORTUNITY FOR INDIVIDUALS WITH DISABILITIES--§ 12101. Findings and purpose"
9. DDS Service Policy 3004-I Maltreatment Prevention, Reporting and Investigation;
10. DHS Policy 1090, Incident Reporting.
11. DDS Administrative Policy 1077
12. Chemical Right to Know
13. The Health Insurance Portability and Accountability Act (HIPAA)

NOTE: POSSIBLE TRAINING RESOURCES INCLUDE ASPEN PUBLICATIONS, WHICH HAS MATERIALS ON BOARD/ORGANIZATION AND ADMINISTRATOR TRAINING. (WWW.ASPENPUBLISHERS.COM) Resources or additional information should be obtained from DDS Licensure.

B. All new Board members as they begin service shall participate in training. Board members may disseminate training information to new Board members if they are unable to attend formal training sessions. Documentation of the information provided, date provided and the board member(s) involved must be maintained for review by DDS. (Note: Training may be documented in Board minutes or by Certificates of Attendance.)

109.2 All Board members shall complete a minimum of three hours annual training. Topics may be selected by the Board of Directors and must be germane to the annual plan and services provided. Training should be documented in Board minutes, by Certificates of Attendance or sign in sheets from approved training.

110 Board members shall visit service components of the organization during operating hours yearly.

A. All components of the organization must be observed annually. If on-site observations to each physical location are not feasible, at least 1 physical site from each program component must be observed during the calendar year. The sites must be rotated yearly. Committees or individual Board Members may be appointed to visit specific components and report back to the other Board members on observations. Documentation of reports in Board minutes shall be accepted as verification.

111 The Board/organization shall establish and approve policies and procedures which define Eligibility criteria, Readmission criteria, and transition/discharge/exit criteria

112 The Board/organization shall establish policy regarding financial oversight of the organization that addresses the following:

A. The organization's financial planning and management activities reflect strategic planning designed to meet:

1. Established outcomes for the persons served.
2. Organizational performance objectives.

B. Budgets are prepared that:
   1. Include:
      a. Reasonable projections of revenues and expenditures.
      b. Input from various stakeholders, as required.
      c. Comparison to historical performance.
   2. Are disseminated to:
      a. Appropriate personnel.
      b. Other stakeholders, as appropriate.
   3. Are written.

C. Actual financial results are:
   1. Compared to budget.
   2. Reported to:
      a. Appropriate personnel.
      b. Persons served, as appropriate.
      c. Other stakeholders, as required.
   3. Reviewed at least quarterly.

D. The organization identifies and reviews, at a minimum:
   1. Revenues and expenses.
   2. Internal and external:
      a. Financial trends.
      b. Financial challenges.
      c. Financial opportunities.
      d. Business trends.
      e. Management information.
   3. Financial solvency, with the development and implementation of remediation plans, if appropriate.

113 For-profit organizations or organizations who receive less than $10,000 in compensation for services under this program shall submit a compilation report that includes a balance sheet and statement of revenue and expense to DDS at the close of each financial period.

Note: Sections 102 & 104 do not apply to organizations that are not governed by a Board of Directors

200 PERSONNEL PROCEDURES & RECORDS

201 The organization shall maintain written personnel procedures that are approved by the Board and are reviewed annually and which conform to state and federal laws, rules and regulations.

NOTE: DDS SHALL NOT BECOME DIRECTLY INVOLVED IN PERSONNEL ISSUES UNLESS IT DIRECTLY IMPACTS CONSUMER CARE AND/OR SAFETY.

201.1 Personnel procedures shall be clearly stated and available in written form to employees as required by 42 U.S.C. § 2000a – 2000 h-6 "Title VI of the Civil Rights Act of 1964" and U.S.C. § 1201 et. Seq. Americans with Disabilities Act. These include but are not limited to:

A. Hiring and promotional procedures which are nondiscriminatory by reason of sex, age, disability, creed, marital status, ethnic, or national membership

B. A procedure for discipline, suspension and/or dismissal of staff which includes opportunities for appeal

C. An appeals procedure allowing for objective review of concerns and complaints

201.2 One copy of the organization's Personnel procedures must be available in the personnel or administrator's office. This copy must be readily accessible to each employee.

201.3 The organization shall develop and implement steps to voice grievances within the organization. All grievances are subject to review by the Governing Board and Court of Law (29 U.S.C. §§ 706(8), 794 – 794(b), the "Rehabilitation Act of 1973 Section 504; 20 U.S.C. § 1400 et. Seq. Section 615 "The Individual Disabilities Education Act".

A. All steps in the Grievance Procedure should be time-bound and documented, including initial filing of grievance.

201.4 The organization shall develop and implement policies regarding whether pre-employment and random drug testing will be required. If the organization chooses to do drug testing they must establish guidelines for actions to be taken when the drug test results are obtained, whether positive or negative.

Note: The organization may contact Arkansas Transit Association for further information on drug testing

202 Prior to employment, a completed job application must be submitted which includes the following documents.

A. The organization shall obtain and verify PRIOR to employment and maintain documentation of the following:

1. The credentials required
2. That required credentials remain current
3. The applicant has completed a statement related to criminal convictions
4. A criminal background check has been initiated. Refer to DDS Policy 1087.
5. Declaration of truth of statement on job application.
6. A release to complete reference checks is signed and reference checks have been completed

7. Results of pre-employment drug screen, if required by organization.

NOTE: THE ITEMS IN 202A.5 AND 202A.6 WILL NOT BE RATED FOR EMPLOYEES HIRED PRIOR TO JULY 1, 1986.

B. The organization shall obtain and verify within 30 days of employment and maintain documentation of the following:
   1. Adult Maltreatment Central Registry Ark. Code Ann. §§ 5-28-201 has been completed and the response is filed, or a second request submitted
   2. Arkansas Child Maltreatment Central Registry Ark. Code Ann. §§ 12-12-501 – 12-12-515 has been completed and the response is filed, or a second request submitted. This check will provide documentation that prospective employee's name do not appear on the statewide Central Registry.
      a. The organization should adopt policy requiring subsequent criminal checks and registry checks. The organizations that provide licensed daycare services must adhere to Child Care Licensing regulations regarding Criminal background checks and central registry checks.

      Note: Staff holding professional licenses may be used in lieu of criminal background and adult and child maltreatment checks.
   3. TB skin test
      a. Renewed yearly for ALL STAFF.
   4. Hepatitis B series or signed declination
   5. The results of criminal background check of the will be on file.
   6. Employment reference verification and signed release
      a. On file within thirty (30) days of hire date

C. The organization shall obtain and verify information in 202 A and B in response to information received (i.e., a complaint is received that a person's license has lapsed or a person has been convicted of a crime since they were hired).

203 The agency shall ensure sub-contractor's services meet all applicable standards and will assess performance on a regular basis.

A. The organization shall ensure that sub-contractors providing direct care services are in compliance with DDS policies and must have verification and documentation of all applicable items listed in 202A.

   Note: Staff holding professional licenses may be used in lieu of criminal background and adult and child maltreatment checks.

B. The organization shall demonstrate:
   1. Reviews of all contract personnel utilized by the organization that:
      a. Assess performance of their contracts
      b. Ensure all applicable policies and procedures of the organization are followed
      c. Ensure they conform to DDS standards applicable to the services provided
      d. Are performed annually

204 The organization shall develop, implement and monitor policies and procedures for staff recruitment and retention so that sufficient staff is maintained to ensure the health and safety of the individuals served, according to their plans of care.

A. The organization must ensure there are an adequate number of personnel to:
   1. Meet the established outcomes of the persons served.
   2. Ensure the safety of persons served.
   3. Deal with unplanned absences of personnel.
   4. Meet the performance expectations of the organization.

B. The organization shall demonstrate:
   1. Recruitment efforts.
   2. Retention efforts.
   3. Identification of any trends in personnel turnover.

205 The organization shall develop and implement procedures governing access to staff members' personnel file.

A. An access sheet shall be kept in front of the file to be signed and dated by those who are examining contents, with stated reasons for examination.

B. The policy shall clearly state who, when, and what is available concerning access to personnel files and be in compliance with the Federal Privacy Act and Freedom of Information Act. At no time shall the policy allow access that violates the provisions of the Health Insurance Portability and Accountability Act (HIPAA).

206 The organization shall develop written job descriptions which describe the duties, responsibilities, and qualifications of each staff position.

A. The organization shall:
   1. Identify the skills and characteristics needed by personnel to:
      a. Assist the persons served in the accomplishment of their established outcomes.
      b. Support the organization in the accomplishment of its mission and goals.
   2. Assess the current knowledge and competencies of personnel at least annually.
   3. Provide for the orientation and training needs of personnel.
   4. Provide the resources to personnel for learning and growth.
   5. Identify the supervisor of the position and the positions to be supervised.

B. Performance management shall include:
   1. Job descriptions that are reviewed and/or updated annually.
   2. Promotion guidelines.
   3. Job posting guidelines.
   4. Performance evaluations for all personnel directly employed by the organization shall be:
      a. Based on measurable objectives that tie back to specific duties as listed in the Job Description.
      b. Evident in personnel files.
      c. Conducted in collaboration with the direct supervisor with evidence of input from the personnel being evaluated.

d. Used to:
    1. Assess performance related to objectives established in the last evaluation period.
    2. Establish measurable performance objectives for the next year.
e. Performed annually.

207 The organization shall establish employment policies/practices for students, interns, volunteers and trainees utilized by the organization who have regular, routine contact with consumers.

A. The organization shall define who has and what constitutes regular, routine contact with consumers.

B. If students, interns, volunteers or trainees are used by the organization, the following shall be in place:
    1. A signed agreement.
        a. If professional services are provided, standards or qualifications applied to comparable positions must be met.
    2. Identification of:
        a. Duties.
        b. Scope of responsibility.
        c. Supervision.
    3. Orientation and training.
    4. Assessment of performance.
    5. Policies and written procedures for dismissal.
    6. Confidentiality policies.
    7. Background checks, when required.

300 STAFF TRAINING

Guiding Principle: Staff Training is an organized program which prepares new employees to perform their assigned duties competently and maintains and improves the competencies of all employees. Staff Training for the organization shall provide an on-going mechanism for the evaluation of the impact of the program on services provided to individuals with developmental disabilities. This should include service outcomes to individuals, meeting of the organization objectives and overall mission, compliance with regulatory and professional standards and positive changes in staff performance and attitudes. The needs of individuals with developmental disabilities require the efforts of competent personnel who continually seek to expand knowledge in their fields.

300.1 The organization shall establish a policy designating one or more employees to be responsible for coordinating in-service staff training.

A. The employee responsible for staff training should have broad knowledge of care and service needs of persons with developmental disabilities, and possess the necessary skills to organize and implement an in-service training program as evidenced in resume.

301 The organization shall establish a written training plan. This plan must show how the training will be provided and the areas covered. If training occurs during regularly scheduled service hours, documentation must be present that individual staff ratios were maintained.

301.1 ALL Personnel shall receive initial and annual competency-based training to include, but not limited to:

A. Health and safety practices.

1. First Aid (review yearly, renew as required by American Heart Association, Red Cross, or Medic First Aid, applicable for ALL direct service personnel)

a. There is immediate access to:

(1) First aid expertise.

(2) First aid equipment and supplies.

(3) Emergency information on the:

(a) Persons served.

(b) Personnel.

b. Infection Control Plan

1. The organization shall implement an infection control plan that includes:

(a). Training regarding the prevention and control of infections and communicable diseases for:

(1). Persons served, when applicable.

(2). Personnel.

(b). The appropriate use of standard or universal precautions by all personnel.

(c). Procedures that specify that employees with infectious diseases shall be prohibited from contact with individuals until a physician's release has been provided to the organization director.

B. Identification of unsafe environmental factors.
   1. Issues Regarding Prevention of Acquired Immunodeficiency Syndrome (AIDS), Hepatitis B (HIV) and other Bloodborne Pathogens

C. Emergency procedures and Evacuation Procedures
   1. Emergency and Disaster Preparedness
   2. Fire and Tornado Drills, Violence in the Workplace, Bomb Threats, Earthquake

D. General Information
   1. Overview of Department of Human Services
   2. Overview of Developmental Disabilities Services
   3. Philosophy, Goals, Programs, Practices, Policies, and Procedures of Local Organization
   4. HIPPA policies and procedures
   5. Orientation to history of Developmental Disabilities
   6. Current Issues Affecting Individuals with Developmental Disabilities
   7. Introduction to Principles of Normalization
   8. Procedures for Incident Reporting
   9. Appeals Procedure for Individuals Served by the Program
   10. Introduction to Behavior Management
   11. Community Integration Training.

E. Legal
   1. Overview of Federal and State Laws related to serving individuals with a developmental disability (NOTE: Laws may change every 2 years)
   2. Legal Rights of Individuals with Developmental Disabilities
   3. Application of Federal Civil Rights Laws to Persons with AIDS or HIV related condition (or those who may be perceived to have AIDS or HIV related conditions).
   4. Ark. Code Ann. §§6-41-201 – 6-41-222--The Children With Disabilities Act of 1973
   5. Ark. Code Ann. §§20-48-201 – 20-48-211; --Arkansas Mental Retardation Act
   6. Ark. Code Ann. §§25-19-101 – 25-19-107 --Freedom of Information Act
   7. Ark. Code Ann. §§28-65-101 – 28-65-109; --Guardians Generally
   8. Ark. Code Ann. §§5-28-101 – 5-28-109; --Abuse of Adults
   9. Ark. Code Ann. §§12-12-501 – 12-12-515; --Arkansas Child Maltreatment Act
   10. Ark. Code Ann. §§25-2-104, 25-2-105, 25-2-107, Type 1, Type 2 and Type 4 Transfers
   11. Ark. Code Ann. §§25-10-102 – 25-10-116; Department of Health and Human Services General Provisions
   12. Ark. Code Ann. §§20-78-215 -- Child sexual abuse - Federal funds
   13. U.S.C. § 12101 et. seq. --Americans with Disabilities Act of 1990 P. L. 101-336
   14. 20 U.S.C. §1400 et. seq. (Part B and Part C -- P. L. 94-142 Individuals with Disability Education (IDEA) P.L. 99-457 Part C
   15. 42U.S.C. §2000a – 2000 h-6-- Title VI of the Civil Rights Act of 1964

16. 29 U.S.C. §§706 (8) Rehabilitation Act of 1973, 794 – 794(b) Section 504
17. 5 U.S.C. §552a-- Federal Privacy Act
18. 42 U.S.C. §6000-- Developmentally Disabled Assistance & Bill of Rights Act of 1984
19. P.L. 109-171, Deficit Reduction Act, and 30 U.S.C. §3729 et.seq. False Claims Act

Note: Documentation of prior training of individual staff may be used for the required topics, if this situation is addressed in the organization's training plan.

301.2. Documentation of prior training of individual staff may be used for the required topics, if this situation is addressed in the organization's training plan.

301.3. Training Requirements for professional/administrative staff, as defined by the agencies policies

1. Twelve (12) hours minimum completed within ninety (90) days of employment (does not include First Aid and CPR training)

301.4. Training Requirements for direct care staff

1. Twelve (12) hours minimum completed within (30) days of employment (does not include First Aid and CPR training)
2. In addition to the training requirements specified Section 301.1, all direct care staff must receive the following training:
   a. CPR (I nitial Certification, renew as required by American Heart Association, Medic First Aid, or Red Cross).
      1. ALL direct care staff members, including bus and van drivers, shall be trained and certified to provide CPR, unless they are deemed incapable of performing this task by a licensed medical professional, such as a nurse or doctor. Documentation must be maintained in the personnel file. Staff that are physically incapable of performing CPR must complete and have documentation of CPR training.
   b. The organization shall develop and implement and monitor policy regarding timeframe for CPR certification after hire date. (Timeframe not to exceed 90 days.)
3. Medication—Implications, Side Effects, Legality of Administering medication.

NOTE: IN ADDITION TO THOSE AREAS ADDRESSED IN THESE STANDARDS, OTHER IDENTIFIED NEEDS BASED ON STAFF INPUT SHOULD BE ADDRESSED.

NOTE: SEE APPENDIX B for Training Resources

301.5 In addition to the requirements in Section 301.1-301.4, all direct care staff shall receive annual in-service training and/or continuing education as follows:

A. Minimum of twelve (12) hours of training annually, including the required topics.
   1. Topics must be applicable to the job and are to be chosen by the organization based on identified needs. Topics may be a combination of required and job specific training.

2. Behavior management techniques/programming

B. Documentation of the training shall be maintained in the staff's personnel file and shall be evidenced by the signatures of the trainer and the direct care staff, the date the training was provided and the specific information covered.

302 Annual in-service training and/or continuing education for Managerial Staff, as defined by the agencies policies.

A. Topics Chosen must be related to the job performed.

B. Minimum of twelve (12) hours of training required yearly, from the following list:

1. Issues Regarding Prevention of Acquired Immunodeficiency Syndrome (AIDS), Hepatitis B (HIV) and other Blood Borne Pathogens
2. Application of Federal Civil Rights Laws to persons with AIDS or HIV related Conditions (or those who may be perceived to have AIDS or HIV Related conditions)
3. Management of Non-Profit Organizations
4. Procedures for Preventing and Reporting Alleged Maltreatment of Children and Adults
5. Effective Supervision/Management Techniques
6. Selection and Interviewing
7. Fair Employment Principles
8. Performance Evaluation
9. Techniques for Working with the Board
10. Overview of Federal and State Laws Related to Serving Individuals with a Developmental Disability (up-dated every two (2) years)
11. Federal and State Laws:
    a. Ark. Code Ann. §§6-41-201 – 6-41-222--The Children With Disabilities Act of 1973
    b. Ark. Code Ann. §§20-48-201 – 20-48-211-Arkansas Mental Retardation Act
    c. Ark. Code Ann. §§25-19-101 – 25-19-107 --Freedom of Information Act
    d. Ark. Code Ann. §§28-65-101 – 28-65-109; --Guardians Generally
    e. Ark. Code Ann. §§5-28-101 – 5-28-109; --Abuse of Adults
    f. Ark. Code Ann. §§12-12-501 – 12-12-515; --Arkansas Child Maltreatment Act
    g. Ark. Code Ann. §§25-2-104, 25-2-105, 25-2-107, Type 1, Type 2 and Type 4 Transfers
    h. Ark. Code Ann. §§25-10-102 – 25-10-116; Department of Health and Human Services General Provisions
    i. Ark. Code Ann. §§20-78-215 -- Child sexual abuse - Federal funds
    j. U.S.C. § 12101 et. seq. --Americans with Disabilities Act of 1990 P. L. 101-336
    k. 20 U.S.C. §1400 et. seq. (Part B and Part C -- P. L. 94-142 Individuals with Disability Education (IDEA) P.L. 99-457 Part C
    l. 42U.S.C. §2000a – 2000 h-6-- Title VI of the Civil Rights Act of 1964
    m. 29 U.S.C. §§706 (8) Rehabilitation Act of 1973, 794 – 794(b) Section 504

n. 5 U.S.C. §552a-- Federal Privacy Act

o. 42 U.S.C. §6000 – 6083-- Developmentally Disabled Assistance & Bill of Rights Act of 1984

C. Managerial Staff, as defined by the agencies policies, who have been with the agency for 2 or more years may select from the above list or choose from continuing education courses.

NOTE: SEE APPENDIX B FOR TRAINING RESOURCES

303 All employees who provide transportation services shall have the following training scheduled within thirty (30) days of employment and completed within seventy-five (75) days of employment. This training shall be in addition to the required new employee training listed in Section 301

A. A course of instruction in consumer assistance and transfer techniques, lift operation and how to properly secure a wheelchair, if applicable, prior to transporting consumers; and

B. The provider must assure and document that each driver obtains the following:

1. A certificate of completion of an introductory defensive driving course;
2. A certification of completion of training addressing the transport of older persons and people with disabilities, and a refresher course every three years thereafter, both of which must include:
   a. Sensitivity to aging training;
   b. An overview of diseases and functional factors commonly affecting older adults;
   c. Environmental considerations affecting passengers;
   d. Instruction in consumer assistance and transfer techniques;
   e. Training on the management of wheelchairs, and how to properly secure a wheelchair;
   f. The inspection and operation of wheelchair lifts and other assistive equipment; and,
   g. Emergency procedures.

C. D. Drivers are required to complete refresher courses every three years after the date the certificate(s) of completion was received.

Note: For all transportation workers employed prior to 11/01/07, documentation of the required training must be on file no later than 11/01/08.

304 Providers must assure:

A. Maintenance of a safety checklist completed prior to transporting consumer(s) and/or travel attendants. Checklist items shall include, but not be limited to, fire extinguisher; first aid kit,

B. Maintenance of service logs or trip sheets that include the date of service the consumer's name, the pick-up point and destination point for each trip, total mileage per trip, and the driver's signature.

C. Assistance in transfer of the consumer, as necessary, safely from the consumer's door to the vehicle and from the vehicle to the entrance of the destination point. The provider must perform the same transfer assist service when transporting the consumer back to the consumer's residence.

400 INDIVIDUAL/PARENT/GUARDIAN RIGHTS

Guiding Principle: The organization shall implement a system of rights that nurtures and protects the dignity and respect of the persons served. The organization shall protect and promote the rights of the persons served. This commitment shall guide the delivery of services and ongoing interactions with the persons served.

401 The organization shall implement policies promoting the following rights of the persons served and ensures all information is transmitted to the person served and/or their parent or guardian in a manner and fashion that is clear and understandable:

A. Being free from physical or psychological abuse or neglect, retaliation, humiliation, and from financial exploitation.
B. Having control over their own financial resources.
C. Being able to receive, purchase, have and use their own personal property.
D. Actively and meaningfully making decisions affecting their life.
E. Access to information pertinent to the person served in sufficient time to facilitate his or her decision making.
F. Having Privacy.
G. Being able to associate and communicate publicly or privately with any person or group of people of the individual's choice.
H. Being able to practice the religion of their choice.
I. Being free from the inappropriate use of a physical or chemical restraint, medication, or isolation as punishment, for the convenience of the provider or agent, in conflict with a physician's order or as a substitute for treatment, except when a physical restraint is in furtherance of the health and safety of the individual.
J. Not being required to work without compensation, except when the individual is residing and being provided services outside of the home of a member of the individual's family, and then only for the purposes of the upkeep of their own living space and of common living area and grounds that the individual shares with others.
K. Being treated with dignity and respect.
L. Receiving due process.
M. Having access to their own records, including information about how their funds are accessed and utilized and what services were billed for on the individual's behalf.
N. Informed consent or refusal or expression of choice regarding:
    1. Service delivery.
    2. Release of information.
    3. Concurrent services.
    4. Composition of the service delivery team.
    5. Involvement in research projects, if applicable.
O. Access or referral to legal entities for appropriate representation.
P. Access to self-help and advocacy support services.
Q. Adherence to research guidelines and ethics when persons served are involved, if applicable.
R. Investigation and resolution of alleged infringement of rights.

1. The agency maintains documentation of all investigations of all alleged violations of individual's rights and actions taken to intervene in such situations. The organization ensures that the individual has been notified of their right to appeal according to DDS Policy 1076.

R. Rights and responsibilities of citizenship

S. Other legal and constitutional rights

402 Records of persons served

A. The organization shall maintain complete records and treat all information related to persons served as confidential.

B. The organization shall create policy for the sharing of confidential billing, utilization, clinical and other administrative and service-related information, and the operation of any Internet-based services that may exist.

1. Information that is used for reporting or billing shall be shared according to confidentiality guidelines that recognize applicable regulatory requirements such as the Health Insurance Portability and Accountability Act (HIPAA).

C. The organization shall comply with its own service delivery design for the development of the record. Electronic records are acceptable. Electronic records must meet the following:

1. Format must meet DHS/ Office of Systems and Technology standards and be acceptable by the Department.
2. Files must be uniformly organized and easily accessible.

D. The location of the case record, and the information contained therein, shall be controlled from a central location as defined by the agency, shall be stored under lock and with protection against fire, water, and other hazards in an accessible location at each site. The organization shall establish and implement policies and procedures to ensure direct care staff have adequate access to the individual's current plan of care and other pertinent information necessary to ensure the individual's health and safety (i.e., name and telephone number of physician, emergency contact information, insurance information, etc.). If services are not provided at the central location, at a minimum the following information must be maintained at the service delivery site:

A. Access Sheet
B. Face Sheet to include emergency contact information and pertinent health information
C. Signed consent for emergency treatment
D. A copy of the consumer's current program plan
E. Copies of current progress reports
F. Documentation of service provision to include date, time in and time out, summary of activities, and signature of implementor for the period of the current program plan

E. Records maintained on computer shall be backed up at a minimum weekly and the duplicate copy shall be stored under lock and with protection against fire, water, and other hazards.

F. A list of the order of the file information shall either be present in each individual case file or provided to DDS Licensure staff upon request. The documents in active individual case records should be organized in a systematic fashion. An indexing and filing system shall be maintained for all case records.

G. Each organization shall have written procedures to cover destruction of records. Procedures must comply with all state and federal regulations

H. Access sheets shall be located in the front of the file to maintain confidentiality according to 5 U.S.C. § 552a. If there is a signed release for a list of authorized persons to review the file, only those not listed will need to sign the access sheet with date, title, reason for reviewing, and signature. If there is not a signed release for authorized persons to review, all persons must sign the access sheet whenever the file is reviewed or any material is placed in the file.

402.1 DDS staff shall have access upon demand to all individual case records as designated in Ark. Code Ann. §§ 20-48-201 – 20-48-211, DDS Policy 1090, Licensing Policy for Center-Based Community Services.

402.2 The organization shall ensure confidentiality of all case records is maintained. Access to case records shall be limited to Individual/Parent/Guardian, professional staff providing direct services to the person served, plus such other individuals as may be authorized administratively or by the consumer. All authorizations either those listed above or others shall be in writing.

A.. Access to individual files shall be limited to only those staff members who have a need to know information contained in the records of persons served.

B. Individual service records shall be maintained according to provisions of the Privacy Act:

C. Access to computer records shall be limited to those authorized to view records

D. The organization shall ensure the right of all persons served to access their own records.

E. The organization shall ensure that all persons served know how to access their records and the organization ensures that appropriate equipment is available.

F. An organization shall not prohibit the persons served from having access to their own records, unless a specific state law indicates otherwise. It is recognized that the organization must comply with HIPAA regulations as it relates to specific information that cannot be disclosed to persons served without authorization (i.e., psychotherapy notes).

402.2 Adult individuals who are legally competent shall have the right to decide whether their family will be involved in planning and implementing the individual service plan. A signed release or document shall be present in individual case record giving permission for family to be involved.

402.3 The Individual /Parent /Guardian shall be informed of their rights. The organization shall maintain documentation in the individual's file that the following information has been provided in writing: THE INFORMATION LISTED IN 402.3 A-I MUST BE PROVIDED UPON ADMISSION AND ANNUALLY THEREAFTER.

A. All possible service options, including those not presently provided by the program.

B. A copy of the rules of conduct and mission statement of the organization.

C. Current list of Board members of the community program.

D. Summary of funding sources.

E. Copy of the appeal procedure for decisions made by the organization.

F. Solicitation Guidelines **See Solicitation under Definitions

G. All external advocacy services.

H. Right to appeal any service decision to DDS, under DDS Policy 1076

I. Name and phone number of the DDS Service Specialist for that area

403 Grievances and Appeals

Guiding Principle: The organization identifies clear protocols related to formal complaints, including grievances and appeals. An organization may have separate policies and procedures for grievances and appeals, or may include these in a common policy and procedure covering complaints, grievances, and appeals. A review of formal complaints, grievances, and appeals gives the organization valuable information to facilitate change that results in better customer service and results for the persons served.

A. The organization shall identify clear protocols related to formal complaints, including grievances and appeals.

B. The organization shall:

1. Implement a policy by which persons served may formally complain to the organization.
2. Implement a procedure concerning formal complaints that:
   a. Is written.
   b. Specifies:
      1. That the action will not result in retaliation or barriers to services.
      2. How efforts will be made to resolve the complaint.
      3. Levels of review, which includes availability of external review.
      4. Time frames that are adequate for prompt consideration and that result in timely decisions for the person served.
      5. Procedures for written notification regarding the actions to be taken to address the complaint.
      6. The rights and responsibilities of each party.
      7. The availability of advocates or other assistance.
3. Make complaint procedures and, if applicable, forms:
   a. Readily available to the persons served.
   b. Understandable to the persons served and in compliance with 29 U. S. C. §§ 706 (8), 794 – 794(b).

C. These procedures shall be explained to personnel and persons served in a format that is easily understandable and meets their needs. This explanation may include, but not limited to a video or audiotape, a handbook, interpreters, etc.

403.1 The organization shall annually review all formal complaints filed.

A. A written review of formal complaints:
   1. Determine:
      a. Trends.
      b. Areas needing performance improvement.
      c. Action plan or changes to be made to improve performance and to reduce complaints

403.2 The organization shall document a review of any action plan or changes made to determine if the plan/changes were effective in reducing complaints and shall make adjustments to the plan as deemed necessary to ensure quality services.

404 Health Related Issues

Guiding Principle: A successful health and safety program goes beyond compliance with regulatory requirements and strives to manage risk and to protect the health and safety of persons served, employees, and visitors. A successful health and safety program addresses both minimizing potential hazards and compliance activities.

A. The organization shall implement policies/procedures to ensure the rights of individuals who have or who are perceived as having Acquired Immunodeficiency Syndrome (AIDS) or Human Immune Virus (HIV) related condition (or those who may be perceived as having AIDS or AIDS related conditions including Hepatitis B are not discriminated against in accordance with 29 U.S.C. §§ 706 (8), 794 – 794(b); U.S.C. § 12101 et. seq. A copy of the policies/procedures shall be provided to each Individual/Parent/Guardian(s).

B. The organization shall implement policies/procedures concerning any person admitted for services or anyone proposed for admission to ensure confidentiality shall be maintained for all information related to HIV testing, positive HIV infection, any HIV associated condition, AIDS or Hepatitis B.

C. Each organization will protect the confidentiality of records or computer data that is maintained which relates to HIV, AIDS or Hepatitis B.

405 Incident / Accident Reporting

A. The organization shall **report the following incidents to the DDS Licensing Unit** in accordance with DHS Policy 1090. This report shall contain: date, accident/injury, time, location, persons involved, action taken, follow-up, signature of person writing the report. The following are reportable incidents:

1. Use of seclusion or restraint.
2. Maltreatment or abuse as defined in statutes (See Ark. Code Ann. §§ 12-12-501 – 12-12-515 (503); Ark. Code Ann. §§ 5-28-101 – 5- 28-109 (102))
3. Incidents involving injury:
    a. Accident/injury reports shall be completed for each accident/injury that requires the attention of an EMT, Paramedic or Physician.
        1. Accident is defined as an event occurring by chance or arising from unknown causes.
        2. Injury is defined as an act that damages or hurts and results in outside medical attention.
        3. A copy of the report, redacted as required by the Freedom of Information Act must be sent to parent/guardian of all children (0-18), and to guardian of adults regardless of severity of injury.
        4. Other health-related conditions resulting in Emergency treatment or hospitalization.
4. Communicable disease
5. Violence or aggression
6. Sentinel events (i.e., an unexpected occurrence involving death or serious physical

or psychological injury or the risk thereof)

7. Elopement and/or wandering defined as anytime the location of a person cannot be determined within 2 hours
8. Vehicular accidents
9. Biohazardous accidents
10. Use or possession of illicit substances or use or possession of licit substances in an unlawful or inappropriate manner (i.e., possession of prescription drugs by a person to whom the drugs have not been prescribed and who has no legitimate interest in possession of prescription drugs, such as a parent or guardian)
11. Arrests or convictions
12. Suicide or attempted suicide
13. Property destruction
14. Any condition or event that prevents the delivery of DHS services for more than 2 hours
15. Behavioral incidents (incidents involving an individual's actions that are aggressive, disruptive and/or present a danger to the individual or to others)
16. Other areas, as required

NOTE: *FOR INDIVIDUALS 3-21 YEARS OF AGE, DESTRUCTION OF INCIDENT REPORTS MUST BE IN COMPLIANCE WITH DEPARTMENT OF EDUCATION.*

B. The organization shall notify the parent/guardian of all children (0-18) or adults who have a guardian any time an incident/ injury report is submitted.

C. The organization shall develop and implement policies and procedures regarding follow-up of all incidents to include a time-line for action, remediation and preventative measures that do not exceed DDS established timeframes, in accordance with DHS Policy 1090.

407 Behavioral Management

A. The organization shall develop policy and procedure that demonstrates a commitment to a system that nurtures personal growth and dignity, and supports the use of positive approaches and supports.

B. The organization's policy and procedure shall ensure that when behavior management approaches are used, positive behavior interventions are implemented prior to the use of restrictive procedures.

C. Written behavior management policy developed by the organization shall ensure the rights of individuals.

1. The policy will be incorporated by the interdisciplinary team in programming, as appropriate.
2. The plan must be reviewed quarterly or as dictated by the needs of the individual served.

3. This shall include all types of behavior management used i.e., time out, token economy, etc… This cannot include procedures that are punishing, physically painful, emotionally frightening, or deprivation, or that puts the individual served at medical risk which are used to modify behaviors

D. If restrictions are placed on the rights of a person served:
   1. The organization shall follow its policies and procedures.
   2. The organization shall obtain informed consent from the individual/parent/guardian prior to implementation.
   3. The organization shall have methods to reinstate rights as soon as possible.
   4. Staff members are trained on proper implementation of all restrictions utilized by the organization.

E. The organization shall assure that maltreatment or corporal punishment of individuals will not be allowed.
   1. Policies and Procedure must state that corporal punishment is prohibited.
      a. "Corporal punishment" refers to the application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior.
      b. 20 U.S.C. § 1400 et. seq.; Maltreatment laws, Ark. Code Ann. §§ 12-12-501 – 12-12-515; Ark. Code Ann. §§ 5-28-101 – 5-28-109 .

F. Individuals shall have the right to obtain and retain private property.
   1. Personal possessions are regarded as the private property of the individuals and shall not be taken away unless danger to safety of the individual or to others is present.

G. Emergency Basis Procedure

An emergency safety situation is defined as unanticipated behavior that places the person served or others at serious threat of violence or risk of injury if no intervention occurs.

   1. The organization shall establish policies/procedures for the use of restraint and/or emergency intervention procedures that must be used/undertaken in the event of a emergency circumstances for a consumer who has no behavior management plan in place. The policies/procedures must identify the circumstances under which emergency procedures will be used as a protective measure in a life- or safety-threatening situation only when de-escalation has failed or is not possible.
   2. Emergency basis procedures may not be repeated more than three (3) times within six months without the interdisciplinary team meeting to revise the individual program plan. Each incident consists of: a behavior was exhibited, a procedure was used, the individual was no longer thought to be dangerous, the procedure was discontinued.

      Note: The number three (3) means three (3) distinct incidents. The three (3) distinct occurrences could take place in one (1) day.

500 SERVICE PROVISION STANDARDS

501 The organization shall establish written policies and procedures for intake, evaluation, and diagnosis necessary to determine the eligibility of a person to receive services shall be documented.

501.1 The organization shall designate specific staff positions assigned with the responsibility for intake, evaluation, assessment, family contact, planning, updating, and alternate placement.

502 Face sheets shall be completed at intake and shall be updated as needed and at least annually as documented by date of signature of the person designated in organization's policy.

502.1 Every person receiving services shall have a service record face sheet that contains the information in 502.1 A-S and will be filed in a prominent location in the front of the file.

A. Full name of individual
B. Address, county of residence, telephone number and email address, if applicable
C. Marital status, if applicable
D. Race and gender
E. Birth date
F. Social Security number
G. Medicaid Number
H. Legal status
I. Parents or guardian's name and address and relationship, if applicable
J. Name, address, telephone number and relationship of person to contact in emergency, someone other than item H
K. Health insurance benefits and policy number
L. Primary language
M. Admission date
N. Statement of primary/secondary disability
O. Physician's name, address and telephone number
P. Current medications with dosage and frequency, if applicable
Q. All known allergies or indicate none, if applicable
R. The results of all independent, annual developmental screens conducted by the DHS third-party vendor, or authorized waiver of the developmental screen requirement.

502 A case manager/service coordinator/evaluator shall be designated in writing and shall organize the provision of services for every individual served. The case manager/service coordinator/evaluator shall provide the individual or parent/guardian with the name and contact information in writing.

A. For every individual served, the case manager /service coordinator/ evaluator shall:
    1. Assume responsibility for intake, assessment, planning and services to the person
    2. Coordinate the individual program plan
    3. Cultivate the individual's participation in the services
    4. Monitor and update services to assure that:
        a. The person is adequately oriented
        b. Services proceed in an orderly, purposeful, and timely manner

c. The transition and/or discharge decision and arrangements for follow-up are properly made.

503 Intake

A. A written intake procedure shall be available upon request, shall be understandable to the individual receiving the services, shall be presented to those requesting services, and shall be followed by the organization in the evaluation of a person to determine eligibility for services.

B. The organization shall implement policies and procedures for acceptance into services. Policies and procedures must:

1. Establish the criteria for the order of acceptance of any person awaiting service.
2. Identify the position or entity responsible for making acceptance decisions.
3. Provide opportunities for persons to learn about the organization and its services.
4. When a person is found ineligible:
   a. The person is informed of the reasons.
   b. The person is given information about potential alternative services.
5. Ensure that all involved are aware of their responsibilities regarding services prior to the planning and delivery of services
6. Ensure signed informed consent for services are obtained and retained as required by funding sources and for legal reasons
7. Ensure persons served are given information about setting their individual service goals, when applicable, planning the services to be delivered and how progress on service goals will be communicated with them.

504 Information gathered prior to admission shall include the following information and shall be filed in the individual's record:

A. The results of the independent, annual developmental screen conducted by the DHS third-party vendor, or the authorized waiver of the developmental screen requirement.

B. Signed emergency medical release and all other necessary release forms (i.e., Publicity, field trip, fund raising, etc.). The emergency medical release form shall remain current (yearly) for the protection of the organization and the individual.

1. Competent adults must always sign their releases
2. Publicity releases shall be obtained on an as-needed basis (for each occurrence)
3. Field trip releases shall be obtained on a per occurrence basis unless that field trip is part of the regular program (i.e. bowling each week, swimming each week, etc.)
4. Emergency medical releases must be taken on field trips or incorporated in the field trip release.

C. Statement of Legal (competency) status; See Ark. Code Ann. §§ 28-65-101 – 28-65-109 (see index)

1. If the individual is under the age of 18, he/she is a minor. Organizations shall determine the who is the legal guardian of the child: Natural parent(s), ward of the state (DCFS/foster home, etc.) and shall ensure the legal guardian signs all appropriate documents.
2. If the individual is age 18 or older, he/she is considered competent unless the court has appointed a legal guardian. Copies of guardianship orders must be maintained in the individual's record.

Note: An individual for whom a guardian has been appointed retains all legal and civil rights except those which have been expressly limited by court order or which have been specifically granted by order of the court to the guardian. 4.

505 Application for services

A. The organization shall develop and implement a written application to be made available upon request or presented to those requesting services. At a minimum, the application shall contain name, address and telephone number of individual/parent/guardian and a statement of the individual's needs. Applications shall be available in an alternate format and assistance to complete shall be offered to individual's that may require it

506 The organization shall complete a Financial Screen for all applicants for services as applicable.

A. The screen shall be completed prior to admission and is used by the program in the evaluation of a person's financial status

B. The organization shall include all information about benefits for Medicaid eligibility and, for individuals who may not be eligible for Medicaid, shall include information about Tax Equity Family Reform Act eligibility.

507 Medical prescription for services shall be obtained, if applicable

A. A current prescription for services (within twelve months), signed by qualified medical personnel, shall be on file prior to admission

508 The organization shall complete or obtain a full assessment at the time of the admission process. The assessment shall include the following items:

A. Social history

1. A social history shall be written or procured within thirty (30) days of admission. The social history must be comprehensive, in narrative form or a completed questionnaire. The social history must be updated annually as evidenced by dated signature.

B. Medical history and evaluation

1. A physical examination/assessment signed by qualified medical personnel shall be on file and current within 5 days but not longer than thirty (30) days after admission. In cases where a physical cannot be obtained within 5 days, documentation of a physical within 1 year will be accepted until a new physical can be obtained

2. Early Periodic Screening Diagnosis Treatment process for Medicaid eligible individuals (0-21)

a. All individuals 0-21 years of age eligible for Medicaid should have evidence in the file that they are participating in the EPSDT process

509 A psychological evaluation report shall be on file prior to admission for adults (age 18 and older) and for children (age 5-18) if applicable

A. Adults (age 18-up) transferring from a DDS Licensed provider may be admitted with a copy of the most current psychological evaluation

B. A new psychological evaluation may be conducted if an Interdisciplinary Team determines that it is reasonable and necessary based on significant life changes of the individual.

510 Therapy evaluations must be completed or procured within thirty (30) days after admission, when applicable or when prescribed by a physician or a therapist working under a physician's orders. Recommendations from therapy evaluations shall be incorporated into the individual's plan of care as appropriate.

511 When applicable, all psychiatric evaluation shall completed by a qualified person and must be on file within thirty (30) days after admission. Recommendations from psychiatric evaluations shall be incorporated into the individual's plan of care as appropriate.

512 The service needs assessment must be completed on every individual seeking services

NOTE: SEE SECTION 521 FOR FURTHER GUIDELINES (CHILDREN'S SERVICES SECTION).

A. The person and/or family served and/or their legal representatives shall be involved in:
1. Assessments of potential risks to each person's health in the setting in which they receive services as well as in the community
2. Assessments of potential risks to each person's safety in the setting in which they receive services as well as the community
3. Decisions to accept or reject such risks
4. Identification of actions to be taken to minimize risks
5. Identification of individuals responsible for those actions

513 Personal Futures Planning

Guiding Principle: Individual's with developmental disabilities and their families have competencies, capabilities and personal goals that shall be recognized, supported, encouraged, and any assistance to such individual's shall be provided in an individualized manner, consistent with the unique strengths, resources, priorities, concerns, abilities, and capabilities of such individuals. Any plan of service developed should significantly reflect the person for whom it is intended. Services/ supports are most effective when they are adapted to address individual outcomes

1. The organization shall prepare a written person-centered support plan for each individual that shall meet their individual needs. At a minimum, the plan shall:
   A. Be developed only after consultation with the individual/parent/guardian, and other individuals from the individual's support network as determined by the individual/parent/guardian;
   B. Contain a description of the individual's preferred lifestyle, including:
      1. The type of setting in which the individual wants to live or work;
      2. With whom the individual wants to socialize;
      3. The social, leisure, religious, or other activities in which the individuals wants to participate;
      4. Reflect the individual's / family's choice of services which are relevant to the individual's age, abilities, life goals/outcomes

5. Address areas such as the individual's / family's health, safety and challenging behaviors which may put the individual at risk
6. Demonstrates the rights and dignity of individual/ family
7. Incorporates the culture and value system of the individual/family
8. Ensures the individual's/ family's orientation and integration to the community, its services and resources.
9. The necessary activities, training, materials, equipment, assistive technology and services needed to assist the individual in achieving their preferred lifestyle;
10. Describes how opportunities for individual choice will be provided;
11. Be approved, in writing by the individual/parent/guardian.

2. The organization shall regularly review and revise the plan whenever necessary to reflect changes in the individual's preferred lifestyle; achievement of goals or skills outlined within the plan or the goal is no longer deemed appropriate for the individual

514 Every individual shall have a written Individualized Program Plan

NOTE: SEE INDIVIDUAL PROGRAM SECTIONS FOR SPECIFIC TIME FRAMES (CHILDREN'S SERVICES, SEE SECTION 521).

A. The organization shall include the person served as an active participant giving direction in all aspects of the planning and revision processes
B. Services shall be provided based on the choices of the individual/parent/guardian (as appropriate) and on the strengths and needs of the individuals to be served by the organization
C. Individual choice shall be determined by personal futures planning as specified in Section 513 and a comprehensive assessment which addresses:
   1. Relevant medical history
   2. Relevant psychological information
   3. Relevant social information
   4. Information on previous direct services and supports
   5. Strengths
   6. Abilities
   7. Needs
   8. Preferences
   9. Desired outcomes
   10. Cultural background
   11. Other issues, as identified

514.1 The Individualized Program Plan:
   A. Shall be developed with the input of the person served and/or their legal guardian.
   B. Shall Identify:
      1. Least restrictive environment

a. Documentation of discussion of least restrictive environment appropriate for individual strengths and needs

b. The program must document the justification for specialized environments if they are to be used. Plans shall be made for return to normal environments as soon as possible.

1. Individuals shall be in contact as much as possible with those who do not have disabilities

2. Individual program plans will be reviewed for provisions of program services in the least restrictive environment appropriate to the ability of the individual. Document this item with a summary of the discussion by the entire team about the least restrictive alternatives

3. If the person chooses community integration or a less restrictive environment, documentation of referral attempts for alternate placement shall be present

2. Barriers

a. Describe the conditions or barriers that interfere with the achievement of the goal(s) or skills(s). Describe why a particular individual's needs cannot be met or what needs to be accomplished to meet the need.

b. Resources and/or environment changes, adaptations or modifications necessary to attain the goal or skill shall be listed. The person responsible for attempting to get the service must be identified.

Note: Example of barriers are: lack of contract work, lack of funds, lack of staff, individual absent due to illness, prosthetic devices, equipment space, etc. The responsible person may be staff member, individual, family, etc.

c. Documentation of efforts made to remove the identified barriers shall be noted in the individual's progress reports.

3. Long-range goals (addressing a period of 3-5 years) and annual goals

a. The plan shall incorporate the goals and objectives of the individual's person centered plan.

b. The planning process shall support the individual / family in decision making and choosing options by actively involving the individual/ family in the Individual Plan (IP) development

4. Specific measurable objectives.

514.2 Short-term objectives (3-6 months' time frame) shall be developed, as needed, for each of the annual goals.

A. Each objective must have criteria for success that states what the individual must do to complete the objective.

B. Short-term objectives must have methods/materials for implementation and give a simple statement describing the procedures to be used in individual training.

C. The person responsible for implementation of each short-term and service-objective shall be specified.

Note: Utilization of title is recommended. This could be the individual or parent/guardian.

D. Short-term objectives shall have an initiation date, a target date, and, when completed, a completion date

E. Target dates –

1. The target date shall be individualized and noted at the same time of the initiation date and the projected date when the individual can realistically be expected to achieve an objective.
2. The target date shall be used as a prompt to see if expectations for the individual are realistic in relation to attainment and appropriateness of goals and objectives. If the starting or target dates need to be revised, the organization shall mark through, initial and put in a new date.
3. The ending date shall be entered in as the person completes each objective.

514.3 Service Objectives

A. Shall be reviewed on a regular basis with respect to expected outcomes.

B. Shall be revised, as appropriate:

1. Based on the satisfaction of the person served.
2. To remain meaningful to the person served.
3. Based on the changing needs of the person served.

C. Shall include a target date, which is a projected date when the team thinks the individual will no longer need the service or the service provision should be reviewed.

514.4 The following areas shall be assessed to determine needs in the plan and shall be documented:

A. Assistive technology.

B. Reasonable accommodations.

C. Identified health and safety risks

514.5 The individual program plan shall be communicated in a manner that is understandable:

A. To the person served and/or their guardian / advocate/ representative.

B. To the persons responsible for implementing the plan.

514.6 The organization shall ensure that persons involved or their legal guardian/advocate understand the plans and their own involvement in achieving the outcomes.

A. Active participation of the persons served, or their guardian or advocate in setting goals and planning services shall be documented. Documentation may be through interviews, records, checklists, etc. and shall be maintained in the individual's file

B. If a person served needs services that are not available through the organization, the organization shall make referrals to other providers as indicated. Documentation of the referral(s) shall be maintained in the individual's file.

NOTE: CONTACT DDS FOR A LIST OF PROVIDERS THAT PROVIDE THE REQUESTED SERVICE.

515 Every ninety (90) days of service delivery, the service provider shall complete a quarterly report on the goals/objectives of the IPP. If needed, modifications may be made with meeting of entire team. Quarterly reports must be specific to reflect the individual's performance concerning

implemented goals and short-term objectives as specified in the individual program plan and shall be based on the case notes for the reporting period.

A. The quarterly notes shall establish goals or short-term objectives which are:
   1. Accomplished
   2. To be continued
   3. Modified or deleted (with statement of reason or barrier) and
   4. Will be worked on for the next three months or ninety (90) days

B. Data Collection/case notes shall be utilized in writing progress reports.

C. Quarterly reports shall be written, dated, and signed by persons responsible for case management. All persons responsible for implementation of services must contribute to the report.

D. Quarterly reports shall document referral to interdisciplinary team for modification of the annual goals as needed, in compliance with state and federal regulations

E. Documentation of communication of quarterly reports to the individual/parent/guardian (as appropriate) shall occur at least every three (3) months or ninety (90) days as in compliance with state and federal regulations.

F. Quarterly reports must include space for individual and/or parental/guardian evaluation of services. The organization shall document that the persons served and/or the parent guardian has opportunity to evaluate the services received as in accordance with state and federal guidelines.

516 Updating

A. The organization shall have policies and procedures in place for updating individual program plans. Updates shall be done at least annually and more often if monitoring reports indicate a need or if federal regulations require more frequent updates.

B. The organization shall have policies and procedures in place for revising individual program plans when goals change.

C. Annually update – financial, if applicable, social, medical, medical prescription for services, evaluations as applicable, IPP's, and service needs assessment;

517 Termination of services or alternate placement

NOTE: SEE THE SPECIFIC PROGRAMMING SECTION FOR MORE DETAILED INFORMATION (CHILDREN'S SERVICES 521).

A. An exit summary shall be prepared each time a person leaves a service, not just when the person is leaving the organization.
   1. The report shall summarize the results of the services received by the person and makes recommendations for future services to continue the achievement of the person's life goals.
   2. The plan may suggest referrals to other services that are not available through the organization

518 Data Collection Requirements

A. Data collections shall provide specific information on annual goals and short-term objectives and should be designed to measure and record the progress on each short-term objective.

B. Data collection shall consist of sufficient written documentation to support each. *Daily* service documentation must, at a minimum, include:

- The specific services furnished;
- The date and actual beginning and ending time of day the services were performed;
- Name(s) and title(s) of the person(s) providing the service(s);
- The relationship of the services to the goals and objectives described in the person's individualized plan of care and

C. Data collection shall also consist of weekly or more frequent progress notes, signed or initialed by the person providing the service(s), describing each individual's status with respect to his or her goals and objectives.

D. Data Collection shall be filed in the individual's file at least monthly and shall be available for review upon request.

520 The organization shall establish and maintain each individual's daily schedule based upon the individual's program plan. The schedule shall indicate general activities throughout the day for each individual. As appropriate the schedule should reflect time segments for the individual to exercise choice in the selection of activities.

521 Children's Services Individual Program Planning

As a key element in establishing goals/objectives/ personal outcomes, the agency shall assess an individual's/family's preferences, desires, lifestyle choices, strengths, needs, skills, etc. through individual observations or interviews. Documentation of the assessment shall be maintained in the individual's file. At a minimum, the assessment must include:

A. Developmental Assessment
   1. Initial evaluation shall include 2 developmental assessments; 1 standardized and 1 criterion based.
   2. Documentation must include:
      a. A written summary that includes standard deviation and/or percentage of delay as determined by the test protocols
      b. An informed clinical opinion
   3. Must be in a format that is understandable to the parent.
   4. Must be signed by the evaluator.

B. An annual assessment must be conducted using a criterion based test.

C. A Social History must be completed, signed and dated on the approved form from DOE.

521.1 Children 3-5-The Individual Program Plan shall include a statement of the specific services necessary to meet the identified needs of the child/family.

A. At a minimum the IPP must include:
   1. Frequency- Number of days or sessions that a service will be provided
   2. Intensity- The length of time the service is provided during each session, and whether the service is provided on an individual or group basis
   3. Location- Location where the service is provided (e.g., in the child's home, early intervention center, or other setting) as appropriate to the age and needs of the child

4. Method- How a service is provided
5. Dates and duration- Projected dates of initiation of the services, a target date for completion and/or review and the anticipated duration of those services. If either of these dates needs to be revised, then simply mark through, initial and put in new date.

B. Completion of the IPP must meet all State and Federal requirements

C. In order to revise an individual's objectives, at least three (3) members of the team must be present. Parent(s) must be included.

521.2 Quarterly reviews must include a Family Rating which must be documented on the appropriate form as designated by DDS.

521.3 Children reaching 5 years of age must have a transition plan.

A. This plan must be developed 180 days prior to age 5 as per State and Federal guidelines.

B. The plan must be child specific and must include specific steps to ensure a smooth transition for the child and family, and must be in accordance with State and Federal Guidelines.

C. The plan must include a transition plan at kindergarten age. Children entering public schools must have a transition plan.

D. The individual program shall include the steps to be taken to support the transition of the child upon reaching kindergarten age.

E. The organization must document contact with the agency which will provide services following the transition, and must demonstrate an attempt to involve that agency in the transition planning. Documentation must be maintained in the individual's file.

521.4 If the organization is using the supervising teacher model, the organization must follow all State and Federal Guidelines and maintain appropriate documentation of supervision and direct contact with the child on file for review.

522 Vocational Maintenance & Monitoring

Vocational Maintenance & Monitoring

A. Case Notes

1. Case notes shall document each contact with the individual the frequency of each contact will be determined by the team during the development of the IPP it should include date, time and summary of each contact.
2. Service Objectives shall be listed in an outcome oriented manner.
   - A. Each service objective shall specify any environment modification necessary to facilitate the individual's accomplishment.
   - B. Each service objective, including physical adaptations or modifications of the individual's environment, shall be stated as a single specific outcome.
   - C. Service objectives shall provide opportunities in the social environment to support community integration and the enhancement of individual relationships.

D. Based on the individual's choice, and the needs assessment, plans shall include facilitation of the individual's participation in normal activities in normal settings of same-age peers.

523 STAFF RATIOS

523.1 Staff Ratios for Early Intervention Day Treatment Day Programming:

Ratios for Day Programming for Children 0-18 months
1:4

Ratios for Day Programming for Children 18-36 months
1:5

Ratios for Day Programming for Children 3-4 Years
1:7

Ratios for Day Programming for Children 4-6
1:8

Ratios for Day Program for Children 6 and over
1:10

523.2 Ratios for Adult Developmental Day Treatment Day Programming
The organization shall maintain a 1:10 ratio throughout the building.

523.3 For all Day Programming
The Direct Care Staff must have VISUAL CONTACT WHILE ACTIVELY ENGAGED IN PROVIDING SUPPORT AND SUPERVISION TO CONSUMERS.

524 Square Footage

A minimum of forty (40) square feet of program training area per individual served shall be required. This is program-training area only. This does not include halls, storage areas, or administrative offices.

600 FOOD SERVICES

A. This standards section shall be applied to all provider owned/leased/rented facilities. If the facility contracts for food services, the organization shall ensure compliance with DDS policies.

601 Written procedure shall be established that addresses how food services are provided to the individuals served by the facility:

A. Procedure shall include how meals are provided as well as staff responsible.

601.1 All Day services programs shall assure that organization provided meals are approved, adequate diets, which conform to the recommended dietary allowance.

601.2 Licensed Group Homes shall assure that three (3) meals a day are available for individuals served.

A. The organization shall keep on hand suitable food for preparing sack lunches, if appropriate.

B. All meals shall be part of an approved, adequate diet, which conforms to the recommended dietary allowance.

C. Facilities with apartment units shall have a mechanism for monitoring the resident's food related skills.

602 The organization shall keep menus on file. Menu preparation should occur at least one week in advance in order to:

A. Allow adequate time to purchase foods to avoid too frequent menu substitutions. Meal planning shall occur so that identical meals are not served on the same day of consecutive weeks.

B. Serve as a reminder for scheduling advance preparation;

C. Allow menus to be available as a teaching tool for instruction of individuals, to include development of menus by individuals.

Menus shall be kept on file for a minimum of three (3) months.

603 Menus shall be prepared or approved by a registered dietitian/nutritionist. Organizations may contract with a dietitian/nutritionist.

A. Dietitian/nutritionist shall check for nutritional adequacy of menus and acceptable food safety and sanitation practices. This must be documented by a written report at least annually.

B. DDS shall accept Arkansas Nutrition Program approval, or site monitoring reports, as adequate approval for Centers that participate in the free/reduced lunch program.

604 The organization shall develop and implement written procedures that address provisions for special diets.

A. Special diets pertain to allergies, weight control, diabetes, religion, hypertension, and other medical conditions as documented in the consumers file.

605 Food items and toxic items shall not be stored together.

700 TRANSPORTATION

A. The organization shall establish written procedures that address how transportation services are provided to individuals served by the program.

B. The procedures shall address transportation to the persons served, as well as staff responsible.

C. The organization shall ensure that all individuals receiving services are provided with a copy of the transportation policies and shall document receipt of this information in the individual's file.

701 The organization shall assure safety for all persons being transported. For all transportation services provided for the persons served by the organization, the organization shall ensure:

A. For all vehicles owned or operated by the organization:

1. Compliance with all applicable federal, state, county, and city requirements.
   a. All vehicles shall be properly licensed by the State of Arkansas.
2. Appropriate licensing of all drivers.
   a. All drivers must be licensed according to state requirements for providers of public transportation.
3. Review of driving records of all drivers on an initial and annual basis.
4. Insurance requirements for vehicles and personnel.
   a. The organization shall maintain insurance coverage providing a minimum of $1,000,000 comprehensive, liability, and property damage.
5. Safety equipment / features in vehicle(s).
   a. Fire extinguisher in every program vehicle used to transport consumers.
   b. Each vehicle shall utilize seat belts or suitable restraints when in motion in accordance with Ark Code 27-37-702 "Seat Belt Use Required" and 27-34-101-107 "The Child Passenger Protection Act"
   c. The organization shall establish policy and procedure to ensure Child Safety Alarms on every vehicle required under Ark Code 20-78-225 (all vehicles designed or used to transport more than 7 passengers and 1 bus driver)
6. Accessibility based on the individual's needs and reasonable requests.
7. Training of drivers in the organization's transportation requirements.
8. Written emergency procedures.
   a. Each vehicle used in transporting clients shall have a documented emergency drill once every six months.
9. Availability of communication devices (i.e., cell phones 2-way radios, etc.).
10. Road warning/hazard equipment (i.e., safety cones, flairs, reflector signs, etc.)
11. First aid supplies.
   a. Every program vehicle used to transport consumers shall maintain a First Aid kit.
12. Maintenance of vehicles owned or operated by the organization according to manufacturers' recommendations.
   a. The organization shall establish/implement procedures that ensures a vehicle maintenance log is kept up to date for all vehicles used to transport consumers.

1. The procedure shall establish who is responsible for upkeep of vehicle and who is responsible for documentation and update of log.

b. The maintenance log shall document the following:
   1. Oil changes
   2. Tires and brakes repair/inspection
   3. Head and tail lights and turn signals repair/inspection
   4. Windshield washer and wiper blades repair/inspection
   5. Air conditioner (if any), and defroster inspection/repair
   6. Hoses and fan belts inspection/replacement
   7. Fluid levels inspection and replacement
   8. Exhaust system inspection/repair
   9. Emergency warning system inspection/repair
   10. Steering assemblage inspection/repair

13. If services are contracted:
   a. An annual review of the contract against elements 1-12 of this standard shall be performed by the organization.
   b. Personnel or contractors shall provide transportation services for the persons served in a safe manner, with drivers having knowledge of unique needs of persons served, and consistent with the regulations of the local authorities.
      1. This standard shall apply when any vehicle, including a personal vehicle, is used to provide transportation for persons served.

702 The organization shall establish written policy and procedure to address apparent abandonment of consumer by family and/or guardian.

A. The organization shall develop a procedure to be followed by transportation staff when unable to leave individuals at home or alternate sites as specified by family that ensure the safety of the individual at all times.

703 At least one responsible person, in addition to the driver, shall be present in the vehicle if any of the following conditions apply:

A. Any person being transported has medical conditions as defined by the organization guidelines.

B. Any person being transported has a severe disability as defined by the organization's guidelines.

NOTE: 'Responsible person' shall be defined by the organization's policy.

704 Organizations operating vehicles transporting children shall comply with the child:staff ratio specified by the Child Care Licensing Standards for Transportation

705 Organizations operating vehicles transporting adults shall establish/implement policies related to adult: staff ratios.

NOTE: DDS RECOMMENDS A 1 TO 10 RATIO AT ALL TIMES.

800 PHYSICAL PLANT, ACCESSIBILITY AND SAFETY

A. The organization shall provide a physical plant compatible with services provided and with the needs of the individuals and staff; provide an accessible and safe environment and be in compliance with U.S.C. § 12101 et. seq. "American with Disabilities Act of 1990" at all owned, leased, and/or rented program site(s).

801 The organization shall promote accessibility in all settings. The organization shall assess all physical sites to ensure accessibility for individuals and their families and shall establish time lines and actions to be taken for removal of identified barriers.

A. Organizations shall ensure that all physical sites address accessibility issues in order to:
   1. Enhance the quality of life for those served in their programs and services.
   2. Meet legal and regulatory requirements.
   3. Meet the expectations of stakeholders in the area of accessibility.

801.1 Accessibility Requirements

A. The organization shall ensure architectural accessibility at each facility based on the individual's needs.
   1. Ramps, doors, corridors, toileting and bathing facilities, furnishings, and equipment are designed to meet the individual's needs.

B. The organization shall ensure that all their facilities are in compliance with 29 U.S.C. §§ 706 (8), 794 – 794(b) "Disability Rights of 1964" and U.S.C. § 12101 et. seq. "American with Disabilities Act of 1990". Compliance with the aforementioned laws is required to receive federal monies. Admissions criteria of who can be served shall identify any persons the facility or staff would be prevented from serving due to accessibility issues.

801.2 Accessibility Assessment and Planning

A. The organization shall assess all facilities. The assessment shall identify all barriers and shall develop a plan for removal of barriers in the following areas:
   1. Architecture
      a. Architectural or physical barriers which may include steps that prevent access to a building for an individual who uses a wheelchair, narrow doorways that need to be widened, bathrooms that need to be made accessible, the absence of light alarms for individuals who have a hearing impairment, and the absence of signs in Braille for individuals who have visual impairments.
   2. Environment
      a. Any location or characteristic of the setting that compromises, hinders, or impedes service delivery and the benefits to be gained.

802 Physical Plant Structure

802.1 Architecture

A. All water, food service, and sewage disposal systems must meet all local, state, and federal regulatory agencies, as applicable. The organization shall maintain documentation of all approved inspections for review by DDS.

1. Sewer inspections are not required if the site is on city water and sewage lines.
2. Sites using a well and/or septic tank, shall be obtain an inspection by the Division of Health documenting compliance with the DOH and local regulations.

B. Floor furnaces, gas heaters, electric heaters, hot radiators, and exposed water heaters must be protected by screens or guards that are without sharp corners and are attached to floor or wall to prevent persons from falling against the guard and knocking it over.

C. Enclosed gas heaters must be properly vented to the outside, and installed with permanent connection that includes a cut-off valve in the rigid part of the gas supply pipe.

Note: DDS recommends gas heaters with a pilot light and automatic cut-off valve which automatically cuts off gas to the main burner when the pilot light goes out.

D. Restroom facilities used by individuals must provide for individual privacy and be appropriate for the individuals served regarding size and accessibility.

802.2 Environment

A. Temperature of each facility must be maintained within a normal comfort range for the climate. Recognizing that there may be variances within a building, the organization shall make reasonable efforts to maintain a comfortable temperature range throughout the facility.

Note: The recommended standard for range of comfort is from 65 to 80 degrees F (U.S. Atmospheric Standards 29.1)

B. All areas of the facility shall be sufficiently lighted to meet the needs of the individuals being served and the usage of the area.

C. The organization shall maintain the interior and exterior of the building in a sanitary and repaired condition.

D. The premises shall be free of offensive odors.

E. The grounds and all buildings on the grounds shall be maintained in a clean and repaired condition.

1. Play and activity areas shall be free of dense undergrowth and refuse accumulations. All landscape plantings and the lawn shall be well groomed.

F. The facility shall be maintained free of infestations of insects and rodents.

1. The organization shall maintain a contract for pest control that is administered by appropriately licensed professionals.

G. The organization shall establish written procedures regarding smoking that is in accordance with The Clean Air Indoor Act (Act 8 of 2006).

1. For all congregate, day-hab settings, and licensed group homes, smoking will not be permitted in the following areas:
   a. Common Work Areas
   b. Auditoriums
   c. Classrooms
   d. Conference and Meeting Rooms
   e. Private Offices
   f. Elevators
   g. Hallways
   h. Health Care Facilities

i. Cafeterias
j. Employee Lounges
k. Stairs
l. Restrooms
m. All other enclosed areas.

2. Approved Exemptions:
   a. Private residences or health care facility
   b. All workplaces of any employer with fewer than three (3) employees. (Note: This exemption does not apply to any public place)
   c. Outdoor areas of places of employment or group homes

H. All materials and equipment and supplies shall be stored and maintained in a safe condition. Cleaning fluids and detergents must be stored in original containers with labels describing contents.

1. The organization shall maintain an MSDS manual in a location that is accessible to all employees. All MSDS sheets must be on file and current.

803 Safety Inspections

803.1 The organization shall ensure that annual safety inspections are completed by qualified individuals to enhance and maintain the organization's health and safety practices.

A. All applicable inspections shall be maintained on file, and current within one year or as specified by law/regulation (i.e., Annual Fire Department, Local Health Department, Safety Engineer, OSHA, Safety Specialist, and Insurance Carrier).

B. A comprehensive inspection shall be conducted annually at all facilities where the organization delivers services or provides administration on a regular and consistent basis. Inspections shall be conducted by a qualified external authority(ies).

1. Results of each inspection shall contain written documentation that:
   a. Identifies the areas inspected.
   b. Identifies recommendations for areas needing improvement.
   c. Identifies actions taken to respond to the recommendation(s).

C. All applicable licenses, inspections, etc., shall be current. This shall include health inspections for food service preparation, if applicable. Residential facilities with more than ten (10) residents must have a Division of Health inspection.

803.2 Regular self-inspections shall be completed to assist personnel in internalizing current health and safety requirements into everyday practices.

A. The organization may designate professional personnel (managers, supervisors, direct service employees, maintenance personnel) or internal groups (safety committees, safety circles, operation teams, consumers or advocates) within the organizational structure to conduct self- inspections. The organization shall ensure that all staff involved in self-inspections have received training in conducting inspections prior to participation.

B. The organization shall maintain a schedule of when self-inspections will be conducted.

1. At a minimum, self-inspections must be conducted:
   a. At least twice a year.
   b. At all facilities where the organization delivers services or provides administration on a regular and consistent basis.

2. Results of self-inspections shall contain written documentation that:

a. Identifies the areas inspected.
b. Identifies recommendations for areas needing improvement.
c. Identifies actions taken to respond to the recommendation(s).

804 Emergency Procedures

804.1 The organization shall establish emergency procedures that detail actions to be taken in the event of emergency and to promote safety for the individuals served.

A. Emergency procedures shall be in written form, and shall be available and communicated to all members of the staff and other supervisory personnel.

1. At a minimum, emergency procedures shall be implemented for:
   a. Fires.
   b. Bomb threats
   c. Natural disasters.
   d. Utility failures
   e. Medical emergencies
   f. Safety during violent or other threatening situations (i.e., intruders)
2. Written emergency procedures shall:
   a. Meet the requirements of all applicable authorities.
   b. Implement practices appropriate for the locale (i.e., Arkansas Chemical Stockpile Emergency Preparedness Program/CSEPP)

B. The organization shall maintain an emergency alarm system for each type of drill (fire and tornado).

C. The organization shall ensure that persons served, as appropriate, are be educated and trained about emergency and evacuation procedures.

D. The organization shall evaluate and consider modification of all emergency procedures during the following times:
   a. Training.
   b. After training drills.
   c. As risks increase.
   d. After actual emergencies.
   e. When responsibility is reassigned.
   f. When changes are made to the physical plant.
   g. When changes occur in the physical plant proximity.
   h. When a policy or procedure is revised.
   i. When briefing personnel on emergency plan changes.

E. The organization shall analyze tests of the emergency and evacuation procedures annually and shall use the results of the analysis to improve or to affirm satisfactory current practices.

804.2 For all facilities where the organization delivers services or provides administration on a regular and consistent basis, the organizations shall establish/implement written procedures for evacuations.

A. Evacuation procedures shall address:
   1. When evacuation is appropriate.
   2. Complete evacuation from the physical facility.
   3. The safety of evacuees.

4. Accounting for all persons involved.
5. Temporary shelter, when applicable.
6. Identification of essential services.
7. Continuation of essential services.
8. Emergency phone numbers.
9. Notification of the appropriate emergency authorities.

B. Evacuation routes must be posted in conspicuous places, except in residential settings and must be easily understandable to the individuals served.

804.3 As a part of an organization's performance improvement activities shall include emergency procedure testing.

A. A tornado drill must be held monthly.
   1. Written reports telling date, hour of day, evacuation time, and other areas of concern shall be maintained.

B. A fire drill must be held monthly.
   1. Written reports telling date, hour of day, evacuation time, and other areas of concern shall be maintained.

804.4 Detectors

Battery operated or electronic smoke detectors, heat sensors, carbon monoxide detectors and/or sprinklers shall be provided in all buildings where services are provided and shall meet life safety codes.

A. Fire Marshall's report shall be followed as to placement of these devices.
B. Equipment shall be tested at least quarterly or as recommended by the manufacturer/monitoring contractor.

804.5 Fire Extinguishers

Fire extinguishers shall be required to the extent specified by the State Fire Marshall or his designee and shall be checked annually.

A. The Fire Marshall uses Ark. Code Ann. §§12-13-101 - 12-13-116 "Fire Prevention Act" that follows the Life Safety Code 101 and additional National Fire Prevention Agency publications.

804.6 Emergency Lighting

The organization shall maintain emergency lighting, (i.e., flashlight or other battery operated lights) as required by the life safety codes.

804.7 First Aid

The organization shall maintain a first aid kit and current first aid manual at all sites where services are provided on a regular, consistent basis.

A. Antidote charts and the telephone numbers of poison control centers shall be readily accessible to staff and individuals served.
   Note: This can be obtained through Poison Control Center at University of Arkansas Medical Science Center in Little Rock if you cannot get locally.

804.8 Water Temperatures

Provisions shall be made to control water temperature at facilities where services are provided on a regular, consistent basis.

A. To ensure the safety of individuals served, each organization shall develop/implement policy and procedure concerning water temperature adhering to current literature regarding water safety with a maximum temperature of 120 degrees. If the thermostat of the hot water heater is set above 120 degrees, a mixer must be to the lavatories and bathing facilities to maintain safety.

Note: This standard shall apply only to service areas and where consumers are working.

APPENDIX A

SUGGESTED
BOARD/ORGANIZATION TRAINING TOPICS

Policy Development and Implementation

Planning and Evaluation
Equal Employment Opportunity/Affirmative Action
Employee Performance Evaluation
Team Building
Performance Management
Effective meetings
Due Process
Freedom of Information

Overview of Department of Human Services
Overview of Developmental Disabilities Services
Philosophy and Goals
Programs, Practices, Policies and procedures of Local Organizations
Overview of Community Integration

History, Philosophy, Causes and Types, Functional Levels, Severity Levels, Prevention and Program Issues in Mental Retardation and Other Developmental Disabilities.

Introduction to Principles of Normalization
Legal rights of Individuals with a Developmental Disability
Interdisciplinary Approach Overview
Age Appropriate Programming
Medications – Implications, Side Effects, legality of Administering

Overview of Federal and State Laws related to serving people with Developmental Disabilities (see index):

U.S.C. S2000a – 2000 h-6; Ark. Code Ann. SS 6-41-222; 20 U.S.C S 14000 et. seq. (Part B & Part H); 29 U.S.C SS 706(8), 794-794(b);
5 U.S.C S 552a; 42 U.S.C SS 6000-6083; Ark. Code Ann. SS 20-48-201 – 20-48-211; Ark. Code Ann. SS 28-65-101 – 28-65-109; Ark. Code Ann. SS 5-28-101 – 5-28-109; Ark. Code Ann. SS 12-12-501 – 12-12-515; Ark. Code Ann. SS 25-2-104, 25-2-105, 25-2-107, Ark. Code Ann. SS 25-10-102 – 25-10-116; Ark. Code Ann. SS 20-18-215; U.S.C. S 12101 et. Seq.; DHS Administrative Policy 3002-I (Revised) and DDS Service Policy 3016, Prevention of Transmission of Disease Borne by Blood or other Body Fluids such as AIDS and Hepatitis B; DDS Administrative Policy 1077 Chemical Right to Know; DDS Service Policy 3004-I Maltreatment Prevention, Reporting and Investigation.

INDEX

ARKANSAS CODE ANNOTATIONS		ACTS
Ark. Code Ann. SS	6-41-201 - 6-41-222	102 of 1972 Handicapped Children's Act
Ark. Code Ann. SS	20-48-201 - 20-48-211	265 of 1969 AR Mental Retardation Act
Ark. Code Ann. SS	25-19-101 - 25-19-515	AR Freedom of Information Act
Ark. Code Ann. SS	12-12-501 - 12-12-515	397 of 1975 Child Abuse and Neglect Act
Ark. Code Ann. SS	5-28-101 - 5-28-109, 5-28-201 - 5-28-215, 5-28-301 - 5-28-305	452 of 1983 Adult Abuse
Ark. Code Ann. SS	28-65-101 - 28-65-109, 28-65-201 - 28-65-220, 28-65-301 - 28-65-320, 28-65-401 - 28-65-403, 28-65-502, 28-65-601 - 28-65-602	940 of 1985 Guardianship Law
Ark. Code Ann. SS	25-10-102 - 25-10-116, 20-46-202, 20-46-310, 25-2-104, 25-2-105, 25-2-107	348 of 1985 DHS Reorganization
Ark. Code Ann. SS	20-48-601 - 20-48-611	611 of 1987 Location of Community Homes
Ark. Code Ann. SS	12-12-501 et. Seq.	Child Maltreatment
Ark. Code Ann. SS	27-34-101 - 27-34-107	Child Safety Seat Use
Ark. Code Ann. SS	20-78-215	1050 of 1985 Federal Funds for Child Sexual Abuse
Ark. Code Ann. SS	6-21-609	854 of 1987 Exposure to Smoke

UNITED STATES CITATIONS	ACTS
42 U.S.C. S2000a – 2000 h-6	Title VI of the Civil Rights Act of 1964
20 U.S.C. S14000 et. Seq.	P. L. 94-142 Individuals with Disability Education (IDEA) P.L. 99-457 Part H
29 U.S.C. SS 706(8), 794 – 794(b)	Rehabilitation Act of 1973 Section 504
42 U. S. C. S 552	Federal Freedom of Information Act
42 U.S.C. S 6000 – 6083	Developmentally Disabled Assistance and Bill of Rights Act of 1984 and Amendments of 1987
5 U.S.C. S 552a	Federal Privacy Act
42 U.S.C. S 12101 et. Seq.	Americans with Disabilities Act of 1990 P. L. 101-336
42 U. S. C. S 6000 – 6009 6021 – 6030 6041 – 6043 6061 – 6064 6081 - 6083	P. L. 98-527 Developmentally Disabled Assistance & Bill of Rights Act of 1984

Mark up

Arkansas Department of Human Services

Division of Developmental Disabilities Services

DDS STANDARDS for Certification, Investigation and Monitoring

FOR CENTER-BASED COMMUNITY SERVICES

DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

PHILOSOPHY & MISSION STATEMENT

The Division of Developmental Disabilities Services (DDS), the DDS Board, and its providers are dedicated to the pursuit of the following goals:

- Advocating for adequate funding, staffing, and services to address the needs of persons with developmental disabilities.
- Encouraging an interdisciplinary service system to be utilized in the delivery of appropriate individualized and quality services.
- Protecting the constitutional rights of individuals with disabilities and their rights to personal dignity, respect and freedom from harm.
- Assuring that individuals with developmental disabilities who receive services from DDS are provided uninterrupted essential services until such time a person no longer needs to depend on these services.
- Encouraging family, parent/guardian, individual, and public/community involvement in program development, delivery, and evaluation.
- Engaging in statewide planning that ensures optimal and innovative growth of the Arkansas service system to meet the needs of persons with developmental disabilities and to assist such persons to achieve independence, productivity, and integration into the community.

To accomplish its mission, DDS, the DDS Board, and its providers are committed to the principle and practices of: normalization; least restrictive alternatives; affirmation of individuals' constitutional rights; provision of quality services; the interdisciplinary service delivery model; and the positive management of challenging behaviors.

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INTRODUCTION

The licensing standards for DDS Community Programs have been developed to accomplish: normalization, least restrictive alternatives, affirmation of individuals' constitutional rights, provision of quality services, the interdisciplinary service delivery model, and the positive management of challenging behaviors.

These Standards shall apply to any day treatment program in Arkansas for children and adults, including a "successor programs," as defined in Ark. Code Ann. § 20-48-1101 et seq. The Department of Human Services and its Divisions and Agents shall have the authority to enforce these regulations.

Individual program plans shall be developed with the participation of the individual (18 years and older), as appropriate, the family, and representatives of the services required. The team is responsible for assessing needs, developing a plan to meet them, and contributing to its implementation.

NOTE: It is imperative that all Medicaid providers be enrolled with the Division of Medical Services and meet all enrollment requirements for the specific Medicaid Program for which they are enrolling as an Arkansas Medicaid Provider.

All standards are applicable to all services provided, unless otherwise specified.

Administrative Rules and Regulation Sub-Committee of the Arkansas Legislative Council: ~~October 4, 2007~~

Effective Date: ~~November 1, 2007~~July 1, 2018

Implementation Date: ~~November 1, 2007~~July 1, 2018

Grandfathering Period: ~~November 1, 2007–October 31, 2008~~July 1, 2018—June 30, 2019

100 GOVERNING BOARD/ORGANIZATION / LEADERSHIP

Guiding Principles: The Governing Board/organization/Leadership is that body of people who have been chosen by the corporation and vested with legal authority to be responsible for directing the business and affairs of the corporation. The responsibilities assured by each Board/organization member by their acceptance of membership are to provide effective and ethical governance leadership on behalf of its owners'/stakeholders' interest to ensure that the organization focuses on its purpose and outcomes for persons served, resulting in the organization's long-term success and stability.

The mission statement of the organization is based on the Board/organization's philosophical motivations, the services provided, and values of the members. The mission statement should identify the population to be served and the services to be provided. This description shall be nondiscriminatory by reason of sex, age, disability, creed, marital status, ethnic, or national membership.

NOTE: See Arkansas Code Ann. §§ 20-48-201 - 20-48-211 for examples of Board/organization responsibilities.

NOTE: All information regarding your organization shall be readily available to staff, consumers, referral and funding sources, and the interested public pursuant to the Freedom of Information Act.

101 The organization shall be legally incorporated under the appropriate federal, state or local statues as defined by its official Articles of Incorporation and registered to do business in the State of Arkansas.

A. The governing body should periodically review the appropriateness of its governing documents. (Ark. Code Ann. §§ 20-48-201 – 20-48-211). This shall include the organizations mission statement as filed with the Secretary of State, and the Articles of Incorporation.

B. Any changes in the Articles of Incorporation must be filed with the Secretary of State. This includes name changes, amendments, or any reconstitution of the Governing Board/organization. The organization shall provide copies of any changes to DDS upon filing.

102 Bylaws shall be established which govern the internal affairs of the organization and will address each of the following areas as applicable:

A. Composition of Board

1. This shall include the number of Board members and the eligibility criteria (i.e. citizenship and residency).
2. Selection of Board/ members

a. Twenty percent (20%) consumer and advocate representation on the Board is required. *(Note: defined as a consumer, immediate family member or guardian of a consumer receiving services or has received services at the organization or person in a qualified position that advocates on behalf of the population served)*

B. Term of membership:
   1. Number of years as dictated by the organization's Articles of Incorporation. *Note: It is recommended that membership on the governing body be rotated periodically.*

C. Replacement/removal of directors:
   1. Refers to written criteria for Board membership. Shall include any contingency to include but not be limited to resignation of Board/organization members and removal for non-attendance or other reasons.

D. Election of officers and directors:
   1. Describe the election process

E. Duties and responsibilities of Board officers are described in writing
   1. Must document each position's purpose, structure, responsibilities, authority, if any, and the relationship of the advisory committee of Board members to other entities involved with the organization.

F. Appointment of committees, if applicable;
   1. Duties and functions of standing committees are described in writing, if applicable.

G. Meetings of the Board/organization and its committees. All meetings shall be planned, organized, and conducted in accordance with the organization's by-laws, policies, procedures, applicable statutes, or other appropriate regulations. In no event shall the full Board/organization meet less than four times per year.

   Note: The Board/organization and its committees should meet with a frequency sufficient to discharge their responsibilities effectively.

H. The Board/organization shall adopt written procedures to guide the conduct of its meetings (i.e. Parliamentary Procedure, Robert's Rules of Order, etc.);

I. The Board/organization shall maintain minutes of all actions taken by the Board/organization for review by DDS. Minutes shall accurately document all members present and any action taken at the committee meetings to include any committee recommendations to the Board/organization.
   1. Written minutes of previous Board/organization meetings should be made available by posting the adopted minutes in a location convenient to the staff and individuals served, and made available to members of the public upon request, as required under the Freedom of Information Act.

103 The Board/organization shall establish a procedural statement addressing nepotism as it relates to Board/organization and staff positions.

103.1 The Board shall establish a procedural statement addressing conflict of interest

Note: The intent of the standard does not rule out a business relationship, but does call for the governing body to decide in advance what relationships are in the best interest of the organization.

A. Paid employees may not serve as Board members. (Note: This DOES NOT include individuals receiving services.)

Note: Paid employees serving on the Board as of 11/01/07 may continue to serve for the remainder of their current term at which time they must rotate off the Board.

B. Directors of organizations may serve as non-voting ex officio Board members.

104 Board/organization meetings and public meetings as defined by Ark. Code Ann. §§ 25-19-106 shall be conducted at a time and place which make the meetings accessible to the public. Specifically, except as otherwise specifically provided by law, all meetings, formal or informal, special or regular, of the governing bodies of all municipalities, counties, townships, and school districts and all boards, bureaus, commissions, or organizations of the State of Arkansas, except grand juries, supported wholly or in part by public funds or expending public funds, shall be public meetings.

A. Board/organization meetings and Executive sessions shall be announced to be in compliance with Ark. Code Ann. §§ 25-19-101 – 25-19-107 "Freedom of Information Act"

B. All local media are to be notified one week in advance and a notice posted in a prominent place by the organization. Called meetings shall be announced to the local media and others who have requested notification at least two hours in advance of meeting. Documentation of Notification may include newspaper clippings, copy of item posted on bulletin Board/organization, radio contact forms, etc.

D. If the meetings are held each month at the same time and location, one notification and posting shall be sufficient.

105 The Board/organization of Directors shall adopt a mission statement to guide its activities and to establish goals for the organization. The plan shall show evidence of participation by stakeholders (evidence of open meeting, letters of input, survey, questionnaire, etc.).

105.1 The Board/organization of Directors shall review the mission statement annually and shall make changes as necessary to ensure the overall goals and objectives of the organization are reflected in its mission.

106 The Board/organization maintains a plan which shall identify annual and long range goals; the plan should address community needs and target populations and should be reviewed and updated annually.

A. Each Board/organization will develop and implement a long-range plan of action for that organization. Examples include, but are not limited to starting a new component, accessing individualized services in the community, etc.

B. Development and implementation of the plan shall include stakeholder input. The organization shall maintain evidence of this input (i.e., letters of input, minutes of open meetings, questionnaires, surveys, etc.)

C. The plan shall be reviewed annually and updated as needed. The Board/organization shall approve the initiation, expansion, or modification of the organization's program based on the needs of the community and the capability of the organization to have an effect upon those needs within its established goals and objectives.
Note: The Board/organization of Directors, at its discretion, may assign this responsibility to staff.

107 The Board/organization shall demonstrate corporate social responsibility while maintaining overall accountability for the administration and direction of the organization, and shall delegate authority and responsibility to executive leadership as deemed appropriate by the organization.

A. The organization shall identify:
   1. Its leadership structure.
   2. The roles and responsibilities of each level of leadership.

B. The identified leadership shall guide the following:
   1. Establishment of the mission and direction of the organization.
   2. Promotion of value/achievement of outcomes in the programs and services offered.
   3. Balancing the expectations of both the persons served and other stakeholders, as defined by the organization's policies.
   4. Financial solvency.
   5. Compliance with insurance and risk management requirements.
   6. Ongoing performance improvement.
   7. Development and implementation of corporate responsibilities.
   8. Compliance with all legal and regulatory requirements.

C. The organization shall respond to the diversity of its stakeholders with respect to:
   1. Culture.
   2. Age.
   3. Gender.
   4. Sexual orientation.
   5. Spiritual beliefs.
   6. Socioeconomic status.
   7. Language.

108 The Board/organization shall create a mechanism for monitoring the decisions and operations of the organization's programs which includes provisions for the periodic review and evaluation of its program in relation to the program goals. Documentation of the review must be maintained on file for review. Documentation may include but not be limited to Board/organization minutes, reports, etc.

Guiding Principle: An organized training program for Board/organization Members prepares them for their responsibilities and assures that they are kept up-to-date on issues concerning services offered to individuals with a developmental disability.

109 The Board shall maintain a general plan for Board/organization training and will ensure that all items listed as required topics are covered in the required three-hour training.

A. Training shall be provided for all Board/organization members. Where the Board, because of its size, lacks sufficient resources to conduct a training program, it will make arrangements with another Board, organization, agency, appropriate community resource, or training organization to provide such training.

109.1 New Board Members must participate in a minimum of three hours of training.

A. The following topics shall be required during the first year of service
1. Functions and Responsibilities of the Board
2. Composition and Size of the Board

3. Legal Responsibilities
4. Funding Sources and Responsibilities,
5. Equal Employment Opportunity/Affirmative Action,
6. Due Process
7. Ark. Code Ann. §§ 25-19-101 – 25-19-107 "Freedom of Information Act of 1967"
8. U. S. C. § 12101 et. seq. "Title 42 THE PUBLIC HEALTH AND WELFARE--CHAPTER126—EQUAL OPPORTUNITY FOR INDIVIDUALS WITH DISABILITIES--§ 12101. Findings and purpose"
9. DDS Service Policy 3004-I Maltreatment Prevention, Reporting and Investigation;
10. DHS Policy 1090, Incident Reporting.
11. DDS Administrative Policy 1077
12. Chemical Right to Know
13. The Health Insurance Portability and Accountability Act (HIPAA)

NOTE: POSSIBLE TRAINING RESOURCES INCLUDE ASPEN PUBLICATIONS, WHICH HAS MATERIALS ON BOARD/ORGANIZATION AND ADMINISTRATOR TRAINING. (WWW.ASPENPUBLISHERS.COM) Resources or additional information should be obtained from DDS Licensure.

B. All new Board members as they begin service shall participate in training. Board members may disseminate training information to new Board members if they are unable to attend formal training sessions. Documentation of the information provided, date provided and the board member(s) involved must be maintained for review by DDS. (Note: Training may be documented in Board minutes or by Certificates of Attendance.)

109.2 All Board members shall complete a minimum of three hours annual training. Topics may be selected by the Board of Directors and must be germane to the annual plan and services provided. Training should be documented in Board minutes, by Certificates of Attendance or sign in sheets from approved training.

110 Board members shall visit service components of the organization during operating hours yearly.

A. All components of the organization must be observed annually. If on-site observations to each physical location are not feasible, at least 1 physical site from each program component must be observed during the calendar year. The sites must be rotated yearly. Committees or individual Board Members may be appointed to visit specific components and report back to the other Board members on observations. Documentation of reports in Board minutes shall be accepted as verification.

111 The Board/organization shall establish and approve policies and procedures which define Eligibility criteria, Readmission criteria, and transition/discharge/exit criteria

112 The Board/organization shall establish policy regarding financial oversight of the organization that addresses the following:

A. The organization's financial planning and management activities reflect strategic planning designed to meet:

1. Established outcomes for the persons served.
2. Organizational performance objectives.

B. Budgets are prepared that:
   1. Include:
      a. Reasonable projections of revenues and expenditures.
      b. Input from various stakeholders, as required.
      c. Comparison to historical performance.
   2. Are disseminated to:
      a. Appropriate personnel.
      b. Other stakeholders, as appropriate.
   3. Are written.

C. Actual financial results are:
   1. Compared to budget.
   2. Reported to:
      a. Appropriate personnel.
      b. Persons served, as appropriate.
      c. Other stakeholders, as required.
   3. Reviewed at least quarterly.

D. The organization identifies and reviews, at a minimum:
   1. Revenues and expenses.
   2. Internal and external:
      a. Financial trends.
      b. Financial challenges.
      c. Financial opportunities.
      d. Business trends.
      e. Management information.
   3. Financial solvency, with the development and implementation of remediation plans, if appropriate.

113 For-profit organizations or organizations who receive less than $10,000 in compensation for services under this program shall submit a compilation report that includes a balance sheet and statement of revenue and expense to DDS at the close of each financial period.

Note: Sections 102 & 104 do not apply to organizations that are not governed by a Board of Directors

200 PERSONNEL PROCEDURES & RECORDS

201 The organization shall maintain written personnel procedures that are approved by the Board and are reviewed annually and which conform to state and federal laws, rules and regulations.

NOTE: DDS SHALL NOT BECOME DIRECTLY INVOLVED IN PERSONNEL ISSUES UNLESS IT DIRECTLY IMPACTS CONSUMER CARE AND/OR SAFETY.

201.1 Personnel procedures shall be clearly stated and available in written form to employees as required by 42 U.S.C. § 2000a – 2000 h-6 "Title VI of the Civil Rights Act of 1964" and U.S.C. § 1201 et. Seq. Americans with Disabilities Act. These include but are not limited to:

A. Hiring and promotional procedures which are nondiscriminatory by reason of sex, age, disability, creed, marital status, ethnic, or national membership

B. A procedure for discipline, suspension and/or dismissal of staff which includes opportunities for appeal

C. An appeals procedure allowing for objective review of concerns and complaints

201.2 One copy of the organization's Personnel procedures must be available in the personnel or administrator's office. This copy must be readily accessible to each employee.

201.3 The organization shall develop and implement steps to voice grievances within the organization. All grievances are subject to review by the Governing Board and Court of Law (29 U.S.C. §§ 706(8), 794 – 794(b), the "Rehabilitation Act of 1973 Section 504; 20 U.S.C. § 1400 et. Seq. Section 615 "The Individual Disabilities Education Act".

A. All steps in the Grievance Procedure should be time-bound and documented, including initial filing of grievance.

201.4 The organization shall develop and implement policies regarding whether pre-employment and random drug testing will be required. If the organization chooses to do drug testing they must establish guidelines for actions to be taken when the drug test results are obtained, whether positive or negative.

Note: The organization may contact Arkansas Transit Association for further information on drug testing

202 Prior to employment, a completed job application must be submitted which includes the following documents.

A. The organization shall obtain and verify PRIOR to employment and maintain documentation of the following:

1. The credentials required
2. That required credentials remain current
3. The applicant has completed a statement related to criminal convictions
4. A criminal background check has been initiated. Refer to DDS Policy 1087.
5. Declaration of truth of statement on job application.
6. A release to complete reference checks is signed and reference checks have been completed

7. Results of pre-employment drug screen, if required by organization.

NOTE: THE ITEMS IN 202A.5 AND 202A.6 WILL NOT BE RATED FOR EMPLOYEES HIRED PRIOR TO JULY 1, 1986.

B. The organization shall obtain and verify within 30 days of employment and maintain documentation of the following:
   1. Adult Maltreatment Central Registry Ark. Code Ann. §§ 5-28-201 has been completed and the response is filed, or a second request submitted
   2. Arkansas Child Maltreatment Central Registry Ark. Code Ann. §§ 12-12-501 – 12-12-515 has been completed and the response is filed, or a second request submitted. This check will provide documentation that prospective employee's name do not appear on the statewide Central Registry.
      a. The organization should adopt policy requiring subsequent criminal checks and registry checks. The organizations that provide licensed daycare services must adhere to Child Care Licensing regulations regarding Criminal background checks and central registry checks.

      Note: Staff holding professional licenses may be used in lieu of criminal background and adult and child maltreatment checks.
   3. TB skin test
      a. Renewed yearly for ALL STAFF.
   4. Hepatitis B series or signed declination
   5. The results of criminal background check of the will be on file.
   6. Employment reference verification and signed release
      a. On file within thirty (30) days of hire date

C. The organization shall obtain and verify information in 202 A and B in response to information received (i.e., a complaint is received that a person's license has lapsed or a person has been convicted of a crime since they were hired).

203 The agency shall ensure sub-contractor's services meet all applicable standards and will assess performance on a regular basis.

A. The organization shall ensure that sub-contractors providing direct care services are in compliance with DDS policies and must have verification and documentation of all applicable items listed in 202A.

   Note: Staff holding professional licenses may be used in lieu of criminal background and adult and child maltreatment checks.

B. The organization shall demonstrate:
   1. Reviews of all contract personnel utilized by the organization that:
      a. Assess performance of their contracts
      b. Ensure all applicable policies and procedures of the organization are followed
      c. Ensure they conform to DDS standards applicable to the services provided
      d. Are performed annually

204 The organization shall develop, implement and monitor policies and procedures for staff recruitment and retention so that sufficient staff is maintained to ensure the health and safety of the individuals served, according to their plans of care.

A. The organization must ensure there are an adequate number of personnel to:
   1. Meet the established outcomes of the persons served.
   2. Ensure the safety of persons served.
   3. Deal with unplanned absences of personnel.
   4. Meet the performance expectations of the organization.

B. The organization shall demonstrate:
   1. Recruitment efforts.
   2. Retention efforts.
   3. Identification of any trends in personnel turnover.

205 The organization shall develop and implement procedures governing access to staff members' personnel file.

A. An access sheet shall be kept in front of the file to be signed and dated by those who are examining contents, with stated reasons for examination.

B. The policy shall clearly state who, when, and what is available concerning access to personnel files and be in compliance with the Federal Privacy Act and Freedom of Information Act. At no time shall the policy allow access that violates the provisions of the Health Insurance Portability and Accountability Act (HIPAA).

206 The organization shall develop written job descriptions which describe the duties, responsibilities, and qualifications of each staff position.

A. The organization shall:
   1. Identify the skills and characteristics needed by personnel to:
      a. Assist the persons served in the accomplishment of their established outcomes.
      b. Support the organization in the accomplishment of its mission and goals.
   2. Assess the current knowledge and competencies of personnel at least annually.
   3. Provide for the orientation and training needs of personnel.
   4. Provide the resources to personnel for learning and growth.
   5. Identify the supervisor of the position and the positions to be supervised.

B. Performance management shall include:
   1. Job descriptions that are reviewed and/or updated annually.
   2. Promotion guidelines.
   3. Job posting guidelines.
   4. Performance evaluations for all personnel directly employed by the organization shall be:
      a. Based on measurable objectives that tie back to specific duties as listed in the Job Description.
      b. Evident in personnel files.
      c. Conducted in collaboration with the direct supervisor with evidence of input from the personnel being evaluated.

d. Used to:
    1. Assess performance related to objectives established in the last evaluation period.
    2. Establish measurable performance objectives for the next year.
e. Performed annually.

207 The organization shall establish employment policies/practices for students, interns, volunteers and trainees utilized by the organization who have regular, routine contact with consumers.

A. The organization shall define who has and what constitutes regular, routine contact with consumers.

B. If students, interns, volunteers or trainees are used by the organization, the following shall be in place:
    1. A signed agreement.
        a. If professional services are provided, standards or qualifications applied to comparable positions must be met.
    2. Identification of:
        a. Duties.
        b. Scope of responsibility.
        c. Supervision.
    3. Orientation and training.
    4. Assessment of performance.
    5. Policies and written procedures for dismissal.
    6. Confidentiality policies.
    7. Background checks, when required.

300 STAFF TRAINING

Guiding Principle: Staff Training is an organized program which prepares new employees to perform their assigned duties competently and maintains and improves the competencies of all employees. Staff Training for the organization shall provide an on-going mechanism for the evaluation of the impact of the program on services provided to individuals with developmental disabilities. This should include service outcomes to individuals, meeting of the organization objectives and overall mission, compliance with regulatory and professional standards and positive changes in staff performance and attitudes. The needs of individuals with developmental disabilities require the efforts of competent personnel who continually seek to expand knowledge in their fields.

300.1 The organization shall establish a policy designating one or more employees to be responsible for coordinating in-service staff training.

A. The employee responsible for staff training should have broad knowledge of care and service needs of persons with developmental disabilities, and possess the necessary skills to organize and implement an in-service training program as evidenced in resume.

301 The organization shall establish a written training plan. This plan must show how the training will be provided and the areas covered. If training occurs during regularly scheduled service hours, documentation must be present that individual staff ratios were maintained.

301.1 ALL Personnel shall receive initial and annual competency-based training to include, but not limited to:

A. Health and safety practices.

1. First Aid (review yearly, renew as required by American Heart Association, Red Cross, or Medic First Aid, applicable for ALL direct service personnel)

a. There is immediate access to:

(1) First aid expertise.

(2) First aid equipment and supplies.

(3) Emergency information on the:

(a) Persons served.

(b) Personnel.

b. Infection Control Plan

1. The organization shall implement an infection control plan that includes:

(a). Training regarding the prevention and control of infections and communicable diseases for:

(1). Persons served, when applicable.

(2). Personnel.

(b). The appropriate use of standard or universal precautions by all personnel.

(c). Procedures that specify that employees with infectious diseases shall be prohibited from contact with individuals until a physician's release has been provided to the organization director.

B. Identification of unsafe environmental factors.
   1. Issues Regarding Prevention of Acquired Immunodeficiency Syndrome (AIDS), Hepatitis B (HIV) and other Bloodborne Pathogens

C. Emergency procedures and Evacuation Procedures
   1. Emergency and Disaster Preparedness
   2. Fire and Tornado Drills, Violence in the Workplace, Bomb Threats, Earthquake

D. General Information
   1. Overview of Department of Human Services
   2. Overview of Developmental Disabilities Services
   3. Philosophy, Goals, Programs, Practices, Policies, and Procedures of Local Organization
   4. HIPPA policies and procedures
   5. Orientation to history of Developmental Disabilities
   6. Current Issues Affecting Individuals with Developmental Disabilities
   7. Introduction to Principles of Normalization
   8. Procedures for Incident Reporting
   9. Appeals Procedure for Individuals Served by the Program
   10. Introduction to Behavior Management
   11. Community Integration Training.

E. Legal
   1. Overview of Federal and State Laws related to serving individuals with a developmental disability (NOTE: Laws may change every 2 years)
   2. Legal Rights of Individuals with Developmental Disabilities
   3. Application of Federal Civil Rights Laws to Persons with AIDS or HIV related condition (or those who may be perceived to have AIDS or HIV related conditions).
   4. Ark. Code Ann. §§6-41-201 – 6-41-222--The Children With Disabilities Act of 1973
   5. Ark. Code Ann. §§20-48-201 – 20-48-211; --Arkansas Mental Retardation Act
   6. Ark. Code Ann. §§25-19-101 – 25-19-107 --Freedom of Information Act
   7. Ark. Code Ann. §§28-65-101 – 28-65-109; --Guardians Generally
   8. Ark. Code Ann. §§5-28-101 – 5-28-109; --Abuse of Adults
   9. Ark. Code Ann. §§12-12-501 – 12-12-515; --Arkansas Child Maltreatment Act
   10. Ark. Code Ann. §§25-2-104, 25-2-105, 25-2-107, Type 1, Type 2 and Type 4 Transfers
   11. Ark. Code Ann. §§25-10-102 – 25-10-116; Department of Health and Human Services General Provisions
   12. Ark. Code Ann. §§20-78-215 -- Child sexual abuse - Federal funds
   13. U.S.C. § 12101 et. seq. --Americans with Disabilities Act of 1990 P. L. 101-336
   14. 20 U.S.C. §1400 et. seq. (Part B and Part C -- P. L. 94-142 Individuals with Disability Education (IDEA) P.L. 99-457 Part C
   15. 42U.S.C. §2000a – 2000 h-6-- Title VI of the Civil Rights Act of 1964

16. 29 U.S.C. §§706 (8) Rehabilitation Act of 1973, 794 – 794(b) Section 504
17. 5 U.S.C. §552a-- Federal Privacy Act
18. 42 U.S.C. §6000-- Developmentally Disabled Assistance & Bill of Rights Act of 1984
19. P.L. 109-171, Deficit Reduction Act, and 30 U.S.C. §3729 et.seq. False Claims Act

Note: Documentation of prior training of individual staff may be used for the required topics, if this situation is addressed in the organization's training plan.

301.2. Documentation of prior training of individual staff may be used for the required topics, if this situation is addressed in the organization's training plan.

301.3. Training Requirements for professional/administrative staff, as defined by the agencies policies

1. Twelve (12) hours minimum completed within ninety (90) days of employment (does not include First Aid and CPR training)

301.4. Training Requirements for direct care staff

1. Twelve (12) hours minimum completed within (30) days of employment (does not include First Aid and CPR training)
2. In addition to the training requirements specified Section 301.1, all direct care staff must receive the following training:
   a. CPR (I nitial Certification, renew as required by American Heart Association, Medic First Aid, or Red Cross).
      1. ALL direct care staff members, including bus and van drivers, shall be trained and certified to provide CPR, unless they are deemed incapable of performing this task by a licensed medical professional, such as a nurse or doctor. Documentation must be maintained in the personnel file. Staff that are physically incapable of performing CPR must complete and have documentation of CPR training.
   b. The organization shall develop and implement and monitor policy regarding timeframe for CPR certification after hire date. (Timeframe not to exceed 90 days.)
3. Medication—Implications, Side Effects, Legality of Administering medication.

NOTE: IN ADDITION TO THOSE AREAS ADDRESSED IN THESE STANDARDS, OTHER IDENTIFIED NEEDS BASED ON STAFF INPUT SHOULD BE ADDRESSED.

NOTE: SEE APPENDIX B for Training Resources

301.5 In addition to the requirements in Section 301.1-301.4, all direct care staff shall receive annual in-service training and/or continuing education as follows:

A. Minimum of twelve (12) hours of training annually, including the required topics.
   1. Topics must be applicable to the job and are to be chosen by the organization based on identified needs. Topics may be a combination of required and job specific training.

2. Behavior management techniques/programming

B. Documentation of the training shall be maintained in the staff's personnel file and shall be evidenced by the signatures of the trainer and the direct care staff, the date the training was provided and the specific information covered.

302 Annual in-service training and/or continuing education for Managerial Staff, as defined by the agencies policies.

A. Topics Chosen must be related to the job performed.

B. Minimum of twelve (12) hours of training required yearly, from the following list:

1. Issues Regarding Prevention of Acquired Immunodeficiency Syndrome (AIDS), Hepatitis B (HIV) and other Blood Borne Pathogens
2. Application of Federal Civil Rights Laws to persons with AIDS or HIV related Conditions (or those who may be perceived to have AIDS or HIV Related conditions)
3. Management of Non-Profit Organizations
4. Procedures for Preventing and Reporting Alleged Maltreatment of Children and Adults
5. Effective Supervision/Management Techniques
6. Selection and Interviewing
7. Fair Employment Principles
8. Performance Evaluation
9. Techniques for Working with the Board
10. Overview of Federal and State Laws Related to Serving Individuals with a Developmental Disability (up-dated every two (2) years)
11. Federal and State Laws:
    a. Ark. Code Ann. §§6-41-201 – 6-41-222--The Children With Disabilities Act of 1973
    b. Ark. Code Ann. §§20-48-201 – 20-48-211-Arkansas Mental Retardation Act
    c. Ark. Code Ann. §§25-19-101 – 25-19-107 --Freedom of Information Act
    d. Ark. Code Ann. §§28-65-101 – 28-65-109; --Guardians Generally
    e. Ark. Code Ann. §§5-28-101 – 5-28-109; --Abuse of Adults
    f. Ark. Code Ann. §§12-12-501 – 12-12-515; --Arkansas Child Maltreatment Act
    g. Ark. Code Ann. §§25-2-104, 25-2-105, 25-2-107, Type 1, Type 2 and Type 4 Transfers
    h. Ark. Code Ann. §§25-10-102 – 25-10-116; Department of Health and Human Services General Provisions
    i. Ark. Code Ann. §§20-78-215 -- Child sexual abuse - Federal funds
    j. U.S.C. § 12101 et. seq. --Americans with Disabilities Act of 1990 P. L. 101-336
    k. 20 U.S.C. §1400 et. seq. (Part B and Part C -- P. L. 94-142 Individuals with Disability Education (IDEA) P.L. 99-457 Part C
    l. 42U.S.C. §2000a – 2000 h-6-- Title VI of the Civil Rights Act of 1964
    m. 29 U.S.C. §§706 (8) Rehabilitation Act of 1973, 794 – 794(b) Section 504

n. 5 U.S.C. §552a-- Federal Privacy Act

o. 42 U.S.C. §6000 – 6083-- Developmentally Disabled Assistance & Bill of Rights Act of 1984

C. Managerial Staff, as defined by the agencies policies, who have been with the agency for 2 or more years may select from the above list or choose from continuing education courses.

NOTE: SEE APPENDIX B FOR TRAINING RESOURCES

303 All employees who provide transportation services shall have the following training scheduled within thirty (30) days of employment and completed within seventy-five (75) days of employment. This training shall be in addition to the required new employee training listed in Section 301

A. A course of instruction in consumer assistance and transfer techniques, lift operation and how to properly secure a wheelchair, if applicable, prior to transporting consumers; and

B. The provider must assure and document that each driver obtains the following:

1. A certificate of completion of an introductory defensive driving course;
2. A certification of completion of training addressing the transport of older persons and people with disabilities, and a refresher course every three years thereafter, both of which must include:
   a. Sensitivity to aging training;
   b. An overview of diseases and functional factors commonly affecting older adults;
   c. Environmental considerations affecting passengers;
   d. Instruction in consumer assistance and transfer techniques;
   e. Training on the management of wheelchairs, and how to properly secure a wheelchair;
   f. The inspection and operation of wheelchair lifts and other assistive equipment; and,
   g. Emergency procedures.

C. D. Drivers are required to complete refresher courses every three years after the date the certificate(s) of completion was received.

Note: For all transportation workers employed prior to 11/01/07, documentation of the required training must be on file no later than 11/01/08.

304 Providers must assure:

A. Maintenance of a safety checklist completed prior to transporting consumer(s) and/or travel attendants. Checklist items shall include, but not be limited to, fire extinguisher; first aid kit,

B. Maintenance of service logs or trip sheets that include the date of service the consumer's name, the pick-up point and destination point for each trip, total mileage per trip, and the driver's signature.

C. Assistance in transfer of the consumer, as necessary, safely from the consumer's door to the vehicle and from the vehicle to the entrance of the destination point. The provider must perform the same transfer assist service when transporting the consumer back to the consumer's residence.

400 INDIVIDUAL/PARENT/GUARDIAN RIGHTS

Guiding Principle: The organization shall implement a system of rights that nurtures and protects the dignity and respect of the persons served. The organization shall protect and promote the rights of the persons served. This commitment shall guide the delivery of services and ongoing interactions with the persons served.

401 The organization shall implement policies promoting the following rights of the persons served and ensures all information is transmitted to the person served and/or their parent or guardian in a manner and fashion that is clear and understandable:

A. Being free from physical or psychological abuse or neglect, retaliation, humiliation, and from financial exploitation.
B. Having control over their own financial resources.
C. Being able to receive, purchase, have and use their own personal property.
D. Actively and meaningfully making decisions affecting their life.
E. Access to information pertinent to the person served in sufficient time to facilitate his or her decision making.
F. Having Privacy.
G. Being able to associate and communicate publicly or privately with any person or group of people of the individual's choice.
H. Being able to practice the religion of their choice.
I. Being free from the inappropriate use of a physical or chemical restraint, medication, or isolation as punishment, for the convenience of the provider or agent, in conflict with a physician's order or as a substitute for treatment, except when a physical restraint is in furtherance of the health and safety of the individual.
J. Not being required to work without compensation, except when the individual is residing and being provided services outside of the home of a member of the individual's family, and then only for the purposes of the upkeep of their own living space and of common living area and grounds that the individual shares with others.
K. Being treated with dignity and respect.
L. Receiving due process.
M. Having access to their own records, including information about how their funds are accessed and utilized and what services were billed for on the individual's behalf.
N. Informed consent or refusal or expression of choice regarding:
    1. Service delivery.
    2. Release of information.
    3. Concurrent services.
    4. Composition of the service delivery team.
    5. Involvement in research projects, if applicable.
O. Access or referral to legal entities for appropriate representation.
P. Access to self-help and advocacy support services.
Q. Adherence to research guidelines and ethics when persons served are involved, if applicable.
R. Investigation and resolution of alleged infringement of rights.

1. The agency maintains documentation of all investigations of all alleged violations of individual's rights and actions taken to intervene in such situations. The organization ensures that the individual has been notified of their right to appeal according to DDS Policy 1076.

R. Rights and responsibilities of citizenship

S. Other legal and constitutional rights

402 Records of persons served

A. The organization shall maintain complete records and treat all information related to persons served as confidential.

B. The organization shall create policy for the sharing of confidential billing, utilization, clinical and other administrative and service-related information, and the operation of any Internet-based services that may exist.

1. Information that is used for reporting or billing shall be shared according to confidentiality guidelines that recognize applicable regulatory requirements such as the Health Insurance Portability and Accountability Act (HIPAA).

C. The organization shall comply with its own service delivery design for the development of the record. Electronic records are acceptable. Electronic records must meet the following:

1. Format must meet DHS/ Office of Systems and Technology standards and be acceptable by the Department.
2. Files must be uniformly organized and easily accessible.

D. The location of the case record, and the information contained therein, shall be controlled from a central location as defined by the agency, shall be stored under lock and with protection against fire, water, and other hazards in an accessible location at each site. The organization shall establish and implement policies and procedures to ensure direct care staff have adequate access to the individual's current plan of care and other pertinent information necessary to ensure the individual's health and safety (i.e., name and telephone number of physician, emergency contact information, insurance information, etc.). If services are not provided at the central location, at a minimum the following information must be maintained at the service delivery site:

A. Access Sheet
B. Face Sheet to include emergency contact information and pertinent health information
C. Signed consent for emergency treatment
D. A copy of the consumer's current program plan
E. Copies of current progress reports
F. Documentation of service provision to include date, time in and time out, summary of activities, and signature of implementor for the period of the current program plan

E. Records maintained on computer shall be backed up at a minimum weekly and the duplicate copy shall be stored under lock and with protection against fire, water, and other hazards.

F. A list of the order of the file information shall either be present in each individual case file or provided to DDS Licensure staff upon request. The documents in active individual case records should be organized in a systematic fashion. An indexing and filing system shall be maintained for all case records.

G. Each organization shall have written procedures to cover destruction of records. Procedures must comply with all state and federal regulations

H. Access sheets shall be located in the front of the file to maintain confidentiality according to 5 U.S.C. § 552a. If there is a signed release for a list of authorized persons to review the file, only those not listed will need to sign the access sheet with date, title, reason for reviewing, and signature. If there is not a signed release for authorized persons to review, all persons must sign the access sheet whenever the file is reviewed or any material is placed in the file.

402.1 DDS staff shall have access upon demand to all individual case records as designated in Ark. Code Ann. §§ 20-48-201 – 20-48-211, DDS Policy 1090, Licensing Policy for Center-Based Community Services.

402.2 The organization shall ensure confidentiality of all case records is maintained. Access to case records shall be limited to Individual/Parent/Guardian, professional staff providing direct services to the person served, plus such other individuals as may be authorized administratively or by the consumer. All authorizations either those listed above or others shall be in writing.

A.. Access to individual files shall be limited to only those staff members who have a need to know information contained in the records of persons served.

B. Individual service records shall be maintained according to provisions of the Privacy Act:

C. Access to computer records shall be limited to those authorized to view records

D. The organization shall ensure the right of all persons served to access their own records.

E. The organization shall ensure that all persons served know how to access their records and the organization ensures that appropriate equipment is available.

F. An organization shall not prohibit the persons served from having access to their own records, unless a specific state law indicates otherwise. It is recognized that the organization must comply with HIPAA regulations as it relates to specific information that cannot be disclosed to persons served without authorization (i.e., psychotherapy notes).

402.2 Adult individuals who are legally competent shall have the right to decide whether their family will be involved in planning and implementing the individual service plan. A signed release or document shall be present in individual case record giving permission for family to be involved.

402.3 The Individual /Parent /Guardian shall be informed of their rights. The organization shall maintain documentation in the individual's file that the following information has been provided in writing: THE INFORMATION LISTED IN 402.3 A-I MUST BE PROVIDED UPON ADMISSION AND ANNUALLY THEREAFTER.

A. All possible service options, including those not presently provided by the program.

B. A copy of the rules of conduct and mission statement of the organization.

C. Current list of Board members of the community program.

D. Summary of funding sources.

E. Copy of the appeal procedure for decisions made by the organization.

F. Solicitation Guidelines **See Solicitation under Definitions

G. All external advocacy services.

H. Right to appeal any service decision to DDS, under DDS Policy 1076

I. Name and phone number of the DDS Service Specialist for that area

403 Grievances and Appeals

Guiding Principle: The organization identifies clear protocols related to formal complaints, including grievances and appeals. An organization may have separate policies and procedures for grievances and appeals, or may include these in a common policy and procedure covering complaints, grievances, and appeals. A review of formal complaints, grievances, and appeals gives the organization valuable information to facilitate change that results in better customer service and results for the persons served.

A. The organization shall identify clear protocols related to formal complaints, including grievances and appeals.

B. The organization shall:

1. Implement a policy by which persons served may formally complain to the organization.
2. Implement a procedure concerning formal complaints that:
   a. Is written.
   b. Specifies:
      1. That the action will not result in retaliation or barriers to services.
      2. How efforts will be made to resolve the complaint.
      3. Levels of review, which includes availability of external review.
      4. Time frames that are adequate for prompt consideration and that result in timely decisions for the person served.
      5. Procedures for written notification regarding the actions to be taken to address the complaint.
      6. The rights and responsibilities of each party.
      7. The availability of advocates or other assistance.
3. Make complaint procedures and, if applicable, forms:
   a. Readily available to the persons served.
   b. Understandable to the persons served and in compliance with 29 U. S. C. §§ 706 (8), 794 – 794(b).

C. These procedures shall be explained to personnel and persons served in a format that is easily understandable and meets their needs. This explanation may include, but not limited to a video or audiotape, a handbook, interpreters, etc.

403.1 The organization shall annually review all formal complaints filed.

A. A written review of formal complaints:

1. Determine:
   a. Trends.
   b. Areas needing performance improvement.
   c. Action plan or changes to be made to improve performance and to reduce complaints

403.2 The organization shall document a review of any action plan or changes made to determine if the plan/changes were effective in reducing complaints and shall make adjustments to the plan as deemed necessary to ensure quality services.

404 Health Related Issues

Guiding Principle: A successful health and safety program goes beyond compliance with regulatory requirements and strives to manage risk and to protect the health and safety of persons served, employees, and visitors. A successful health and safety program addresses both minimizing potential hazards and compliance activities.

A. The organization shall implement policies/procedures to ensure the rights of individuals who have or who are perceived as having Acquired Immunodeficiency Syndrome (AIDS) or Human Immune Virus (HIV) related condition (or those who may be perceived as having AIDS or AIDS related conditions including Hepatitis B are not discriminated against in accordance with 29 U.S.C. §§ 706 (8), 794 – 794(b); U.S.C. § 12101 et. seq. A copy of the policies/procedures shall be provided to each Individual/Parent/Guardian(s).

B. The organization shall implement policies/procedures concerning any person admitted for services or anyone proposed for admission to ensure confidentiality shall be maintained for all information related to HIV testing, positive HIV infection, any HIV associated condition, AIDS or Hepatitis B.

C. Each organization will protect the confidentiality of records or computer data that is maintained which relates to HIV, AIDS or Hepatitis B.

405 Incident / Accident Reporting

A. The organization shall **report the following incidents to the DDS Licensing Unit** in accordance with DHS Policy 1090. This report shall contain: date, accident/injury, time, location, persons involved, action taken, follow-up, signature of person writing the report. The following are reportable incidents:

1. Use of seclusion or restraint.
2. Maltreatment or abuse as defined in statutes (See Ark. Code Ann. §§ 12-12-501 – 12-12-515 (503); Ark. Code Ann. §§ 5-28-101 – 5- 28-109 (102))
3. Incidents involving injury:
    a. Accident/injury reports shall be completed for each accident/injury that requires the attention of an EMT, Paramedic or Physician.
        1. Accident is defined as an event occurring by chance or arising from unknown causes.
        2. Injury is defined as an act that damages or hurts and results in outside medical attention.
        3. A copy of the report, redacted as required by the Freedom of Information Act must be sent to parent/guardian of all children (0-18), and to guardian of adults regardless of severity of injury.
        4. Other health-related conditions resulting in Emergency treatment or hospitalization.
4. Communicable disease
5. Violence or aggression
6. Sentinel events (i.e., an unexpected occurrence involving death or serious physical

or psychological injury or the risk thereof)

7. Elopement and/or wandering defined as anytime the location of a person cannot be determined within 2 hours
8. Vehicular accidents
9. Biohazardous accidents
10. Use or possession of illicit substances or use or possession of licit substances in an unlawful or inappropriate manner (i.e., possession of prescription drugs by a person to whom the drugs have not been prescribed and who has no legitimate interest in possession of prescription drugs, such as a parent or guardian)
11. Arrests or convictions
12. Suicide or attempted suicide
13. Property destruction
14. Any condition or event that prevents the delivery of DHS services for more than 2 hours
15. Behavioral incidents (incidents involving an individual's actions that are aggressive, disruptive and/or present a danger to the individual or to others)
16. Other areas, as required

NOTE: *FOR INDIVIDUALS 3-21 YEARS OF AGE, DESTRUCTION OF INCIDENT REPORTS MUST BE IN COMPLIANCE WITH DEPARTMENT OF EDUCATION.*

B. The organization shall notify the parent/guardian of all children (0-18) or adults who have a guardian any time an incident/ injury report is submitted.

C. The organization shall develop and implement policies and procedures regarding follow-up of all incidents to include a time-line for action, remediation and preventative measures that do not exceed DDS established timeframes, in accordance with DHS Policy 1090.

407 Behavioral Management

A. The organization shall develop policy and procedure that demonstrates a commitment to a system that nurtures personal growth and dignity, and supports the use of positive approaches and supports.

B. The organization's policy and procedure shall ensure that when behavior management approaches are used, positive behavior interventions are implemented prior to the use of restrictive procedures.

C. Written behavior management policy developed by the organization shall ensure the rights of individuals.

1. The policy will be incorporated by the interdisciplinary team in programming, as appropriate.
2. The plan must be reviewed quarterly or as dictated by the needs of the individual served.

3. This shall include all types of behavior management used i.e., time out, token economy, etc… This cannot include procedures that are punishing, physically painful, emotionally frightening, or deprivation, or that puts the individual served at medical risk which are used to modify behaviors

D. If restrictions are placed on the rights of a person served:
   1. The organization shall follow its policies and procedures.
   2. The organization shall obtain informed consent from the individual/parent/guardian prior to implementation.
   3. The organization shall have methods to reinstate rights as soon as possible.
   4. Staff members are trained on proper implementation of all restrictions utilized by the organization.

E. The organization shall assure that maltreatment or corporal punishment of individuals will not be allowed.
   1. Policies and Procedure must state that corporal punishment is prohibited.
      a. "Corporal punishment" refers to the application of painful stimuli to the body in an attempt to terminate behavior or as a penalty for behavior.
      b. 20 U.S.C. § 1400 et. seq.; Maltreatment laws, Ark. Code Ann. §§ 12-12-501 – 12-12-515; Ark. Code Ann. §§ 5-28-101 – 5-28-109 .

F. Individuals shall have the right to obtain and retain private property.
   1. Personal possessions are regarded as the private property of the individuals and shall not be taken away unless danger to safety of the individual or to others is present.

G. Emergency Basis Procedure

An emergency safety situation is defined as unanticipated behavior that places the person served or others at serious threat of violence or risk of injury if no intervention occurs.

   1. The organization shall establish policies/procedures for the use of restraint and/or emergency intervention procedures that must be used/undertaken in the event of a emergency circumstances for a consumer who has no behavior management plan in place. The policies/procedures must identify the circumstances under which emergency procedures will be used as a protective measure in a life- or safety-threatening situation only when de-escalation has failed or is not possible.
   2. Emergency basis procedures may not be repeated more than three (3) times within six months without the interdisciplinary team meeting to revise the individual program plan. Each incident consists of: a behavior was exhibited, a procedure was used, the individual was no longer thought to be dangerous, the procedure was discontinued.

      Note: The number three (3) means three (3) distinct incidents. The three (3) distinct occurrences could take place in one (1) day.

500 SERVICE PROVISION STANDARDS

501 The organization shall establish written policies and procedures for intake, evaluation, and diagnosis necessary to determine the eligibility of a person to receive services shall be documented.

501.1 The organization shall designate specific staff positions assigned with the responsibility for intake, evaluation, assessment, family contact, planning, updating, and alternate placement.

502 Face sheets shall be completed at intake and shall be updated as needed and at least annually as documented by date of signature of the person designated in organization's policy.

502.1 Every person receiving services shall have a service record face sheet that contains the information in 502.1 A-S and will be filed in a prominent location in the front of the file.

A. Full name of individual
B. Address, county of residence, telephone number and email address, if applicable
C. Marital status, if applicable
D. Race and gender
E. Birth date
F. Social Security number
G. Medicaid Number
H. Legal status
I. Parents or guardian's name and address and relationship, if applicable
J. Name, address, telephone number and relationship of person to contact in emergency, someone other than item H
K. Health insurance benefits and policy number
L. Primary language
M. Admission date
N. Statement of primary/secondary disability
O. Physician's name, address and telephone number
P. Current medications with dosage and frequency, if applicable
Q. All known allergies or indicate none, if applicable
R. The results of all independent, annual developmental screens conducted by the DHS third-party vendor, or authorized waiver of the developmental screen requirement.

502 A case manager/service coordinator/evaluator shall be designated in writing and shall organize the provision of services for every individual served. The case manager/service coordinator/evaluator shall provide the individual or parent/guardian with the name and contact information in writing.

A. For every individual served, the case manager /service coordinator/ evaluator shall:
    1. Assume responsibility for intake, assessment, planning and services to the person
    2. Coordinate the individual program plan
    3. Cultivate the individual's participation in the services
    4. Monitor and update services to assure that:
        a. The person is adequately oriented
        b. Services proceed in an orderly, purposeful, and timely manner

c. The transition and/or discharge decision and arrangements for follow-up are properly made.

503 Intake

A. A written intake procedure shall be available upon request, shall be understandable to the individual receiving the services, shall be presented to those requesting services, and shall be followed by the organization in the evaluation of a person to determine eligibility for services.

B. The organization shall implement policies and procedures for acceptance into services. Policies and procedures must:

1. Establish the criteria for the order of acceptance of any person awaiting service.
2. Identify the position or entity responsible for making acceptance decisions.
3. Provide opportunities for persons to learn about the organization and its services.
4. When a person is found ineligible:
   a. The person is informed of the reasons.
   b. The person is given information about potential alternative services.
5. Ensure that all involved are aware of their responsibilities regarding services prior to the planning and delivery of services
6. Ensure signed informed consent for services are obtained and retained as required by funding sources and for legal reasons
7. Ensure persons served are given information about setting their individual service goals, when applicable, planning the services to be delivered and how progress on service goals will be communicated with them.

504 Information gathered prior to admission shall include the following information and shall be filed in the individual's record:

A. The results of the independent, annual developmental screen conducted by the DHS third-party vendor, or the authorized waiver of the developmental screen requirement.

B. Signed emergency medical release and all other necessary release forms (i.e., Publicity, field trip, fund raising, etc.). The emergency medical release form shall remain current (yearly) for the protection of the organization and the individual.

1. Competent adults must always sign their releases
2. Publicity releases shall be obtained on an as-needed basis (for each occurrence)
3. Field trip releases shall be obtained on a per occurrence basis unless that field trip is part of the regular program (i.e. bowling each week, swimming each week, etc.)
4. Emergency medical releases must be taken on field trips or incorporated in the field trip release.

C. Statement of Legal (competency) status; See Ark. Code Ann. §§ 28-65-101 – 28-65-109 (see index)

1. If the individual is under the age of 18, he/she is a minor. Organizations shall determine the who is the legal guardian of the child: Natural parent(s), ward of the state (DCFS/foster home, etc.) and shall ensure the legal guardian signs all appropriate documents.
2. If the individual is age 18 or older, he/she is considered competent unless the court has appointed a legal guardian. Copies of guardianship orders must be maintained in the individual's record.

Note: An individual for whom a guardian has been appointed retains all legal and civil rights except those which have been expressly limited by court order or which have been specifically granted by order of the court to the guardian. 4.

505 Application for services

A. The organization shall develop and implement a written application to be made available upon request or presented to those requesting services. At a minimum, the application shall contain name, address and telephone number of individual/parent/guardian and a statement of the individual's needs. Applications shall be available in an alternate format and assistance to complete shall be offered to individual's that may require it

506 The organization shall complete a Financial Screen for all applicants for services as applicable.

A. The screen shall be completed prior to admission and is used by the program in the evaluation of a person's financial status

B. The organization shall include all information about benefits for Medicaid eligibility and, for individuals who may not be eligible for Medicaid, shall include information about Tax Equity Family Reform Act eligibility.

507 Medical prescription for services shall be obtained, if applicable

A. A current prescription for services (within twelve months), signed by qualified medical personnel, shall be on file prior to admission

508 The organization shall complete or obtain a full assessment at the time of the admission process. The assessment shall include the following items:

A. Social history

1. A social history shall be written or procured within thirty (30) days of admission. The social history must be comprehensive, in narrative form or a completed questionnaire. The social history must be updated annually as evidenced by dated signature.

B. Medical history and evaluation

1. A physical examination/assessment signed by qualified medical personnel shall be on file and current within 5 days but not longer than thirty (30) days after admission. In cases where a physical cannot be obtained within 5 days, documentation of a physical within 1 year will be accepted until a new physical can be obtained

2. Early Periodic Screening Diagnosis Treatment process for Medicaid eligible individuals (0-21)

a. All individuals 0-21 years of age eligible for Medicaid should have evidence in the file that they are participating in the EPSDT process

509 A psychological evaluation report shall be on file prior to admission for adults (age 18 and older) and for children (age 5-18) if applicable

A. Adults (age 18-up) transferring from a DDS Licensed provider may be admitted with a copy of the most current psychological evaluation

B. A new psychological evaluation may be conducted if an Interdisciplinary Team determines that it is reasonable and necessary based on significant life changes of the individual.

510 Therapy evaluations must be completed or procured within thirty (30) days after admission, when applicable or when prescribed by a physician or a therapist working under a physician's orders. Recommendations from therapy evaluations shall be incorporated into the individual's plan of care as appropriate.

511 When applicable, all psychiatric evaluation shall completed by a qualified person and must be on file within thirty (30) days after admission. Recommendations from psychiatric evaluations shall be incorporated into the individual's plan of care as appropriate.

512 The service needs assessment must be completed on every individual seeking services

NOTE: SEE SECTION 521 FOR FURTHER GUIDELINES (CHILDREN'S SERVICES SECTION).

A. The person and/or family served and/or their legal representatives shall be involved in:
1. Assessments of potential risks to each person's health in the setting in which they receive services as well as in the community
2. Assessments of potential risks to each person's safety in the setting in which they receive services as well as the community
3. Decisions to accept or reject such risks
4. Identification of actions to be taken to minimize risks
5. Identification of individuals responsible for those actions

513 Personal Futures Planning

Guiding Principle: Individual's with developmental disabilities and their families have competencies, capabilities and personal goals that shall be recognized, supported, encouraged, and any assistance to such individual's shall be provided in an individualized manner, consistent with the unique strengths, resources, priorities, concerns, abilities, and capabilities of such individuals. Any plan of service developed should significantly reflect the person for whom it is intended. Services/ supports are most effective when they are adapted to address individual outcomes

1. The organization shall prepare a written person-centered support plan for each individual that shall meet their individual needs. At a minimum, the plan shall:
   A. Be developed only after consultation with the individual/parent/guardian, and other individuals from the individual's support network as determined by the individual/parent/guardian;
   B. Contain a description of the individual's preferred lifestyle, including:
      1. The type of setting in which the individual wants to live or work;
      2. With whom the individual wants to socialize;
      3. The social, leisure, religious, or other activities in which the individuals wants to participate;
      4. Reflect the individual's / family's choice of services which are relevant to the individual's age, abilities, life goals/outcomes

5. Address areas such as the individual's / family's health, safety and challenging behaviors which may put the individual at risk
6. Demonstrates the rights and dignity of individual/ family
7. Incorporates the culture and value system of the individual/family
8. Ensures the individual's/ family's orientation and integration to the community, its services and resources.
9. The necessary activities, training, materials, equipment, assistive technology and services needed to assist the individual in achieving their preferred lifestyle;
10. Describes how opportunities for individual choice will be provided;
11. Be approved, in writing by the individual/parent/guardian.

2. The organization shall regularly review and revise the plan whenever necessary to reflect changes in the individual's preferred lifestyle; achievement of goals or skills outlined within the plan or the goal is no longer deemed appropriate for the individual

514 Every individual shall have a written Individualized Program Plan

NOTE: SEE INDIVIDUAL PROGRAM SECTIONS FOR SPECIFIC TIME FRAMES (CHILDREN'S SERVICES, SEE SECTION 521).

A. The organization shall include the person served as an active participant giving direction in all aspects of the planning and revision processes
B. Services shall be provided based on the choices of the individual/parent/guardian (as appropriate) and on the strengths and needs of the individuals to be served by the organization
C. Individual choice shall be determined by personal futures planning as specified in Section 513 and a comprehensive assessment which addresses:
   1. Relevant medical history
   2. Relevant psychological information
   3. Relevant social information
   4. Information on previous direct services and supports
   5. Strengths
   6. Abilities
   7. Needs
   8. Preferences
   9. Desired outcomes
   10. Cultural background
   11. Other issues, as identified

514.1 The Individualized Program Plan:
   A. Shall be developed with the input of the person served and/or their legal guardian.
   B. Shall Identify:
      1. Least restrictive environment

a. Documentation of discussion of least restrictive environment appropriate for individual strengths and needs

b. The program must document the justification for specialized environments if they are to be used. Plans shall be made for return to normal environments as soon as possible.

1. Individuals shall be in contact as much as possible with those who do not have disabilities
2. Individual program plans will be reviewed for provisions of program services in the least restrictive environment appropriate to the ability of the individual. Document this item with a summary of the discussion by the entire team about the least restrictive alternatives
3. If the person chooses community integration or a less restrictive environment, documentation of referral attempts for alternate placement shall be present

2. Barriers

a. Describe the conditions or barriers that interfere with the achievement of the goal(s) or skills(s). Describe why a particular individual's needs cannot be met or what needs to be accomplished to meet the need.

b. Resources and/or environment changes, adaptations or modifications necessary to attain the goal or skill shall be listed. The person responsible for attempting to get the service must be identified.

Note: Example of barriers are: lack of contract work, lack of funds, lack of staff, individual absent due to illness, prosthetic devices, equipment space, etc. The responsible person may be staff member, individual, family, etc.

c. Documentation of efforts made to remove the identified barriers shall be noted in the individual's progress reports.

3. Long-range goals (addressing a period of 3-5 years) and annual goals

a. The plan shall incorporate the goals and objectives of the individual's person centered plan.

b. The planning process shall support the individual / family in decision making and choosing options by actively involving the individual/ family in the Individual Plan (IP) development

4. Specific measurable objectives.

514.2 Short-term objectives (3-6 months' time frame) shall be developed, as needed, for each of the annual goals.

A. Each objective must have criteria for success that states what the individual must do to complete the objective.

B. Short-term objectives must have methods/materials for implementation and give a simple statement describing the procedures to be used in individual training.

C. The person responsible for implementation of each short-term and service-objective shall be specified.

Note: Utilization of title is recommended. This could be the individual or parent/guardian.

D. Short-term objectives shall have an initiation date, a target date, and, when completed, a completion date

E. Target dates –

1. The target date shall be individualized and noted at the same time of the initiation date and the projected date when the individual can realistically be expected to achieve an objective.
2. The target date shall be used as a prompt to see if expectations for the individual are realistic in relation to attainment and appropriateness of goals and objectives. If the starting or target dates need to be revised, the organization shall mark through, initial and put in a new date.
3. The ending date shall be entered in as the person completes each objective.

514.3 Service Objectives

A. Shall be reviewed on a regular basis with respect to expected outcomes.

B. Shall be revised, as appropriate:

1. Based on the satisfaction of the person served.
2. To remain meaningful to the person served.
3. Based on the changing needs of the person served.

C. Shall include a target date, which is a projected date when the team thinks the individual will no longer need the service or the service provision should be reviewed.

514.4 The following areas shall be assessed to determine needs in the plan and shall be documented:

A. Assistive technology.

B. Reasonable accommodations.

C. Identified health and safety risks

514.5 The individual program plan shall be communicated in a manner that is understandable:

A. To the person served and/or their guardian / advocate/ representative.

B. To the persons responsible for implementing the plan.

514.6 The organization shall ensure that persons involved or their legal guardian/advocate understand the plans and their own involvement in achieving the outcomes.

A. Active participation of the persons served, or their guardian or advocate in setting goals and planning services shall be documented. Documentation may be through interviews, records, checklists, etc. and shall be maintained in the individual's file

B. If a person served needs services that are not available through the organization, the organization shall make referrals to other providers as indicated. Documentation of the referral(s) shall be maintained in the individual's file.

NOTE: CONTACT DDS FOR A LIST OF PROVIDERS THAT PROVIDE THE REQUESTED SERVICE.

515 Every ninety (90) days of service delivery, the service provider shall complete a quarterly report on the goals/objectives of the IPP. If needed, modifications may be made with meeting of entire team. Quarterly reports must be specific to reflect the individual's performance concerning

implemented goals and short-term objectives as specified in the individual program plan and shall be based on the case notes for the reporting period.

A. The quarterly notes shall establish goals or short-term objectives which are:
   1. Accomplished
   2. To be continued
   3. Modified or deleted (with statement of reason or barrier) and
   4. Will be worked on for the next three months or ninety (90) days

B. Data Collection/case notes shall be utilized in writing progress reports.

C. Quarterly reports shall be written, dated, and signed by persons responsible for case management. All persons responsible for implementation of services must contribute to the report.

D. Quarterly reports shall document referral to interdisciplinary team for modification of the annual goals as needed, in compliance with state and federal regulations

E. Documentation of communication of quarterly reports to the individual/parent/guardian (as appropriate) shall occur at least every three (3) months or ninety (90) days as in compliance with state and federal regulations.

F. Quarterly reports must include space for individual and/or parental/guardian evaluation of services. The organization shall document that the persons served and/or the parent guardian has opportunity to evaluate the services received as in accordance with state and federal guidelines.

516 Updating

A. The organization shall have policies and procedures in place for updating individual program plans. Updates shall be done at least annually and more often if monitoring reports indicate a need or if federal regulations require more frequent updates.

B. The organization shall have policies and procedures in place for revising individual program plans when goals change.

C. Annually update – financial, if applicable, social, medical, medical prescription for services, evaluations as applicable, IPP's, and service needs assessment;

517 Termination of services or alternate placement

NOTE: SEE THE SPECIFIC PROGRAMMING SECTION FOR MORE DETAILED INFORMATION (CHILDREN'S SERVICES 521).

A. An exit summary shall be prepared each time a person leaves a service, not just when the person is leaving the organization.
   1. The report shall summarize the results of the services received by the person and makes recommendations for future services to continue the achievement of the person's life goals.
   2. The plan may suggest referrals to other services that are not available through the organization

518 Data Collection Requirements

A. Data collections shall provide specific information on annual goals and short-term objectives and should be designed to measure and record the progress on each short-term objective.

B. Data collection shall consist of sufficient written documentation to support each. *Daily* service documentation must, at a minimum, include:

- The specific services furnished;
- The date and actual beginning and ending time of day the services were performed;
- Name(s) and title(s) of the person(s) providing the service(s);
- The relationship of the services to the goals and objectives described in the person's individualized plan of care and

C. Data collection shall also consist of weekly or more frequent progress notes, signed or initialed by the person providing the service(s), describing each individual's status with respect to his or her goals and objectives.

D. Data Collection shall be filed in the individual's file at least monthly and shall be available for review upon request.

520 The organization shall establish and maintain each individual's daily schedule based upon the individual's program plan. The schedule shall indicate general activities throughout the day for each individual. As appropriate the schedule should reflect time segments for the individual to exercise choice in the selection of activities.

521 Children's Services Individual Program Planning

As a key element in establishing goals/objectives/ personal outcomes, the agency shall assess an individual's/family's preferences, desires, lifestyle choices, strengths, needs, skills, etc. through individual observations or interviews. Documentation of the assessment shall be maintained in the individual's file. At a minimum, the assessment must include:

A. Developmental Assessment
   1. Initial evaluation shall include 2 developmental assessments; 1 standardized and 1 criterion based.
   2. Documentation must include:
      a. A written summary that includes standard deviation and/or percentage of delay as determined by the test protocols
      b. An informed clinical opinion
   3. Must be in a format that is understandable to the parent.
   4. Must be signed by the evaluator.

B. An annual assessment must be conducted using a criterion based test.

C. A Social History must be completed, signed and dated on the approved form from DOE.

521.1 Children 3-5-The Individual Program Plan shall include a statement of the specific services necessary to meet the identified needs of the child/family.

A. At a minimum the IPP must include:
   1. Frequency- Number of days or sessions that a service will be provided
   2. Intensity- The length of time the service is provided during each session, and whether the service is provided on an individual or group basis
   3. Location- Location where the service is provided (e.g., in the child's home, early intervention center, or other setting) as appropriate to the age and needs of the child

4. Method- How a service is provided
5. Dates and duration- Projected dates of initiation of the services, a target date for completion and/or review and the anticipated duration of those services. If either of these dates needs to be revised, then simply mark through, initial and put in new date.

B. Completion of the IPP must meet all State and Federal requirements

C. In order to revise an individual's objectives, at least three (3) members of the team must be present. Parent(s) must be included.

521.2 Quarterly reviews must include a Family Rating which must be documented on the appropriate form as designated by DDS.

521.3 Children reaching 5 years of age must have a transition plan.

A. This plan must be developed 180 days prior to age 5 as per State and Federal guidelines.

B. The plan must be child specific and must include specific steps to ensure a smooth transition for the child and family, and must be in accordance with State and Federal Guidelines.

C. The plan must include a transition plan at kindergarten age. Children entering public schools must have a transition plan.

D. The individual program shall include the steps to be taken to support the transition of the child upon reaching kindergarten age.

E. The organization must document contact with the agency which will provide services following the transition, and must demonstrate an attempt to involve that agency in the transition planning. Documentation must be maintained in the individual's file.

521.4 If the organization is using the supervising teacher model, the organization must follow all State and Federal Guidelines and maintain appropriate documentation of supervision and direct contact with the child on file for review.

522 Vocational Maintenance & Monitoring

Vocational Maintenance & Monitoring

A. Case Notes

1. Case notes shall document each contact with the individual the frequency of each contact will be determined by the team during the development of the IPP it should include date, time and summary of each contact.
2. Service Objectives shall be listed in an outcome oriented manner.
   - A. Each service objective shall specify any environment modification necessary to facilitate the individual's accomplishment.
   - B. Each service objective, including physical adaptations or modifications of the individual's environment, shall be stated as a single specific outcome.
   - C. Service objectives shall provide opportunities in the social environment to support community integration and the enhancement of individual relationships.

D. Based on the individual's choice, and the needs assessment, plans shall include facilitation of the individual's participation in normal activities in normal settings of same-age peers.

523 STAFF RATIOS

523.1 Staff Ratios for Early Intervention Day Treatment Day Programming:

Ratios for Day Programming for Children 0-18 ~~3 Years~~months
1:4

Ratios for Day Programming for Children 18-36 months
1:5

Ratios for Day Programming for Children 3-~~5~~4 Years
1:7 ~~If non-integrated according to December 1st child count~~
~~1:9 If integrated at the December 1st child count, the center can send in documentation to DDS and use the alternative ratio of 1:9. Provider shall be required to assure DDS that the integrated status is maintained and it will be checked periodically during licensure visits.~~

Ratios for Day Programming for Children 4-6
1:8

Ratios for Day Program for Children 6 and over
1:10

523.2 Ratios for Adult Developmental Day Treatment Day Programming
The organization shall maintain a 1:10 ratio throughout the building.

523.3 For all Day Programming~~Ratios for Adult Day Programming~~
The Direct Care Staff must have VISUAL CONTACT WHILE ACTIVELY ENGAGED IN PROVIDING SUPPORT AND SUPERVISION TO CONSUMERS.~~organization shall maintain a 1:10 ratio throughout the building using the following definition.~~
~~ONE DIRECT CARE STAFF PERSON THAT HAS VISUAL CONTACT WHILE **ACTIVELY ENGAGED** IN PROVIDING SUPPORT AND SUPERVISION TO CONSUMERS.~~

524 Square Footage

A minimum of forty (40) square feet of program training area per individual served shall be required. This is program-training area only. This does not include halls, storage areas, or administrative offices.

600 FOOD SERVICES

A. This standards section shall be applied to all provider owned/leased/rented facilities. If the facility contracts for food services, the organization shall ensure compliance with DDS policies.

601 Written procedure shall be established that addresses how food services are provided to the individuals served by the facility:

A. Procedure shall include how meals are provided as well as staff responsible.

601.1 All Day services programs shall assure that organization provided meals are approved, adequate diets, which conform to the recommended dietary allowance.

601.2 Licensed Group Homes shall assure that three (3) meals a day are available for individuals served.

A. The organization shall keep on hand suitable food for preparing sack lunches, if appropriate.

B. All meals shall be part of an approved, adequate diet, which conforms to the recommended dietary allowance.

C. Facilities with apartment units shall have a mechanism for monitoring the resident's food related skills.

602 The organization shall keep menus on file. Menu preparation should occur at least one week in advance in order to:

A. Allow adequate time to purchase foods to avoid too frequent menu substitutions. Meal planning shall occur so that identical meals are not served on the same day of consecutive weeks.

B. Serve as a reminder for scheduling advance preparation;

C. Allow menus to be available as a teaching tool for instruction of individuals, to include development of menus by individuals.

Menus shall be kept on file for a minimum of three (3) months.

603 Menus shall be prepared or approved by a registered dietitian/nutritionist. Organizations may contract with a dietitian/nutritionist.

A. Dietitian/nutritionist shall check for nutritional adequacy of menus and acceptable food safety and sanitation practices. This must be documented by a written report at least annually.

B. DDS shall accept Arkansas Nutrition Program approval, or site monitoring reports, as adequate approval for Centers that participate in the free/reduced lunch program.

604 The organization shall develop and implement written procedures that address provisions for special diets.

A. Special diets pertain to allergies, weight control, diabetes, religion, hypertension, and other medical conditions as documented in the consumers file.

605 Food items and toxic items shall not be stored together.

700 TRANSPORTATION

A. The organization shall establish written procedures that address how transportation services are provided to individuals served by the program.

B. The procedures shall address transportation to the persons served, as well as staff responsible.

C. The organization shall ensure that all individuals receiving services are provided with a copy of the transportation policies and shall document receipt of this information in the individual's file.

701 The organization shall assure safety for all persons being transported. For all transportation services provided for the persons served by the organization, the organization shall ensure:

A. For all vehicles owned or operated by the organization:

1. Compliance with all applicable federal, state, county, and city requirements.
   a. All vehicles shall be properly licensed by the State of Arkansas.
2. Appropriate licensing of all drivers.
   a. All drivers must be licensed according to state requirements for providers of public transportation.
3. Review of driving records of all drivers on an initial and annual basis.
4. Insurance requirements for vehicles and personnel.
   a. The organization shall maintain insurance coverage providing a minimum of $1,000,000 comprehensive, liability, and property damage.
5. Safety equipment / features in vehicle(s).
   a. Fire extinguisher in every program vehicle used to transport consumers.
   b. Each vehicle shall utilize seat belts or suitable restraints when in motion in accordance with Ark Code 27-37-702 "Seat Belt Use Required" and 27-34-101-107 "The Child Passenger Protection Act"
   c. The organization shall establish policy and procedure to ensure Child Safety Alarms on every vehicle required under Ark Code 20-78-225 (all vehicles designed or used to transport more than 7 passengers and 1 bus driver)
6. Accessibility based on the individual's needs and reasonable requests.
7. Training of drivers in the organization's transportation requirements.
8. Written emergency procedures.
   a. Each vehicle used in transporting clients shall have a documented emergency drill once every six months.
9. Availability of communication devices (i.e., cell phones 2-way radios, etc.).
10. Road warning/hazard equipment (i.e., safety cones, flairs, reflector signs, etc.)
11. First aid supplies.
   a. Every program vehicle used to transport consumers shall maintain a First Aid kit.
12. Maintenance of vehicles owned or operated by the organization according to manufacturers' recommendations.
   a. The organization shall establish/implement procedures that ensures a vehicle maintenance log is kept up to date for all vehicles used to transport consumers.

1. The procedure shall establish who is responsible for upkeep of vehicle and who is responsible for documentation and update of log.

b. The maintenance log shall document the following:
   1. Oil changes
   2. Tires and brakes repair/inspection
   3. Head and tail lights and turn signals repair/inspection
   4. Windshield washer and wiper blades repair/inspection
   5. Air conditioner (if any), and defroster inspection/repair
   6. Hoses and fan belts inspection/replacement
   7. Fluid levels inspection and replacement
   8. Exhaust system inspection/repair
   9. Emergency warning system inspection/repair
   10. Steering assemblage inspection/repair

13. If services are contracted:
   a. An annual review of the contract against elements 1-12 of this standard shall be performed by the organization.
   b. Personnel or contractors shall provide transportation services for the persons served in a safe manner, with drivers having knowledge of unique needs of persons served, and consistent with the regulations of the local authorities.
      1. This standard shall apply when any vehicle, including a personal vehicle, is used to provide transportation for persons served.

702 The organization shall establish written policy and procedure to address apparent abandonment of consumer by family and/or guardian.

A. The organization shall develop a procedure to be followed by transportation staff when unable to leave individuals at home or alternate sites as specified by family that ensure the safety of the individual at all times.

703 At least one responsible person, in addition to the driver, shall be present in the vehicle if any of the following conditions apply:

A. Any person being transported has medical conditions as defined by the organization guidelines.

B. Any person being transported has a severe disability as defined by the organization's guidelines.

NOTE: 'Responsible person' shall be defined by the organization's policy.

704 Organizations operating vehicles transporting children shall comply with the child:staff ratio specified by the Child Care Licensing Standards for Transportation

705 Organizations operating vehicles transporting adults shall establish/implement policies related to adult: staff ratios.

NOTE: DDS RECOMMENDS A 1 TO 10 RATIO AT ALL TIMES.

800 PHYSICAL PLANT, ACCESSIBILITY AND SAFETY

A. The organization shall provide a physical plant compatible with services provided and with the needs of the individuals and staff; provide an accessible and safe environment and be in compliance with U.S.C. § 12101 et. seq. "American with Disabilities Act of 1990" at all owned, leased, and/or rented program site(s).

801 The organization shall promote accessibility in all settings. The organization shall assess all physical sites to ensure accessibility for individuals and their families and shall establish time lines and actions to be taken for removal of identified barriers.

A. Organizations shall ensure that all physical sites address accessibility issues in order to:
   1. Enhance the quality of life for those served in their programs and services.
   2. Meet legal and regulatory requirements.
   3. Meet the expectations of stakeholders in the area of accessibility.

801.1 Accessibility Requirements

A. The organization shall ensure architectural accessibility at each facility based on the individual's needs.
   1. Ramps, doors, corridors, toileting and bathing facilities, furnishings, and equipment are designed to meet the individual's needs.

B. The organization shall ensure that all their facilities are in compliance with 29 U.S.C. §§ 706 (8), 794 – 794(b) "Disability Rights of 1964" and U.S.C. § 12101 et. seq. "American with Disabilities Act of 1990". Compliance with the aforementioned laws is required to receive federal monies. Admissions criteria of who can be served shall identify any persons the facility or staff would be prevented from serving due to accessibility issues.

801.2 Accessibility Assessment and Planning

A. The organization shall assess all facilities. The assessment shall identify all barriers and shall develop a plan for removal of barriers in the following areas:
   1. Architecture
   a. Architectural or physical barriers which may include steps that prevent access to a building for an individual who uses a wheelchair, narrow doorways that need to be widened, bathrooms that need to be made accessible, the absence of light alarms for individuals who have a hearing impairment, and the absence of signs in Braille for individuals who have visual impairments.
   2. Environment
      a. Any location or characteristic of the setting that compromises, hinders, or impedes service delivery and the benefits to be gained.

802 Physical Plant Structure

802.1 Architecture

A. All water, food service, and sewage disposal systems must meet all local, state, and federal regulatory agencies, as applicable. The organization shall maintain documentation of all approved inspections for review by DDS.

1. Sewer inspections are not required if the site is on city water and sewage lines.
2. Sites using a well and/or septic tank, shall be obtain an inspection by the Division of Health documenting compliance with the DOH and local regulations.

B. Floor furnaces, gas heaters, electric heaters, hot radiators, and exposed water heaters must be protected by screens or guards that are without sharp corners and are attached to floor or wall to prevent persons from falling against the guard and knocking it over.

C. Enclosed gas heaters must be properly vented to the outside, and installed with permanent connection that includes a cut-off valve in the rigid part of the gas supply pipe.

Note: DDS recommends gas heaters with a pilot light and automatic cut-off valve which automatically cuts off gas to the main burner when the pilot light goes out.

D. Restroom facilities used by individuals must provide for individual privacy and be appropriate for the individuals served regarding size and accessibility.

802.2 Environment

A. Temperature of each facility must be maintained within a normal comfort range for the climate. Recognizing that there may be variances within a building, the organization shall make reasonable efforts to maintain a comfortable temperature range throughout the facility.

Note: The recommended standard for range of comfort is from 65 to 80 degrees F (U.S. Atmospheric Standards 29.1)

B. All areas of the facility shall be sufficiently lighted to meet the needs of the individuals being served and the usage of the area.

C. The organization shall maintain the interior and exterior of the building in a sanitary and repaired condition.

D. The premises shall be free of offensive odors.

E. The grounds and all buildings on the grounds shall be maintained in a clean and repaired condition.

1. Play and activity areas shall be free of dense undergrowth and refuse accumulations. All landscape plantings and the lawn shall be well groomed.

F. The facility shall be maintained free of infestations of insects and rodents.

1. The organization shall maintain a contract for pest control that is administered by appropriately licensed professionals.

G. The organization shall establish written procedures regarding smoking that is in accordance with The Clean Air Indoor Act (Act 8 of 2006).

1. For all congregate, day-hab settings, and licensed group homes, smoking will not be permitted in the following areas:
   a. Common Work Areas
   b. Auditoriums
   c. Classrooms
   d. Conference and Meeting Rooms
   e. Private Offices
   f. Elevators
   g. Hallways
   h. Health Care Facilities

i. Cafeterias
j. Employee Lounges
k. Stairs
l. Restrooms
m. All other enclosed areas.

2. Approved Exemptions:
   a. Private residences or health care facility
   b. All workplaces of any employer with fewer than three (3) employees. (Note: This exemption does not apply to any public place)
   c. Outdoor areas of places of employment or group homes

H. All materials and equipment and supplies shall be stored and maintained in a safe condition. Cleaning fluids and detergents must be stored in original containers with labels describing contents.
   1. The organization shall maintain an MSDS manual in a location that is accessible to all employees. All MSDS sheets must be on file and current.

803 Safety Inspections

803.1 The organization shall ensure that annual safety inspections are completed by qualified individuals to enhance and maintain the organization's health and safety practices.

A. All applicable inspections shall be maintained on file, and current within one year or as specified by law/regulation (i.e., Annual Fire Department, Local Health Department, Safety Engineer, OSHA, Safety Specialist, and Insurance Carrier).

B. A comprehensive inspection shall be conducted annually at all facilities where the organization delivers services or provides administration on a regular and consistent basis. Inspections shall be conducted by a qualified external authority(ies).
   1. Results of each inspection shall contain written documentation that:
      a. Identifies the areas inspected.
      b. Identifies recommendations for areas needing improvement.
      c. Identifies actions taken to respond to the recommendation(s).

C. All applicable licenses, inspections, etc., shall be current. This shall include health inspections for food service preparation, if applicable. Residential facilities with more than ten (10) residents must have a Division of Health inspection.

803.2 Regular self-inspections shall be completed to assist personnel in internalizing current health and safety requirements into everyday practices.

A. The organization may designate professional personnel (managers, supervisors, direct service employees, maintenance personnel) or internal groups (safety committees, safety circles, operation teams, consumers or advocates) within the organizational structure to conduct self- inspections. The organization shall ensure that all staff involved in self-inspections have received training in conducting inspections prior to participation.

B. The organization shall maintain a schedule of when self-inspections will be conducted.
   1. At a minimum, self-inspections must be conducted:
      a. At least twice a year.
      b. At all facilities where the organization delivers services or provides administration on a regular and consistent basis.
   2. Results of self-inspections shall contain written documentation that:

a. Identifies the areas inspected.
b. Identifies recommendations for areas needing improvement.
c. Identifies actions taken to respond to the recommendation(s).

804 Emergency Procedures

804.1 The organization shall establish emergency procedures that detail actions to be taken in the event of emergency and to promote safety for the individuals served.

A. Emergency procedures shall be in written form, and shall be available and communicated to all members of the staff and other supervisory personnel.

1. At a minimum, emergency procedures shall be implemented for:
   a. Fires.
   b. Bomb threats
   c. Natural disasters.
   d. Utility failures
   e. Medical emergencies
   f. Safety during violent or other threatening situations (i.e., intruders)
2. Written emergency procedures shall:
   a. Meet the requirements of all applicable authorities.
   b. Implement practices appropriate for the locale (i.e., Arkansas Chemical Stockpile Emergency Preparedness Program/CSEPP)

B. The organization shall maintain an emergency alarm system for each type of drill (fire and tornado).

C. The organization shall ensure that persons served, as appropriate, are be educated and trained about emergency and evacuation procedures.

D. The organization shall evaluate and consider modification of all emergency procedures during the following times:
   a. Training.
   b. After training drills.
   c. As risks increase.
   d. After actual emergencies.
   e. When responsibility is reassigned.
   f. When changes are made to the physical plant.
   g. When changes occur in the physical plant proximity.
   h. When a policy or procedure is revised.
   i. When briefing personnel on emergency plan changes.

E. The organization shall analyze tests of the emergency and evacuation procedures annually and shall use the results of the analysis to improve or to affirm satisfactory current practices.

804.2 For all facilities where the organization delivers services or provides administration on a regular and consistent basis, the organizations shall establish/implement written procedures for evacuations.

A. Evacuation procedures shall address:
   1. When evacuation is appropriate.
   2. Complete evacuation from the physical facility.
   3. The safety of evacuees.

4. Accounting for all persons involved.
5. Temporary shelter, when applicable.
6. Identification of essential services.
7. Continuation of essential services.
8. Emergency phone numbers.
9. Notification of the appropriate emergency authorities.

B. Evacuation routes must be posted in conspicuous places, except in residential settings and must be easily understandable to the individuals served.

804.3 As a part of an organization's performance improvement activities shall include emergency procedure testing.

A. A tornado drill must be held monthly.
   1. Written reports telling date, hour of day, evacuation time, and other areas of concern shall be maintained.

B. A fire drill must be held monthly.
   1. Written reports telling date, hour of day, evacuation time, and other areas of concern shall be maintained.

804.4 Detectors

Battery operated or electronic smoke detectors, heat sensors, carbon monoxide detectors and/or sprinklers shall be provided in all buildings where services are provided and shall meet life safety codes.

A. Fire Marshall's report shall be followed as to placement of these devices.
B. Equipment shall be tested at least quarterly or as recommended by the manufacturer/monitoring contractor.

804.5 Fire Extinguishers

Fire extinguishers shall be required to the extent specified by the State Fire Marshall or his designee and shall be checked annually.

A. The Fire Marshall uses Ark. Code Ann. §§12-13-101 - 12-13-116 "Fire Prevention Act" that follows the Life Safety Code 101 and additional National Fire Prevention Agency publications.

804.6 Emergency Lighting

The organization shall maintain emergency lighting, (i.e., flashlight or other battery operated lights) as required by the life safety codes.

804.7 First Aid

The organization shall maintain a first aid kit and current first aid manual at all sites where services are provided on a regular, consistent basis.

A. Antidote charts and the telephone numbers of poison control centers shall be readily accessible to staff and individuals served.
   Note: This can be obtained through Poison Control Center at University of Arkansas Medical Science Center in Little Rock if you cannot get locally.

804.8 Water Temperatures

Provisions shall be made to control water temperature at facilities where services are provided on a regular, consistent basis.

A. To ensure the safety of individuals served, each organization shall develop/implement policy and procedure concerning water temperature adhering to current literature regarding water safety with a maximum temperature of 120 degrees. If the thermostat of the hot water heater is set above 120 degrees, a mixer must be to the lavatories and bathing facilities to maintain safety.

Note: This standard shall apply only to service areas and where consumers are working.

APPENDIX A

SUGGESTED
BOARD/ORGANIZATION TRAINING TOPICS

Policy Development and Implementation

Planning and Evaluation
Equal Employment Opportunity/Affirmative Action
Employee Performance Evaluation
Team Building
Performance Management
Effective meetings
Due Process
Freedom of Information

Overview of Department of Human Services
Overview of Developmental Disabilities Services
Philosophy and Goals
Programs, Practices, Policies and procedures of Local Organizations
Overview of Community Integration

History, Philosophy, Causes and Types, Functional Levels, Severity Levels, Prevention and Program Issues in Mental Retardation and Other Developmental Disabilities.

Introduction to Principles of Normalization
Legal rights of Individuals with a Developmental Disability
Interdisciplinary Approach Overview
Age Appropriate Programming
Medications – Implications, Side Effects, legality of Administering

Overview of Federal and State Laws related to serving people with Developmental Disabilities (see index):

U.S.C. S2000a – 2000 h-6; Ark. Code Ann. SS 6-41-222; 20 U.S.C S 14000 et. seq. (Part B & Part H); 29 U.S.C SS 706(8), 794-794(b);
5 U.S.C S 552a; 42 U.S.C SS 6000-6083; Ark. Code Ann. SS 20-48-201 – 20-48-211; Ark. Code Ann. SS 28-65-101 – 28-65-109; Ark. Code Ann. SS 5-28-101 – 5-28-109; Ark. Code Ann. SS 12-12-501 – 12-12-515; Ark. Code Ann. SS 25-2-104, 25-2-105, 25-2-107, Ark. Code Ann. SS 25-10-102 – 25-10-116; Ark. Code Ann. SS 20-18-215; U.S.C. S 12101 et. Seq.; DHS Administrative Policy 3002-I (Revised) and DDS Service Policy 3016, Prevention of Transmission of Disease Borne by Blood or other Body Fluids such as AIDS and Hepatitis B; DDS Administrative Policy 1077 Chemical Right to Know; DDS Service Policy 3004-I Maltreatment Prevention, Reporting and Investigation.

INDEX

ARKANSAS CODE ANNOTATIONS		ACTS
Ark. Code Ann. SS	6-41-201 - 6-41-222	102 of 1972 Handicapped Children's Act
Ark. Code Ann. SS	20-48-201 - 20-48-211	265 of 1969 AR Mental Retardation Act
Ark. Code Ann. SS	25-19-101 - 25-19-515	AR Freedom of Information Act
Ark. Code Ann. SS	12-12-501 - 12-12-515	397 of 1975 Child Abuse and Neglect Act
Ark. Code Ann. SS	5-28-101 - 5-28-109, 5-28-201 - 5-28-215, 5-28-301 - 5-28-305	452 of 1983 Adult Abuse
Ark. Code Ann. SS	28-65-101 - 28-65-109, 28-65-201 - 28-65-220, 28-65-301 - 28-65-320, 28-65-401 - 28-65-403, 28-65-502, 28-65-601 - 28-65-602	940 of 1985 Guardianship Law
Ark. Code Ann. SS	25-10-102 - 25-10-116, 20-46-202, 20-46-310, 25-2-104, 25-2-105, 25-2-107	348 of 1985 DHS Reorganization
Ark. Code Ann. SS	20-48-601 - 20-48-611	611 of 1987 Location of Community Homes
Ark. Code Ann. SS	12-12-501 et. Seq.	Child Maltreatment
Ark. Code Ann. SS	27-34-101 - 27-34-107	Child Safety Seat Use
Ark. Code Ann. SS	20-78-215	1050 of 1985 Federal Funds for Child Sexual Abuse
Ark. Code Ann. SS	6-21-609	854 of 1987 Exposure to Smoke

UNITED STATES CITATIONS	ACTS
42 U.S.C. S2000a – 2000 h-6	Title VI of the Civil Rights Act of 1964
20 U.S.C. S14000 et. Seq.	P. L. 94-142 Individuals with Disability Education (IDEA) P.L. 99-457 Part H
29 U.S.C. SS 706(8), 794 – 794(b)	Rehabilitation Act of 1973 Section 504
42 U. S. C. S 552	Federal Freedom of Information Act
42 U.S.C. S 6000 – 6083	Developmentally Disabled Assistance and Bill of Rights Act of 1984 and Amendments of 1987
5 U.S.C. S 552a	Federal Privacy Act
42 U.S.C. S 12101 et. Seq.	Americans with Disabilities Act of 1990 P. L. 101-336
42 U. S. C. S 6000 – 6009 6021 – 6030 6041 – 6043 6061 – 6064 6081 - 6083	P. L. 98-527 Developmentally Disabled Assistance & Bill of Rights Act of 1984

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

(2) Apnea (Cardiorespiratory) Monitors

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

(3) ~~Child Health Management Services (CHMS)~~**Early Intervention Day Treatment (EIDT) Services**

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

Core services provided by EIDT are:

a. **Comprehensive Evaluation for ages 0-20, 1 unit per year**
b. **Habilitative Services for ages 0-6—5 units per day, 1 hour each**
c. **Habilitative Services in the Summer for ages 6-20, 5 units per day, 1 hour each**
d. **Physical Therapy as prescribed by a physician and provided under the supervision of a qualified physical therapist**
e. **Speech Therapy as prescribed by a physician, and provided under the supervision of a qualified speech pathologist**
f. **Occupational Therapy as prescribed by a physician, and provided under the supervision of a qualified occupational therapist**
g. **Nursing Services as prescribed by a physician, and provided by a registered nurse or a licensed nurse practitioner, 4 units per day, 15 minutes each**

Individual and group therapy are limited to six (6) units per week. One unit equal 15 minutes. Evaluations are limited to four (4) units per State Fiscal Year (July 1 through July 30). One unit equals 30 minutes.

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

~~**CHMS treatment requires prior authorization to determine and verify the patient's need for CHMS services. Effective March 1, 2000, all CHMS treatment services will require prior authorization. Two of the CHMS treatment procedure codes, Z1573 and Z1574, are limited to four (4) per State Fiscal Year (July 1 through June 30). Extension of the benefit limit will be provided if medically necessary**~~.

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

(2) Apnea (Cardiorespiratory) Monitors

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

(3) ~~Child Health Management Services (CHMS)~~**Early Childhood Intervention Day Treatment (EIDT) Services**

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

Core services provided by EIDT are:

h. **Comprehensive Evaluation for ages 0-20, 1 unit per year**
i. **Habilitative Services for ages 0-6—5 units per day, 1 hour each**
j. **Habilitative Services in the Summer for ages 6-20, 5 units per day, 1 hour each**
k. **Physical Therapy as prescribed by a physician and provided under the supervision of a qualified physical therapist**
l. **Speech Therapy as prescribed by a physician, and provided under the supervision of a qualified speech pathologist**
m. **Occupational Therapy as prescribed by a physician, and provided under the supervision of a qualified occupational therapist**
n. **Nursing Services as prescribed by a physician, and provided by a registered nurse or a licensed nurse practitioner, 4 units per day, 15 minutes each**

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Revised: ~~January 1, 2003~~July 1, 2018

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

(3) ~~Child Health Management Services (CHMS)~~**Early Intervention Day Treatment (EDIT)**

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

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

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

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

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

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

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

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

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