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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.

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.

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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 that $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 (Initial 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-~~Q~~R 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
~~Q.~~R. The results of all 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 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.

~~B~~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.

C.

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

~~• Daily 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.~~

C. Data collection shall also consist of weekly of 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.

~~C.~~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

Ratios for Day Programming for Children 0-3 Years

1:4

Ratios for Day Programming for Children 3-5 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.

523.3 Ratios for Adult Day Programming

The 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

ARKANSAS DEPARTMENT OF HUMAN SERVICES

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TO: Arkansas Medicaid Health Care Providers – Developmental Day Treatment Clinic Services

EFFECTIVE DATE: October 1, 2017

SUBJECT: Provider Manual Update Transmittal DDTCS-2-17

REMOVE		INSERT	
Section	**Effective Date**	**Section**	**Effective Date**
202.200	11-1-06	202.200	10-1-17
—	—	203.000	10-1-17
—	—	204.000	10-1-17
212.000	4-1-07	212.000	10-1-17
214.100	10-13-03	214.100	10-1-17
214.110	10-13-03	214.110	10-1-17
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214.132	7-15-12	214.132	10-1-17
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217.000	3-1-10	217.000	10-1-17
217.100	3-1-10	217.100	10-1-17
217.700	3-1-10	—	—
217.800	3-1-10	—	—
218.000	3-1-10	218.000	10-1-17
218.100	11-1-06	218.100	10-1-17
220.000	7-1-15	220.000	10-1-17
220.100	11-1-10	220.100	10-1-17
220.200	4-16-12	220.200	10-1-17
240.000	10-13-03	240.000	10-1-17
262.100	12-5-05	262.100	10-1-17

Explanation of Updates

Section 202.200 has been updated to change the requirements for DDTCS medical and clinical records.

Section 203.000 has been added to include information regarding Referral to First Connections Program Pursuant to Part C of the Individuals with Disabilities Education Act (IDEA).

Section 204.000 has been added to include information regarding Election to Provide Special Education Services in Accordance with Part B of the Individuals with Disabilities Education Act (IDEA).

Section 212.000 has been updated to add beneficiary restrictions to the scope of this program.

Section 214.100 has been updated to add assessment to DDTCS Core Services.

Section 214.110 has been updated to change Diagnosis and Evaluation (D&E) to Assessment for Adult Development.

Section 214.120 has been updated to change Habilitation information.

Section 214.131 has been updated to change Early Intervention information.

Section 214.132 has been updated to change Pre-School information.

Section 215.100 has been updated to add information for beneficiaries under age 21 for Establishing Medical Necessity for Core Services.

Section 215.300 has been added to include the Definition of Developmental Diagnosis.

Section 217.000 has been updated to change the request procedures for Extension of Benefits/Prior Approval for Therapy Services and to remove "for Beneficiaries Under Age 21".

Section 217.100 has been updated to change the Documentation Requirements for Extension of Benefits/Prior Approval of Therapy Benefits and to remove "for Beneficiaries Under Age 21".

Sections 217.700 (Procedures for Requesting Extended Benefits for Occupational, Physical, and Speech Therapy Provided in the DDTCS Program) and 217.800 (Documentation Requirements for Benefit Extensions for Beneficiaries Over Age 21) have been removed and their contents deleted.

Section 218.000 has been updated to change the Administrative Reconsideration of Extension of Benefits/Prior Approval of Therapy Services Denial.

Section 218.100 has been updated to change Appeal Process information.

Section 220.000 has been updated to change the Guidelines for Retrospective Review of Occupational, Physical, and Speech Therapy Services.

Sections 220.100 and 220.200 have been updated to remove "for Retrospective Review" from the section headings.

Section 240.000 has been updated with new Prior Authorization information.

Section 262.100 has been updated to remove a procedure code from DDTCS Core Services.

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.

Dawn Stehle

Dawn Stehle
Director

SECTION II - DEVELOPMENTAL DAY TREATMENT CLINIC SERVICES (DDTCS)

CONTENTS

202.200 Clinical Records DDTCS Providers Must Keep

~~11-1-06~~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 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.

~~B~~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.

~~C~~D. ~~Daily s~~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. ~~Daily~~ 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~~10-1-17

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 Individuals with Disabilities Education Act ("IDEA")

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 DDTCS is considered a primary referral source under Part C of IDEA regulations.~~

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.

~~Each DDTCS 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 DDTCS 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)

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 an LEA. Participation as an LEA requires an ~~EIDT~~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: ~~An~~ 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 ~~an~~ 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: ~~An~~ DDTCS that elects to not 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 (3rd) 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 1st 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.

An DDTCS may change its election at any time; however, a decision to change will only be effective as of July 1st. ~~An~~ 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 an 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

212.000 Scope ~~4-1-07~~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, and
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 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 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.

214.000 Coverage of DDTCS Services

214.100 DDTCS Core Services

~~10-13-03~~10-1-17

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~~10-13-03~~

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

~~11-1-06~~10-1-17

A. Habilitation is instruction in areas of self-help, socialization, ~~communication, etc.~~communication, or cognitive development; or to reinforce skills learned and practiced in occupational, physical, or speech therapy. Habilitation activities must be ~~based~~ designed to teach habilitation ~~on the~~ goals and objectives ~~of~~ 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~~10-1-17

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.

~~A physician must prescribe the amount early intervention level of care habilitative services needed by a beneficiary after review of the annual developmental screen, which will be used to determine eligibility for services. The developmental screen and prescription are valid for one (1) 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~~10-1-17

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.

~~A physician must prescribe the amount of pre-school level of care habilitative services needed by a beneficiary after review of the annual developmental screen, which will be used to determine eligibility for services. The developmental screen and prescription are valid for one (1) year.~~

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.

215.000 Establishing Medical Necessity for DDTCS

215.100 Establishing Medical Necessity for Core Services

10-1-17~~10-13-03~~

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. ~~DDTCS core services do not require a referral from the individual's primary care physician (PCP).~~ For beneficiaries under age 18, the prescription must be based on the results of the developmental screen performed by DHS' Third Party Assessor, as well as the results of the D&E.

215.300 Establishing Medical Necessity for Core Services A. A developmental disability is:

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

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

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

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

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

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

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

   NOTE: Each of these four conditions is sufficient for determination of eligibility independent of each other. This means that a person who is intellectually disabled does not have to have a diagnosis of autism spectrum disorder,

epilepsy, spina bifida, down syndrome, or cerebral palsy. Conversely, a person who has autism spectrum disorder, cerebral palsy, epilepsy, spina bifida, or Down syndrome does not have to have an intellectual disability to receive services.

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

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

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

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

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

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

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

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

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

217.000 **Procedures for Requesting ~~Extended~~ Extension of Benefits/Prior Approval for Therapy Services for Occupational, Physical and Speech Therapy (Evaluation or Treatment) ~~for Beneficiaries Under Age 21~~** 10-1-17~~3-1-10~~

A. Requests for ~~benefit extension~~extension of benefits/prior approval of therapy services for beneficiaries ~~under age 21~~ must be ~~mailed~~ submitted to the ~~Arkansas Foundation for~~

~~Medical Care, Inc. (AFMC)~~Quality Improvement Organization (QIO) under contract to the Arkansas Medicaid Program via mail, fax or electronically. **View or print the ~~Arkansas Foundation for Medical Care, Inc.~~QIO's contact information**. The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.

1. Requests ~~for benefit extensions of therapy services are considered only after a claim is denied because a regular benefit is exceeded~~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 ~~AFMC within 90 calendar days of the date of the benefits exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits exceeded denial appears.~~the QIO and processed before the provider may bill for extended benefits.
3. ~~Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exceeded benefits. Do not send a claim.~~
4. ~~AFMC will not accept requests sent via electronic facsimile (FAX) or e-mail.~~

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. ~~AFMC~~ The QIO will approve, deny, or ask for additional information, within ~~30~~ 3 ~~calendar~~ business days of receiving a ~~the request~~complete request. ~~AFMC~~ 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 ~~Extended~~ Extension of Benefits/Prior Approval of Therapy Benefits ~~for Beneficiaries Under 21~~ ~~3-1-10~~10-1-17

A. To request ~~extended~~ 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.

~~**217.700 Procedures for Requesting Extended Benefits for Occupational, Physical and Speech Therapy Provided in the DDTCS Program (Evaluation or Treatment) for Beneficiaries Over Age 21**~~ ~~3-1-10~~

~~A. Requests for extended benefits for therapy services provided in the DDTCS program for beneficiaries over age 21 must be mailed to the Arkansas Foundation for Medical Care, Inc. (AFMC). The request must meet the medical necessity requirement, and adequate documentation must be provided to support this request.~~

1. Requests for extended DDTCS benefits for therapy services are considered only after a claim is denied because a regular benefit is exceeded.

2. The request must be received by AFMC within 90 calendar days of the date of the benefits exceeded denial. The count begins on the next working day after the date of the Remittance and Status Report (RA) on which the benefits exceeded denial appears.

3. Submit with the request a copy of the Medical Assistance Remittance and Status Report reflecting the claim's denial for exceeded benefits. Do not send a claim.

4. AFMC will not accept requests sent via electronic facsimile (FAX) or e-mail.

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. . 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 documentation that supports the medical necessity of the request should be attached.

C. AFMC will approve, deny, or ask for additional information, within 30 calendar days of their receiving the request. AFMC 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.

217.800 Documentation Requirements for Benefit Extensions for Beneficiaries Over age 21 3-1-10

A. To request extended therapy services, all applicable documentation supporting 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 specific request

2. Be signed 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 Extended Extension of Benefit/Prior Approval of Therapy Services Denial 3-1-1010-1-17

A A request for administrative reconsideration of an extended therapy service request denialdenial of a request for extension of benefits/prior approval of therpay must be in writing and sent to AFMC 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 AFMC 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 11-1-0610-1-17

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 Health and Human

Services. ~~The provider may request a fair hearing from the Department of Health.~~ See DDS Policy 1076.

The appeal request must be in writing and received by the ~~Appeals and Hearings Section of the Department of Health and Human Services~~appropriate office within thirty (30) days of the date of the denial notification. *See Sections 160.000 & 190.000.*

occupational, physical and speech therapy services.

220.000 Guidelines for Retrospective Review of Occupational, Physical and Speech Therapy Services ~~10-1-17~~~~7-1-15~~

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 AFMC 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 ~~for Retrospective Review for Beneficiaries under Age 21~~ ~~11-1-10~~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.

220.200 Speech-Language Therapy Guidelines ~~for Retrospective Review for Beneficiaries Under Age 21~~ ~~4-16-12~~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.

240.000 PRIOR AUTHORIZATION ~~10-1-17 43-65~~

Prior authorization is not required for DDTCS core service or for the first 90 minutes per week of occupational, physical and speech therapy services.

260.000 BILLING PROCEDURES

262.000 CMS-1500 Billing Procedures

262.100 DDTCS Core Services Procedure Codes ~~12-5-05~~10-1-17

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 10-1-17~~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)
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, 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.

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Program Development & Quality Assurance

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TDD/TTY: 501-682-6789

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

EFFECTIVE DATE: October 1, 2017

SUBJECT: Provider Manual Update Transmittal CHMS-2-17

REMOVE		INSERT	
Section	Effective Date	Section	Effective Date
201.000	10-15-09	201.000	10-1-17
210.100	10-15-09	210.100	10-1-17
203.100	2-1-10	203.100	10-1-17
205.000	1-1-07	205.000	10-1-17
206.000	1-1-07	206.000	10-1-17
211.000	1-1-07	211.000	10-1-17
212.000	1-1-07	212.000	10-1-17
212.100	10-13-03	212.100	10-1-17
213.000	4-1-07	213.000	10-1-17
213.100	10-13-03	213.100	10-1-17
213.200	10-13-03	213.200	10-1-17
215.000	1-1-07	215.000	10-1-17
217.000	1-1-07	217.000	10-1-17
217.100	10-13-03	217.100	10-1-17
217.110	12-1-07	—	—
217.120	10-13-03	—	—
217.130	10-13-03	—	—
217.140	1-1-07	—	—
218.100	1-1-07	—	—
218.200	1-1-09	218.200	10-1-17
218.300	10-13-03	218.300	10-1-17
220.100	11-1-05	—	—
220.200	2-1-10	—	—
220.210	1-1-07	—	—
220.300	2-1-10	—	—
222.000	2-1-10	222.000	10-1-17
241.000	1-1-07	241.000	10-1-17

242.000	2-1-10	242.000	10-1-17
245.000	7-1-15	245.000	10-1-17
245.100	11-1-10	245.100	10-1-17
245.200	4-16-12	245.200	10-1-17
262.110	9-15-14	262.110	10-1-17
262.130	7-1-17	262.130	10-1-17

Explanation of Updates

Section 201.000 has been updated to change the Arkansas Foundation for Medical Care (AFMC) to the Arkansas Medicaid Quality Improvement Organization (QIO).

Section 201.100 has been updated to remove the name of specific Department of Health designees.

Section 203.100 has been updated to change the requirements for CHMS medical and clinical records.

Section 205.000 has been updated to remove its original contents and replace them with information regarding Referral to First Connections Program Pursuant to Part C of the Individuals with Disabilities Education Act (IDEA).

Section 206.000 has been updated to remove its original contents and replace them with information regarding Election to Provide Special Education Services in Accordance with Part B of the Individuals with Disabilities Education Act (IDEA).

Section 211.000 has been updated to add the word "eligible" to Medicaid beneficiaries.

Section 212.000 has been updated to change the Scope of the CHMS Program Coverage.

Section 212.100 has been updated to change Intervention/Treatment Services to Day Treatment Services and to add beneficiary restrictions.

Section 213.000 has been updated to correct the name of the Arkansas Department of Human Services.

Section 213.100 has been updated to change Intervention/Treatment Services to Day Treatment Services.

Section 213.200 has been updated with new Definitions of Staff.

Section 215.000 has been updated with new General Standards.

Section 217.000 has been updated with a new section heading and new information regarding Establishing a Need for CHMS.

Section 217.100 has been updated to move its original contents for Establishing a Need for CHMS to Section 217.000. New content has been added regarding Definition of Developmental Diagnosis.

Sections 217.110 (Medical Diagnosis Only), 217.120 (Developmental Diagnosis), 217.130 (Complex with Multiple Diagnoses), 217.140 (Medical-Developmental Diagnoses and/or Social-Emotional Trauma/Risk/Neglect), and 218.100 (Medical Multi-Disciplinary Diagnosis and Evaluation) have been removed and their contents deleted.

Section 218.200 has been updated with Individual Treatment Planning information.

Section 218.300 has been updated with Day Treatment Services information.

Sections 220.100 (Benefit Limits for CHMS Diagnosis and Evaluation Procedures), 220.200 (Procedures for Extension of Benefits of CHMS Diagnosis/Evaluation), 220.210 (Administrative Reconsideration for Extension of Benefits Denial), and 220.300 (Procedures for Extension of Benefits of CHMS Diagnosis/Evaluation or Specified Treatment Services) have been removed and their contents deleted.

Section 222.000 has been updated to change AFMC to QIO.

Section 241.000 has been updated to remove information regarding the Diagnosis/Evaluation Process.

Section 242.000 has been updated to change information regarding prior authorization to determine and verify patient need.

Section 245.000 has been updated to change the Guidelines for Retrospective Review of Occupational, Physical, and Speech Therapy Services.

Sections 245.100 and 245.200 have been updated to remove "for Retrospective Review" from the section headings.

Section 262.110 has been updated to remove a diagnosis and evaluation procedure code.

Section 262.130 has been updated to remove procedure codes related to the Foster Care Program.

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.

Dawn Stehle

Dawn Stehle
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 ~~10-15-09~~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 ~~Arkansas Foundation for Medical Care, Inc. (AFMC)~~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~~Human Services, Division of Health, Office of Quality Assurance~~ (certification). **View or print the ~~Division~~ Department of Health contact information.**

2. The ~~Arkansas Foundation for Medical Care, Inc. (AFMC)~~Arkansas Medicaid Quality Improvement Organization (certification). **View or print ~~AFMC~~ 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 ~~Division~~ Department of Health~~, Office of Quality Assurance~~;
2. Current certification from ~~AFMC~~ 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.

~~10-15-09~~1-17

The Department of Health or its designees ~~(Arkansas Department of Health, Office of Quality Assurance; and Arkansas Foundation for Medical Care, Inc.)~~ 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.

203.100 Required CHMS Medical/Clinical Records

~~2-1-10~~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.

~~5~~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.;

~~6~~7. Treatment plan signed by a CHMS clinic physician;

~~7~~8. Medication record of all prescribed and/or administered medications;

~~8~~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 and

e. Response to treatment.

~~9~~10. Submittal of prior authorization request (including intervention/treatment needed) to CHMS prior authorization contractor when appropriate.

D. For CHMS ~~Intervention/~~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.~~Documentation of annual developmental screen or approved waiver of the developmental screen in accordance with the Manual for Independent Assessments and Developmental Screens.~~

3. ~~CHMS physician's enrollment orders~~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 or weekly~~ 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 note 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.

205.000 **Developmental Disabilities Services Early Intervention Requirements for Children Ages Birth to ThreeReferral to First Connections program pursuant to Part C of the Individuals with Disabilities Education Act (IDEA)** 1-1-0710-1-17

Part C of the Individuals With Disabilities Education Act (IDEA) mandates the provision of early intervention services to infants and toddlers from birth to thirty-six months of age. Part C and subsequent state legislation require that specific rules and regulations be adhered to by providers of these services to infants and toddlers regardless of funding sources or methods of service provision. The Division of Developmental Disabilities within the Department of Health and Human Services has been designated as the lead agency for the First Connections Program (Part C) in Arkansas. As mandated by Part C, it is the responsibility of the lead agency to ensure that a statewide comprehensive system of services is in place which meets all federal, state and local rules and regulations. Therefore, the Division of Developmental Disabilities has developed the following requirements:

A. Referral Requirements

All referrals of children, from birth to thirty-six months of age, to the CHMS program must be in turn referred to First Connections, the Arkansas Infant and Toddler Program, within two working days. Referrals may be made through the DDS Service Coordinator for the child's county of residence or directly to a licensed DDS community services provider facility.

B. Evaluation Requirements

Evaluations conducted by CHMS must meet the First Connections procedural requirements as mandated by Part C of the Individuals With Disabilities Education Act and Developmental Disabilities Services Policy. Each evaluation conducted must be multi-disciplinary in nature and must include:

1. Two instruments in each area of development (cognitive, self-help/adaptive, communication, gross and fine motor).
2. Specialized evaluations as indicated by the initial evaluation process.
3. A narrative report including the following components:
   a. Individual specific background information
   b. Testing instruments used
   c. Test results
   d. Areas of need
   e. Areas of strength
   f. Informed clinical opinion
   g. Programming recommendations
      1. Specific broad goals
      2. Specific objectives to be accomplished
      3. Criteria for accomplishing specific goals and objectives
   h. Specific placement recommendations, including:
      1. Type of service (example: Speech therapy)
      2. Frequency of service (example: Two sessions per day two days a week)
      3. Duration (example: Twenty minutes per session
      4. Type of session (example: Individual session)
      5. Setting (example: Home)

Upon completion of the evaluation, a copy shall be sent to the First Connections Service Coordinator or the central fax number.

C. Service Provision Requirements

Services provided under the CHMS program must meet the First Connections procedural requirements, as mandated by Part C of the Individuals With Disabilities Education Act and Developmental Disabilities Services Policy.

D. Transition Requirements

CHMS staff must participate in transition conferences scheduled for children for whom the transition process to Part B (within 180 days of the child's third birthday) has begun. Evaluations completed by CHMS and administered within the transition period must meet the requirements of the Local Educational Cooperative's Early Childhood Program.

E. Program/Service Options

Participation in the First Connections program is voluntary; however, CHMS staff may not solicit parent refusal. All family choice options for early intervention services must be presented to the family by the First Connections Service Coordinator.

F. Monitoring and Supervision

Developmental Disabilities Services, as the lead agency for First Connections, the Arkansas Infant and Toddler Program, has responsibility, as mandated by Part C of IDEA, for the monitoring and supervision of all early intervention services provided to infants and toddlers who meet the eligibility criteria for the Part C program. The First Connections staff will conduct monitoring with regularly scheduled monitoring visits and technical assistance visits as needed to assist early intervention programs in meeting federal, state and local rules and regulations governing the First Connections Program. CHMS must provide access to all records pertaining to children enrolled in the program who are ages 0-36 months. CHMS staff must implement recommendations made as a result of monitoring and technical assistance visits and will receive a written report from First Connections and, as necessary, a corrective action plan.

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. ACHMS is considered a primary referral source under Part C of IDEA regulations.

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.

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 EIDTCHMS is responsible for maintaining documentation evidencing that a proper and timely referral to First Connections has been made.

206.000 Coordination with Part B of the Individuals with Disabilities Education Act (IDEA) Amendments of 1997Election to Provide Special Education Services in Accordance with Part B of the Individuals with Disabilities Education Act (IDEA)

1-1-0710-1-17

Local education agencies (LEAs), either individually or through an Education Services Cooperative (ESC), have the responsibility for ensuring a free, appropriate public education to children with disabilities aged 3 to 5 years.

A. Child Health Management Services (CHMS) providers offering any services to a child aged 3 to 5 years who has, or is suspected of having, a disability under Section 619 of Part B of the IDEA '97, must refer the child to the LEA or ESC providing special education and related services to this population of children.

1. The purpose of this referral is to ensure that special education and related services meet all the requirements of the IDEA '97 including, but not limited to, the following:

   a. Are provided at no cost to the parent,

   b. Are not duplicative and

   c. Are in accordance with the child's individualized education plan.

2. A CHMS clinic that provides special education and related services to children aged 3 to 5 years with disabilities shall meet the qualified provider requirements established by the Arkansas Department of Education in accordance with the requirements of IDEA '97.

B. The CHMS provider shall enter into an interagency agreement with each ESC and/or LEA providing special education and related services to children with disabilities aged 3 to 5 years in the CHMS provider's service area. Such agreements shall address:

1. The process for making and receiving referrals between CHMS and the LEA/ESC,

2. Required due process procedures and the participation of CHMS in such process,

3. Transition planning and coordination between providers,

4. Provision of special education and related services by the LEA/ESC at the CHMS site and

5. Provision for resolution of disputes relative to implementation of the terms of the interagency agreement.

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 an LEA. Participation as an LEA requires an 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 ~~an EIDT~~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 to not 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 1st 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

~~1-1-07~~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~~10-1-17

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

~~10-13-03~~10-10-17

Services are limited to the following components:

Audiology	Neuropsychology	Psychological
Behavior	Nutrition	Social work
~~Intervention/~~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 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.

212.400 Other Personnel Requirements and Duties

~~10-13-03~~10-1-17

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~~4-1-07~~

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 Health and~~ 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

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. ~~Intervention/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

~~10-13-03~~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 ~~thirtyfifty~~ (3050) 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.

215.000 General Standards

~~1-1-07~~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-three years: one (1) staff for every four (4) beneficiaries.

(2) For children three to six years: one (1) staff for every seven (7) beneficiaries.

(3) for children six and up: one (1) staff for every ten (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.

217.000 **~~Reason for Referral to a CHMS Clinic~~Establishing Need for CHMS Services** ~~1-1-07~~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.

~~All beneficiaries must undergo an annual developmental screen by DHS' third party vendor or have an approved waiver of the developmental screen. This screen will be used to determine eligibility for day treatment.~~

~~To be eligible to receive services at a CHMS, the beneficiary must:~~

~~(1) Be eligible to receive at least one (1) hour of day treatment as prescribed by the PCP, based upon the results of the annual developmental screen; and~~

(2) Be eligible to receive services in at least one (1) therapy discipline (physical, occupational, or speech), or

Be eligible to receive at least one of the following: medical, nutrition, or audiology services.

The developmental screen and prescription are valid for one (1) year.

Factors to be considered in determining the appropriateness of accepting a patient into the Intervention/Treatment Services Component of a CHMS program are provided below.

A. Children referred for intervention/treatment services at CHMS clinics present a wide variety of medical and developmental diagnoses. The services that these children need to address their special health care needs are also varied.

An individualized treatment plan must be developed by the interdisciplinary CHMS team in order to address the varied health and developmental needs of each patient.

B. Very young children with special health care needs frequently face improved or deteriorated prognoses based on social/emotional issues of the family that provides the child's care and supervision and is responsible for compliance with the child's prescribed treatment plan. The social/emotional deprivation or neglect factor cannot be discounted in determining the appropriate treatment necessary for pediatric patients.

C. The severity of impairment of the child's ability to accomplish age-appropriate developmental skills in self-help, activities of daily living and communication has a significant impact on the supportive resources required to surround and/or be incorporated into treatment for very young children.

217.100 Establishing Need for Child Health Management Services 10-1-1710-13-03

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 and

E. Additional family contact for education and support.

F. These children will often require tTherapy services from more than one discipline (occupational, physical, speech).

217.100 Definition of Developmental Diagnosis

A. A developmental disability is:

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

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

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

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

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

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

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

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

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

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

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

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

d. For infants and toddlers 0-36 months, eligibility for DDS Services will be indicated by a 25% delay in two or more areas based on an assessment

instrument which yields scores in months. The areas to be assessed include: cognition; communication; social/emotion; motor; and adaptive.

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

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

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

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

217.200 Cognition Testing

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.

~~217.110 Medical Diagnosis Only~~ ~~12-1-07~~10-1-17

~~A. Listing of Medical Diagnoses~~

~~The presence of a significant medical diagnosis may be adequate to identify a child in need of Child Health Management Services. The following, though not a complete list, are examples of diagnoses that may indicate a child in need of care. The current clinical medical records relied upon to substantiate or support the diagnosis that establishes the~~

need for services must accompany all requests for prior authorization or extension of benefits.

- AIDS
- Cerebral Degeneration
- Child Maltreatment Syndrome (abuse or neglect) – must provide documentation of when and what events occurred and evidence of involvement of DHHS in current social situation.
- Chronic Renal Failure
- CMV
- Congenital Heart Disease
- Congenital Hypothyroidism
- Cystic Fibrosis
- Down's Syndrome
- Encepholomalacia
- Esophageal Atresia
- Failure to Thrive – must provide documentation and detailed history, medical evaluation, nutritional evaluation and up-to-date growth chart.
- Gastroschisis
- HIV – must provide documentation of medical treatments and necessity of daily medical care.
- Hydrocephaly with Shunt
- Hypopituitarism
- Hypoxic Hemmorraghic Encephalopathy
- Lead Poisoning – must document lead level and extent of injury
- Macrocephaly – must have documented head circumference on growth chart and medical evaluation with results of MRI, CT, etc.
- Metabolic Disorder
- Microcephaly – must have documented head circumference on growth chart and medical evaluation with results of MRI, CT, etc.
- Neuroblastoma
- Newborn Intraventricular Hemorrhage – document degree of hemorrhage
- Periventricular Leukomalacia
- Prematurity (less than 37 weeks gestation) – must include documentation of neonatal course and any additional significant medical problems for a child less than 12 months of age.
- Prenatal Drug/Alcohol Exposure – documentation of extent of exposure and medical effects of exposure.

- Seizure Disorder – does not include febrile seizures. Documentation to include medications, type and frequency of seizures.
- Sickle Cell Disease – documentation of actual disease, not trait. Documentation should include history of treatment for the disease.
- Spina Bifida
- Tracheomalacia
- Tuberous Sclerosis and Other Neurodermatoses
- Various Syndromes/Severity Determined by Physician

B. Mechanism for Establishing Need for Care (Medical Only)

- A medical diagnosis alone will not adequately document the necessity for CHMS. Documentation must include a complete medical evaluation by a pediatrician or pediatric specialist to include a history and physical. There must be documentation to support the need for ongoing intervention by a medical multi-disciplinary diagnosis and treatment team within a CHMS clinic.

217.120 Developmental Diagnosis

10-13-0310-1-17

A. Listing of Developmental Diagnoses

- Care is required for those patients presenting a significant medical developmental diagnosis that limits their ability to be self-sufficient and to engage in a full range of age appropriate developmental, self-help and daily living activities. A developmental diagnosis must be supported by medical documentation to determine the needs of the child. The current clinical medical records relied upon to substantiate or support the diagnosis that establishes the need for services must accompany all requests for prior authorization or extension of benefits.
- Diagnoses for this group of patients may include (but are not limited to) the following:
- Autism – must have a documented evaluation that supports the diagnosis.
- Blindness or Visual Impairment – must have documented ophthamalogical exam.
- Cerebral Palsy
- Cognitive Disorders
- Deafness or Hearing Impairment – must have documented audiological evaluation performed when the child does not have otitis media.
- Developmental Delay (standard score of 70 or less or a 25% delay in one or more domains) based on appropriate assessment/evaluation that requires intervention.
- Learning Disabilities
- Mental Retardation
- Motor Skills Disorders
- PDD (Pervasive Developmental Delay)

B. Mechanism for Establishing Need for Care (Developmental Diagnosis)

Determination for inclusion in this category of care is based on the diagnostic medical findings performed or accepted by a CHMS Medical Director. There must be documentation to support the need for ongoing intervention by a medical multi-disciplinary diagnosis and treatment team within a CHMS clinic. Documentation of a psychological evaluation is required for:

1. Autism
2. Developmental Delay (standard score of 70 or less or a 25% delay in one or more domains)
3. Mental Retardation
4. PDD

The findings are to be reported by:

a. An appropriately credentialed professional describing the results (standard scores and percentage of delay), the test instrument used, the level of confidence in findings and recommendations for remediation, or

b. Psychological and Speech/Language evaluations for speech/language delay; findings to be reported by appropriately credentialed professional describing results, test instrument used, the level of confidence in findings and recommendations for remediation or

c. Specialty medical evaluation appropriate to the diagnosis; requiring the report of the specialist making the diagnosis. Examples: motor deficit, genetic abnormality, further complicating medical condition, blindness/visual impairment, deafness/hearing impairment.

217.130 Complex with Multiple Diagnoses 10-13-0310-1-17

Care is also required for those patients presenting multiple diagnoses inclusive of 3 or more medical, developmental, behavioral or environmental conditions/traumas. The combination of these conditions define a patient for whom extraordinary services and resources are necessary to overcome limitations in self sufficiency, age appropriate development, self-help and daily living activities.

It is expected that these patients will require additional education and support for family members and will receive a maximum amount of individual attention from CHMS staff.

Need will be justified by documentation of medical evaluation and additional testing by appropriate CHMS providers using standardized test instruments and professional informed opinion. One of the reasons for services is developmental delay, which is reflected by a score of 79 or less in one or more developmental domains as documented on a standardized assessment administered by an appropriate CHMS professional. Medical diagnoses must relate to current problems under treatment and documented by physician evaluation. The current clinical medical records relied upon to substantiate or support the diagnosis that establishes the need for services must accompany all requests for prior authorization or extension of benefits.

Examples (not intended to be all-inclusive):

A. Chronic Recurrent Otitis Media (CROM), Developmental Delay (79 or less) and documented Child Maltreatment Syndrome/Neglect;

B. GE Reflux, Developmental Delay (79 or less), Family Trauma and Speech Delay.

217.140 Medical-Developmental Diagnoses and/or Social-Emotional Trauma/Risk/Neglect 1-1-07

A. Discussion and Examples

This type of care is characterized by a less significant medical-developmental diagnosis which is coupled with one or more additional medical or developmental diagnoses and/or social-emotional trauma/risk/neglect.

These patients are at great risk for poor outcomes without appropriate intervention and management of the array of services they warrant. Despite multiple diagnoses, these patients respond rather quickly to appropriate treatment and may not require an extended period of services.

Documentation supporting the social-emotional trauma/risk/neglect must be furnished. If the child is documented to live in a high-risk environment, specific information regarding current living arrangements, custody issues and DHHS involvement is required. The current clinical medical records and documentation relied upon to substantiate or support the diagnosis that establishes the need for services must accompany all requests for prior authorization or extension of benefits.

Examples (not intended to be all inclusive) of combined diagnoses:

1. Hearing Loss + Developmental Language Delay
2. CROM+Reactive Airway Disease (RAD)+ Mild Developmental Language Delay or Speech Delay
3. Hypotonia + Very Low Birth Weight
4. Mild Developmental Delay + Maternal Neglect
5. Ex-premature 18 mo. old + Teen Mom + Mild Developmental Delay
6. Meconium Aspiration + Speech/Language Delay + Suspected Neglect
7. Strabismus + Speech Delay + Retinopathy of Prematurity

Children in need of this type of care require a core of services including assessment, treatment planning, developmental and medical intervention, periodic medical monitoring and may require ancillary therapy services of some sort. Parent education and service coordination are of extreme importance for these children experiencing social/emotional trauma or neglect. Without this additional service, the period of treatment services will be extended or have less likelihood of accomplishing the desired normalizing outcomes for the child.

B. Mechanism for Establishing Need for this Type of Care

Appropriate CHMS professionals may justify care authorization with medical evaluation, developmental testing and speech or psychological evaluation. Social history and/or completion of a standardized interview to determine risk factors may be indicated. Nutritional evaluation to support diagnosis and plan of care will be appropriate for some diagnoses.

218.100 Medical Multi-Disciplinary Diagnosis and Evaluation 1-1-07

Under the direction of a CHMS physician, a team of CHMS professionals will initiate an evaluation of each patient to establish a comprehensive range of diagnoses presented by the patient. This team will be informed by the parent/patient concerns, medical history and the current physical condition of the patient. The initial diagnosis by the medical director will determine the area of expertise of the additional team members. Multi-Disciplinary Diagnosis and Evaluation services are available to patients from birth to age 21.

Initial diagnosis and evaluation services are considered to be a complete service if this is the reason for referral from the PCP. Ongoing diagnosis and evaluation are a component of the intervention/treatment services offered at clinic sites.

Completion of an adequate evaluation is necessary to justify treatment.

Prior authorization does not apply to the Medical Multi-Disciplinary Diagnosis and Evaluation. PCP referral is required.

218.200 Individual Treatment Planning

1-1-0910-1-17

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 when required. 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 identified for the beneficiaryduring evaluation.

For those children receiving intervention/day treatment services on a daily/ orweekly basis, the individualized treatment plan will be written for a period of 12 months and will be updated as needed. The treatment plan for children birth to 3 years of age may be in the form of the state accepted Individualized Family Services Plan (IFSP). A continuing PCP referral is required every 6 months.

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 Intervention/Day Treatment Services

10-13-0310-1-17

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.

-orders/treatment plan signed by a CHMS physician with PCP approval. The annual developmental screen will determine eligibility for day treatment. The prescription and annual developmental screen are valid for one (1) year.

220.000 BENEFIT LIMITS

220.100 Benefit Limits for CHMS Diagnosis and Evaluation Procedures 11-1-05

Diagnosis and evaluation procedures are limited to two (2) diagnosis and evaluation encounters per state fiscal year (July 1 through June 30). If additional diagnosis and evaluation services are required, the CHMS provider must request an extension of benefits from the Arkansas Foundation for Medical Care, Inc. (AFMC).

220.200 Procedures for Extension of Benefits of CHMS Diagnosis/Evaluation 2-1-10

A. Extension of benefits for medically necessary CHMS diagnosis and evaluation procedures may be requested. To request extension of benefits, submit a completed form DMS-699-A CHMS Benefit Extension for Diagnosis/Evaluation Procedures and additional medical records including the most recent multidisciplinary evaluation to substantiate medical necessity to AFMC. .:

B. AFMC, which includes medical personnel, will review the medical records and will notify the requesting provider of the approval or denial of the request. AFMC will forward the approved Benefit Extension Numbers to the provider for the procedure codes requested.

220.210 Administrative Reconsideration for Extension of Benefits Denial 1-1-07

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

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 AFMC within 35 calendar days of a denial will be deemed timely. A request received later than 35 calendar days will be considered on an individual basis. Reconsideration requests must be mailed and will not be accepted via facsimile.

B. Please see Section 190.000 of this manual for information regarding administrative appeals.

220.300 Procedures for Extension of Benefits of CHMS Diagnosis/Evaluation or Specified Treatment Services 2-1-10

To request benefit extensions for medically necessary CHMS diagnosis/evaluation procedure codes or specified treatment procedure codes:

Submit a CHMS Benefit Extension form and additional medical records including the most recent multidisciplinary evaluation to substantiate medical necessity to AFMC. .:

AFMC, which includes medical personnel, will review the medical records and will notify the requesting provider of the approval or denial of the request. AFMC will forward the approved Benefit Extension Numbers to the provider for the procedure codes requested.

222.000 Inspection of Care

2-1-1010-1-17

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, AFMC the QIO will select patients currently being served by the CHMS clinic. The AFMC 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 for 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 n AFMC 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 AFMC 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 AFMCthe 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 and Diagnosis/Evaluation Process

10-1-171-1-07

A. A referral prescription from the primary care physician (PCP) must be received by the CHMS clinic for assessment and evaluation of the patient for services. Note: If the beneficiary is exempt from the PCP process, then the referrals for services must be made by the child's attending physician. For a beneficiary to receive CHMS services.

B. The CHMS clinic must conduct an intake and assessment once the referral prescription is received. PCP referrals should be renewed no less often than each six (6) months. **Prior authorization is not required for the diagnosis/evaluation procedure codes located in Section 262.110.**

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 ~~for an evaluation.~~

~~6. The CHMS pediatrician or other professional staff will evaluate the patient for medical conditions, developmental delays and other special health care needs. If additional testing is recommended, further testing will be completed.~~

7. After the ~~evaluation~~ visit is completed and the developmental screen results, as well as all other evaluation results are reviewed, admission for treatment services will be ~~recommended or not recommended~~prescribed ~~or not prescribed~~ by the ~~CHMS professionals~~physician.

~~B. CHMS procedure codes for diagnosis/evaluation listed in Section 262.110 of this manual may be billed two (2) times per state fiscal year (July 1 through June 30) without extension of benefits.~~

~~C. If these diagnosis/evaluation procedures are required for additional services, the CHMS provider must request an extension of the benefit limit. Refer to Section 220.300 of this manual for procedures to request extension of benefits for diagnosis/evaluation services.~~

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

~~2-1-10~~10-1-17

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

A. When a recommendation is made for ~~intervention/~~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 ~~or~~ fax to the ~~Arkansas Foundation for Medical Care (AFMC)~~QIO. Fax transmission will be limited to 25 pages. For those clinics wishing to utilize electronic submission, contact ~~AFMC~~ the QIO and request specifics. **View or print CHMS Request for Prior Authorization form DMS-102 and instructions for completion. View or print ~~AFMC~~ QIO contact information.**

The request must include a report of the findings from the developmental screen, the diagnostic evaluation, ~~and other relevant evaluations~~ 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 ~~Arkansas Foundation for Medical Care (AFMC)~~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.

245.000 Guidelines for Retrospective Review of Occupational, Physical and Speech Therapy Services ~~7-1-15~~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 ~~AFMC~~ 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 ~~for Retrospective Review~~ ~~11-1-10~~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 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 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.

245.200 Speech-Language Therapy Guidelines ~~for Retrospective Review~~ 4-16-12

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.

260.000 BILLING PROCEDURES

262.110 Diagnosis and Evaluation Procedure Codes

~~9-15-14~~10-1-17

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)

Procedure Code	Required Modifier(s)	Description
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)
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

262.130 CHMS Procedure Codes – Foster Care Program

~~7-1-17~~10-1-17

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)
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.