

**Part C System Transformation:  
Questions and Answers**  
October 1, 2009

These questions were generated during the Local System Manager Training or submitted to the Part C Office since that time. Some of the questions posed have since been answered in System Transformation Updates and/or statewide memos from Mary Ann Discenza. Those questions and answers are not repeated here.

General:

1. What is the status of the local contract beginning October 1st?

*The SFY-2010 Local Contract for Participation in Part C, which will run October 1, 2009 – June 30, 2010 is in the Office of the Attorney General for review and will be disseminated as soon as possible.*

2. What is the status of the emergency personnel regulations?

*A link was provided in both of the August System Transformation Updates that allows you to check the status of these regulations at any time.*

<http://www.townhall.virginia.gov/L/ViewAction.cfm?actionid=3065>

3. There are many questions about the expectations regarding billing for MR and MH TCM. We need comprehensive guidance regarding the expectation of using TCM and parent choice in this.

*As indicated on the Implementation Checklist that was sent to local system managers on September 16, 2009, local systems that do not currently have a mechanism for billing MR and MH TCM are expected to be reviewing manuals and information provided through previous technical assistance calls to analyze their system's readiness to access these resources. We recognize that there is a need for further training and technical assistance, particularly related to MH TCM. We will be working with DMAS to address these needs after we have gotten through the first few months of implementation of the Medicaid EI Initiative.*

*Parents have the choice of whether or not they will accept targeted case management.*

4. Facing continuing budget cuts and requirements to increase child find numbers, local systems may run out of funding earlier in the fiscal year. What is the process to notify the Part C Office when we can not serve more families?

*The Local Contract requires the local lead agency to "Notify DBHDS of budget shortfalls, including supporting documentation of need, specific reasons for need and efforts to secure other available funding, upon the identification of the financial need."*

Specific Requirements:

5. Do we need to do a new Addendum Page before October 1 for each existing IFSP to have the family sign the statement about provider choice?

*No. For children who had an IFSP before October 1, the new Addendum Page must be used at the annual IFSP. For this group of children, the new addendum page with documentation of parent choice of provider is required prior to the annual IFSP only if a new service is added.*

6. After October 1<sup>st</sup>, we wonder if there could be some kind of self-review process developed (that would match the process for a formal review/audit) that we could each implement as a way to check to ensure that we are meeting all the new requirements.

*We appreciate this suggestion and will consider this as we finalize plans related to quality assurance.*

7. The DMAS Manual – Chapter VI, page 6 says: Early Intervention providers are responsible to “Deliver services in accordance with the IFSP. When a provider cancels a visit, the visit must be rescheduled to ensure that the service is delivered at the frequency and intensity listed on the IFSP.” What about when the provider offers to reschedule and the family says “no thanks” and we document in the contact note that the family prefers not to reschedule?

*It is acceptable to document in a contact note the family’s preference not to reschedule.*

8. During the intake visit, the educator does a screening using the ASQ, and in addition to her doing a screening, she writes up a paragraph describing the child’s development. Can her write-up be used as a discipline and her time billed during the assessment process?

*If the educator has gathered assessment information during intake, through screening and observation of the child, that will assist in identifying the child’s developmental strengths and needs and will assist the IFSP team in identifying the early intervention supports and services necessary to address the child’s unique needs, then the educator may be considered one of the two disciplines required for the assessment for service planning. However, this would not be reimbursed as assessment for service planning since it took place before the child was found eligible. Part C funds may be used as payor of last resort to reimburse providers for participation in intake activities.*

9. In the practice manual, p. 113, it says to maintain a financial record separate from the EI record. Does this mean that NO financial information should be in the record?

*That’s correct. Although we are requiring that you maintain a financial record that is separate from the EI record, we are not making any requirement about where that financial record must be physically kept.*

10. Will the Part C office be creating all the Medicaid forms needed? Like provider choice, appeal, etc.? Can these be added to Procedural Safeguards forms?

*All required forms are on the Infant & Toddler Connection of Virginia website ([www.infantva.org](http://www.infantva.org)) and/or on the Department of Medical Assistance Services website ([www.dmas.virginia.gov](http://www.dmas.virginia.gov)).*

11. Do you need age scores on IFSP and assessment for service planning? What about at annual IFSP? If we don’t need scores, how do we determine the 3 outcome numbers?

*Age levels will not be required on initial or annual IFSPs, and there is no requirement to report a child’s scores in each area of development in conjunction with determining the child’s status on the 3 child outcome indicators. A child’s status on the 3 child outcome indicators is based on his/her functional skills rather than on scores from assessment instruments. Please see Chapter 7 of the Infant & Toddler Connection of Virginia Practice Manual for more information on determining a child’s status on the 3 outcome indicators.*

12. What screening instrument do we use for a child who is less than 1 month old? ASQ does not screen birth to 1 month.

*Information from a variety of resources can be used to compare the child's development to what is expected for a child who is less than one month old, including online developmental websites, print resources, and relevant sections of developmental assessment tools. Screening should include identification of potential atypical development such as issues with tone and posture, sleep, feeding and self-regulation.*

13. Do you need 2 disciplines to determine eligibility at the annual IFSP review? If the child is only seen by one provider, can the annual be done by that provider with desk eligibility from a 2<sup>nd</sup> discipline?

*Two disciplines are required to confirm ongoing eligibility at the time of the annual IFSP. Generally, those individuals who are providing supports and services to the child will participate in the confirmation of ongoing eligibility since they know the child. If, for example, the child is receiving only service coordination and occupational therapy or the child is only receiving service coordination, then it will be necessary to pull in a second discipline to participate with the occupational therapist and the service coordinator or to pull in 2 disciplines to participate with the service coordinator in the determination of ongoing eligibility. The method of interaction between the 2 disciplines may vary, as it can for the initial determination of eligibility. Eligibility determination team members may communicate through a face-to-face meeting, phone call, email, fax, video conference, or other electronic means. The confirmation of ongoing eligibility may occur prior to or during the annual IFSP meeting.*

*For children who are receiving services in addition to service coordination, ongoing assessment in all areas of development should be a part of the intervention. The contact notes from team members who currently provide services for the child should provide information about the child's development in all areas. If a child is receiving only service coordination, then the same types of information that are gathered for initial eligibility determination would be gathered for this annual confirmation of eligibility (e.g., current developmental screening results, observation, parent report, current information from the physician, etc.)*

14. Does each assessor have to do a separate assessment note or is their signature on the IFSP – Team Assessment sufficient?

*Separate assessment notes or reports are not necessary to meet Part C or Medicaid requirements.*

15. How much information is needed to count the referral as Day 1? For example, if the referral source does not have a valid address, phone number, etc?

*The referral source must provide at least a name and one method of contact in order for it to be considered a referral.*

16. What if a child is close to transition age when they are referred to Part C?

*Inform referred families whose children are close to the age of eligibility for early childhood special education services through the local school division (under Part B) that they have the option to be referred to Part B instead of or simultaneously with referral to Part C. When the child's age at referral to the Infant & Toddler Connection of Virginia means the child will no longer be age eligible for Part C services by the time the Part C process can be completed (e.g., eligibility determination, assessment for service planning, IFSP development and beginning services), then the child may be referred directly to the local school division for early childhood special education services under Part B.*

17. If the parent calls and the child is 28 months old and uses 1 word, do you still need to do a screening?

*A developmental screening using a tool is required unless there is (1) a diagnosed physical or mental condition with a high probability of resulting in developmental delay, (2) documented developmental delay or atypical development, or (3) the child has already received a developmental assessment or screening prior to referral.*

18. If a child is found ineligible, can the family still request assessment?

*No. If the child is found ineligible then the service coordinator provides the parents with a copy and explanation of the Parental Prior Notice form (indicating “Your child is not eligible for Infant & Toddler Connection of Virginia”) and the Notice of Child and Family Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System. The service coordinator should facilitate an opportunity for the family to talk with the eligibility determination team if the family has questions or disagrees with the eligibility finding and if desired by the family. In explaining the Notice of Child and Family Safeguards, the service coordinator reviews and explains the complaint procedures available to the family if they disagree with the eligibility decision.*

19. Is there any chance that Part B will adopt the processes from the practice manual?

*The Infant & Toddler Connection of Virginia Practice Manual addresses practices only under Part C of IDEA.*

20. For documentation purposes, is all we need for documentation for eligibility the form, or do we need contact notes?

*The Eligibility Determination Form documents the team’s decision about the child’s eligibility and summarizes the supporting evidence for that decision. Contact notes are necessary to document the information gathered at referral and intake and efforts to gather information from outside sources (e.g., physician) for use in eligibility determination.*

21. Can we use findings from intake, if done by qualified personnel, for eligibility determination?

*Yes. You will just need a second discipline to ensure a multidisciplinary eligibility process.*

22. What do we need from providers, other than service coordinators, who participate in eligibility determination? Can we bill for their preparation?

*Contact notes and the Eligibility Determination Form document providers’ participation. Part C or local funds may be used to pay providers for their role in eligibility determination.*

23. Can a service coordinator be one of the disciplines for eligibility determination?

*A service coordinator would only count as one of the disciplines on the multidisciplinary team for eligibility determination if she/he was also a certified early intervention professional (e.g., the service coordinator is also an occupational therapist).*

24. What about using informed clinical opinion?

*Informed clinical opinion is the result of synthesizing medical and developmental information (based on a tool, observation, parent report, medical records, etc.) with professional expertise and experience to make a determination regarding a child’s developmental status and/or eligibility. Informed clinical opinion may be used to establish a child’s eligibility even when screening or assessment instruments or other information does not establish that eligibility.*

*However, informed clinical opinion cannot be used to negate eligibility established through the use of appropriate assessment instruments or procedures.*

25. If a nurse provides developmental services, do I list nursing on page 6 of the IFSP or developmental services?

*You would list "Nursing, Including Developmental Services."*

*Note: Although nursing services were no longer specified in the definition of early intervention services in the 2004 reauthorization of the Individuals with Disabilities Education Act, nursing services may still be an entitled early intervention service as long as that service meets the criteria of an early intervention service under Part C (i.e., services that are provided under public supervision, by qualified personnel, in accordance with the State's system of payments, selected in collaboration with the family, and designed to meet the developmental needs of the child or the needs of the family to assist appropriately in the child's development).*

#### Provider Certification and Medicaid Enrollment:

26. I have a PT who wants to do special instruction (now called developmental services). Does she have to become certified in early childhood special education or one of the other certifications?

*In Part C, we have developmental outcomes/goals, not speech goals, not PT goals, not developmental services goals. IFSP outcomes and short-term goals are functional and are not "owned" by any certain discipline. Rather than focus on providing a service with a different name, developmental services, focus on how the PT can address developmental goals that span areas of development beyond gross motor development. Services provided by the PT would still be listed on the IFSP as physical therapy. If a PT wants to provide the service called developmental services, then he/she would need to have licensure in early childhood special education or one of the other qualifications listed in Table A: Practitioner Qualifications and Responsibilities (at the end of Chapter 12 in the Infant & Toddler Connection of Virginia Practice Manual) as providing developmental services.*

27. Does an audiologist need to be EI certified if he/she is providing audiology services other than assessment? Will he/she be reimbursed under the Medicaid Early Intervention Services Program?

Although it is not required, audiologists are strongly encouraged to become EI certified if they will be providing services other than assessment. Audiologists will be reimbursed through their current process with Medicaid rather than through the Medicaid Early Intervention Services Program.

#### Billing and Reimbursement:

28. Can Part C funds be used to pay for time that goes over the 6 units for assessment/IFSP development? For example, typical assess/IFSP development typically lasts 2 hours – can Part C funds pay for the last ½ hour?

*The code for Assessment for Service Planning and IFSP Development has a maximum of 24 units/day. This allows 2 hours for three different disciplines or more than 2 hours for 2 different disciplines. Part C funds may not be used to supplement Medicaid reimbursement.*

29. We have a playgroup 1x week, usually 8-12 children, for special instruction. Progress notes are completed for each child in attendance. Is this a situation where congregate billing would be used?

*The congregate billing code is appropriate when multiple children are seen together in a natural environment setting by one provider and all children are working on the very same goal(s). If the setting is center-based, then this would be billed as a center-based group service. See the "Medicaid Early Intervention Program Reimbursement Information" table at the end of Chapter 11 in the Infant & Toddler Connection of Virginia Practice Manual.*

30. Can you give a general breakout for the cost of direct services -- direct time, supervision, training, and documentation? If the \$110 or \$150 were allocated in these categories, what would that look like?

*The Virginia Cost Study Update report by Solutions, Inc. describes the costs that were factored into the rates. This report was sent to local system managers on May 21, 2009. However, there is not a specific breakdown on how much each specific category contributes to the rate.*

31. Can intake/screenings be billable services through Medicaid/TCM? If so, can this process be explained?

*As indicated in the table titled "Reimbursement Sources and EI Codes for Components of the Early Intervention Process for Children with Medicaid or FAMIS Coverage" at the end of Chapter 11 in the Infant & Toddler Connection of Virginia Practice Manual, intake and screening activities may be reimbursed under TCM, local funds/grants/donations, or Part C funds as payor of last resort. Please see the relevant Medicaid manuals for more information on billing under TCM (Mental Retardation Community Services Manual for TCM-MR and Community Mental Health Rehabilitation Services Manual for TCM-MH).*

32. Will Medicaid not pay for EI services if a child is eligible for TCM (MR/MH) and not receiving/re-enrolled in these services?

*A child does not have to be receiving TCM in order for Medicaid to reimburse for other early intervention services.*

33. Will private insurance eventually pay for special instruction (now called developmental services)?

*Following implementation of the Medicaid Early Intervention Services Program on October 1, 2009, the Part C Office will begin working with the Bureau of Insurance to discuss possible expansion of private insurance reimbursement for early intervention services – adding reimbursement for developmental services increasing existing reimbursement rates to at least the standard EI rate.*

34. The reimbursement tables at the end of Chapter 11 in the practice manual and on the provider information sheets have a row for team meetings without the child and family present. When would this be reimbursed as a separate service (and not considered a routine part of regular service delivery)?

*Team meetings without the child and family present would be considered a separate, reimbursable service only when listed on the IFSP. This would be a planned service listed as method b (consultation) on page 6 of the IFSP and is distinct from the routine kinds of phone calls or discussion between providers that occur as part of service delivery. Please see the IFSP Instructions at the end of Chapter 7 in the Infant & Toddler Connection of Virginia Practice Manual for further information about when a service is considered consultation and would, therefore, be considered a team meeting without the child or family present.*

*Although this service is not reimbursed by public or private insurance, it can be reimbursed with Part C funds (as payor of last resort). The standard EI rates for reimbursement of team meetings without the child or family present will be the same as:*

- *The center-based individual services rate, if no travel is involved; or*
- *The individual EI services rate, if travel by the provider is required.*

*A provider will not be reimbursed for participation in team meetings by phone.*

35. Do we need to be outpatient rehabilitation certified to be able to bill private insurance for therapy?

*No.*

36. Could you please clarify about the central billing project?

*There is no plan or project to pursue centralized billing at this time.*

37. Will the state be providing concrete guidance on establishing a rate that local lead agencies should charge contracted providers if the local lead agency will be doing the provider's billing?

*The local lead agency is expected to determine their cost for providing this service (billing) and to charge the same amount for that service across all providers that will have the local lead agency do their billing.*

38. If I have a blended model of services (with the same individual providing service coordination and another Part C service) but am not billing for targeted case management, can I continue to list the Part C service coordinator as the service provider with private funds paying for service coordination for children with Medicaid?

*If local system practices allow practitioners to provide both service coordination and other Part C services to the same family, and the family chooses to have the service coordinator also provide another Part C service, then there will only be reimbursement for one service – either the time spent providing service coordination or the time spent providing the other Part C service – not both (unless the local system has local funds available to reimburse for the second service). Local systems are not required to allow this choice, and this dual role only affects reimbursement if the practitioner serves in that dual role with the same family. There is no issue if the practitioner provides only developmental services, for instance, for one set of children and families and only service coordination for another set of children and families.*

39. How can a Healthy Families Targeted Case Manager provide Part C service coordination? How can the payor of last resort requirement be met? Can the Part C service coordinator be required to provide oversight of Healthy Families' services, like developing the plan, etc?

*Providers of targeted case management (TCM) can provide Part C service coordination by becoming certified as an Early Intervention Service Coordinator. All providers of targeted case management should be strongly encouraged to seek this certification so that families have the option of receiving targeted case management (if the child is eligible of TCM) and Part C service coordination from the same practitioner. This eliminates duplication of effort and helps to ensure all available sources of funding are accessed. However, parents have the choice of whether or not they will accept targeted case management.*

40. Do we have to have a physician's order for a PT evaluation?

*PT licensure requirements call for physician orders for evaluations (assessments). Physician's orders are not required for assessment by Medicaid.*

41. If private insurance reimburses at the \$150 rate, \$20 of that is the family co-pay, and the family has a \$0 cap on the fee scale, does Part C pay the co-pay?

*Part C funds will be used to cover the family's co-pay of \$20 in this example.*

42. When must the family cost share process be completed?

*The family cost share practices are introduced at referral and intake and reviewed prior to IFSP development. The Family Cost Share Agreement form is completed after eligibility determination and prior to the initial IFSP meeting. See Chapters 3, 4, 6, and 11 of the Infant & Toddler Connection of Virginia Practice Manual.*

43. If a child is receiving developmental services and has Medicaid as their secondary insurance, how can the local system demonstrate / meet requirements for billing Medicaid after the primary insurance has been billed?

*DMAS has been able to remove the edits (requirements to submit proof of billing commercial insurance if the client has Medicaid as secondary) for the following billing codes: T1023 and T1023 U1; T1024 and T1024 U1; T1027 and T1027 U1; and T1015 and T1015 U1. This means providers will not have to go through the additional paperwork step of providing an explanation for why commercial insurance is not being billed or is not paying for developmental services and for assessments.*

44. How does the system transformation affect provider agreements with insurance companies?

*The Early Intervention System Transformation is not addressing commercial insurance at this time. Provider agreements with commercial insurance companies should not be impacted.*

45. If we have multiple providers, will we have different rates to do their billing?

*No. Please see response to question #35.*

46. Do we have a rate for non-targeted case management?

*No, there is not a standard rate for Part C service coordination.*

47. Are the standard early intervention rates the rates that are billable or reimbursable?

*The EI rates are the allowable reimbursement rates. Providers must **always** bill their usual and customary charge. If a provider charges less than DMAS reimburses then DMAS will pay the lesser charge.*

48. With the U1 modifiers, does the space have to be there between the billing code and the modifier?

*There is a specific place on the CMS 1500 form to record the modifier.*

49. Do we use the code T1023 billing code for IFSP reviews?

*Use T1024 (Reimbursement Category 2) and T1024 U1 (Reimbursement Category 1) for IFSP reviews.*

50. If you have a certified rehab provider and an educator from the same agency, can you have more than 6 units that day?

*Yes, the DMAS system will now allow 6 units per provider even if they are from the same provider agency.*

51. If a child is receiving developmental services from an educator and then switches to receive that same service from a nurse (either within the same system or because they move to another local system), then the rate for that service changes from \$110 to \$150. How can we justify that given that the educator and nurse are providing the exact same service?

*As indicated in the response to question #25, the service listed on the IFSP will be "Nursing, including developmental services" if the service is provided by a nurse and "Developmental services" if provided by an educator. The different reimbursement rates for nurses and educators are based on cost study data indicating that there is a significant difference in market wages for nurses and educators.*

52. Can a provider be reimbursed for participating in an IFSP meeting by phone?

*No, the provider must be physically present at the meeting in order to be reimbursed.*

53. There are co-pays associated with FAMIS, but under the family cost share practices families with FAMIS have a \$0 monthly cap. If Part C pays the family's co-pay does this violate statements made that Medicaid must be accepted as payment in full for children with Medicaid or FAMIS?

*It is not a conflict for Part C to reimburse providers for the family's co-pay because Medicaid's total reimbursement amount includes the co-pay. This total reimbursement amount (including the co-pay) is what the provider must accept as payment in full.*

54. Will Medicaid reimburse for a service if the child sleeps through the entire visit since there would still be teaching/coaching with the family?

*It is okay to provide parent teaching and bill for the service, though it is expected that this would be infrequent and that the session would likely not be as long as planned since the strategies cannot be practiced with the child.*

#### Procedural Safeguards:

55. Can a family use dispute resolution if the screening indicated no areas of concern, but the family still wants an assessment?

*Please see the response to question #18.*

56. Are the changes in surrogate parent policies, particularly the Code of Virginia regulations related to foster care, in place now or will they change as of October 1? Will these new regulations help in situations when you can't find or reach the parent?

*The Code of Virginia regulations related to foster care situations went into effect on 7/1/09. These regulations are intended to prevent delays in the provision of services for children in foster care and should be especially helpful in those situations where the child's biological parents retain parental rights but cannot be located or reached.*

57. Is it necessary to include a self-addressed, stamped envelope to document decline of referral?

*You are not required to include a self-addressed, stamped envelope when mailing a Declining Early Intervention Services form.*

58. Are we under FERPA or HIPAA?

*FERPA*

ITOTS Data Entry:

59. What is the final decision regarding the deadline for entering information into ITOTS? Does the Medicaid number have to be entered earlier than IFSP information? If yes, what is the deadline for that? Also, if yes, ITOTS has to be modified as currently the Medicaid number cannot be entered until all the IFSP information plus indicator information are entered.

*For now, local systems must enter data within 10 business days of the IFSP date. ITOTS will be updated to allow data entry earlier in the process, and you will be notified when that occurs.*

60. Are there situations that “Screened, Eval Unnecessary” would be used? With the service pathway, any child screened has to go to eligibility determination unless the family declines – is that correct?

*Yes, that is correct, and you will no longer need to use “Screened, Eval Unnecessary.”*

61. If the family declines eligibility determination after screening, is that “Declining an Evaluation.” We’re not sure what category we should use to distinguish that situation from declining the assessment for service planning. Would declining assessment for service planning be “Eligible, Declined Services” or “Declined Evaluation?”

*Until ITOTS can be revised, mark “Declined Evaluation” if the family declines eligibility determination and “Eligible, Declined Services” if they decline the assessment for service planning.*

62. Can we get the names or the number children 0-3 with Medicaid in our catchment area?

*As we move forward, DMAS will be sharing with DBHDS on a regular basis a listing of children enrolled in Medicaid who are not enrolled in Part C but who are potentially eligible for Part C.*

63. Will it be possible to make corrections to agency information with ITOTS 1.6?

*Yes, ITOTS users with Administrator status are able to correct agency information with ITOTS 1.6.*

64. When a child moves from system A to system B, how can system B ensure they can enter their new child and get reimbursement if System A takes the full time to discharge the child from their system in ITOTS?

*As a state-level function, the child will be enrolled in System B as they are discharged from System A so that there will be no interruption in that child’s enrollment in the Part C system. Therefore, there will be no interruption in Medicaid reimbursement. As indicated in the ITOTS instructions, System A needs to use the date the child leaves that system as the discharge date, not the date they enter the discharge information into ITOTS.*

65. If a child loses Medicaid coverage and local system has tried to keep up with the child’s insurance status but didn’t know the child no longer had Medicaid, does it count against the local system’s compliance with the requirement for timely and accurate data? Does the child have to be taken out of Medicaid and then re-enroll?

*Service coordinators or other provider are expected to routinely confirm with families whether their insurance is the same or has changed. DMAS also will be notifying DBHDS when children lose Medicaid coverage. Local systems are not to delete the Medicaid/FAMIS record in ITOTS when the child loses Medicaid coverage.*

66. How will state know if child is inactive?

*Changes in the child's status (inactive, active, discharge) must be documented in ITOTS by the local system within 10 business days of the event. There is an ITOTS screen that will be accessed on a routine basis at the state level to view these changes in child status.*

67. What should local systems do regarding children who lose Medicaid coverage for longer than 60 or 90 days? Is it necessary to take the Medicaid information out of ITOTS? Will the child drop off the Medicaid list with the end date?

*See response to questions # 63.*

68. Is there another trigger we can use (other than the IFSP) for the Part C office to know to enroll children? Could it be the assessment date in ITOTS? Do we need to create a new data point, like the date the child is determined eligible?

*The child who has Medicaid or FAMIS coverage becomes eligible for the Medicaid Early Intervention Program on the date that the child is found eligible for Part C. Currently, ITOTS does not accept all of the required information (including Medicaid number) until the child has an IFSP. Therefore, enrollment of the child in the Medicaid Early Intervention Program will occur after the assessment for service planning and the IFSP. The Assessment for Service Planning and the IFSP meeting will be reimbursed by Medicaid, but the Medicaid data system will not recognize the child as eligible for the Medicaid Early Intervention benefits until the child is enrolled. The local system has 10 business days after the IFSP to enter the IFSP and Medicaid information. The Part C Office has 15 business days from the IFSP (5 days if the local system takes the full 10 days) to enroll the child in the Medicaid data system. ITOTS will be updated to allow data entry earlier in the process, and you will be notified when that occurs.*

69. Can providers have access to data match reports that DBHDS and DMAS run on an ongoing basis?

*Local systems will be notified on an ongoing basis any time there are issues with a Medicaid match.*

70. How will errors in data entry (e.g., Medicaid number) be identified? Will you send that to local system managers so that we can improve data entry?

*Yes. DMAS will provide a master list with Medicaid numbers.*

71. Who will make corrections if data are wrong?

*Corrections will occur at the local level.*

72. Do we need to enter MCO numbers in ITOTS? What about FAMIS numbers?

*You need to place a check beside "Medicaid" for children who have Medicaid, Medicaid or FAMIS coverage and enter the permanent Medicaid 12 digit number. The FAMIS number is the same as the Medicaid number. You do not need to enter a check or number next to the Medicaid MCO or FAMIS. The Medicaid data system tracks which type of coverage each child has according to their permanent 12 digit Medicaid number.*

73. Should we use physical address or mailing list in ITOTS?

*Use the physical address.*

74. With billing information for agencies/providers... the CSB has an NPI number and agencies do, too. Should both numbers be entered? Just the provider's number? Just the CSB's number?

*If an agency is doing the billing, just the agency NPI is entered even if the employee providing the service as an individual NPI number. See Chapter V of the Medicaid Early Intervention Services Manual.*

75. Will we be able to enter and edit practitioner links to our local systems in ITOTS?

*Yes, ITOTS 1.6 allows this.*

#### Revenue and Expense Reporting:

76. When a CSB or contract agency bills for TCM through a non-Part C program/unit and when the expense of that non-Part C program/unit is not included in the accounting of total expenses for the local Part C system, we request a mechanism for separate revenue reporting for TCM in these circumstances. This would prevent an artificial inflation of revenue to expenses in those local systems and help to ensure that the Part C revenue reporting is accurate.

*Local lead agencies and providers should be reporting all expenses and revenue.*

77. How quickly will additional funding be disbursed to local systems when a deficit is identified?

*When a local lead agency notifies DBHDS of budget shortfalls, including supporting documentation of need, specific reasons for need and efforts to secure other available funding, we will work with the local lead agency to address the deficit situation.*

78. The financial reporting form for private providers (Part C Therapy Provider Quarterly Report form) has the rate column set and the expense column automatically calculated, but this amount may not match what the system pays out to contractors. How is this reconciled in reporting?

*The total amount of revenue and expenses for the local system will be reflected when the revenue and expense information from the private providers is combined with the revenue and expense information from the local lead agency.*

79. How can local systems be held accountable for private, contracted providers submitting revenue/expense data to the state Part C office?

*Local lead agencies should include this requirement in contracts with all providers. In order to obtain EI certification practitioners must sign assurances, which include "I understand that I must provide to the Part C system (Local Lead Agency or State Lead Agency) revenue information and other data required by the Part C system for children within the Part C system for whom I provide services (unless I am an employee or contracted with a provider agency that provides this information for me to the Part C system)."*

80. Where do '09 carryover funds go on '10 form?

*Record these funds in one of the "Other" lines in Section B: Revenues of Source and specify to the right that they are FY-09 carry-over funds.*

81. Is the data in top right section (Data for Current Quarter) of the Part C System Costs expenditure report form to reflect only billing done by the local lead agency?

Yes.

82. The Part C System Costs form reflects money coming into and out of our system, right?

*That's correct. This form reflects the money administered by the local lead agency (not providers).*

83. Will ITOTS spit out services provided information?

*Not yet, but this functionality will be added in future enhancements to the data system.*

84. Should vision teachers and others who are separate providers (not part of any agency) report their revenue and expenditures? How do they do that?

*Yes. They can use the Part C Therapy Provider Quarterly Report form to report revenue and expense information.*

85. Can the Part C Therapy Provider Quarterly Report form be submitted to reflect services provided to all local systems in which that provider works rather than being separated into revenue and expenses each local system?

*The revenue and expense data need to be reported by individual system.*

86. If providers do not report data in a timely manner, what is the role of the local system manager to follow-up with providers who do not turn in information?

*Local lead agencies should include this requirement in contracts with all providers and are expected to monitor those contracts for compliance. The Local Contract for Participation in Part C requires the local lead agency to notify their Part C Technical Assistance Consultant of local barriers to timely reporting of required data. It is also important for DBHDS to know if there are issues with timely reporting of data since, in order to obtain EI certification practitioners must agree to provide to the Part C system with revenue information and other data required by the Part C system.*

87. On the Part C Therapy Provider Quarterly Reports, will the rates apply (\$37.50) for the first quarter?

*Though the standard EI rates do not go into effect until October 1, 2009, the \$37.50 and the \$27.50 rate should be used on the report for indicating the providers' expense since this part of the report reflects expenses, not revenue. Using these rates on the reporting form for the first quarter will just give the state Part C Office a sense of the costs of providing the services in that quarter.*

88. If a provider does not provide services that quarter, should they turn in a report with \$0.00?

Yes

#### ARRA Funds:

89. Is the figure that is used for the FY-2010 ARRA funds distribution based on 12/1 child count or on annualized count?

December 1

90. Will we have one budget for ARRA funding or two?

*We will share more specific ARRA budgeting information with local systems when those funds are allocated.*

91. Looking at the ARRA reporting form:

- In Section B, what is the baseline status?  
*Your local system's most recent status on that indicator as reported to you by the Part C Office*
- What do we use for the first quarter?  
*Use updated data gathered from local record reviews or ITOTS to document current status and show any progress.*
- What if we didn't have a Corrective Action Plan related to an indicator but want to use ARRA funding to keep reach or maintain 100% compliance or increase number of children birth -12 months served in the local system?  
*That's fine. You'll still use data to show baseline status and progress.*
- Will there still be a report due, even though no warrant has been provided to allocate the funds?  
*If you have not yet received funds, then it is not necessary to submit a report.*

92. For vendor tracking:

- If the vendor has \$100,000 but \$80,000 of that is funded from state/federal Part C funds?  
*The \$25,000 threshold only applies to payments of ARRA funds over \$25,000.*
- Will this be cumulative?  
*Yes. If the total will be over \$25,000 for the full year (or historic records indicate it's likely to be over \$25,000 even if that much is not spent in the first quarter), it's necessary to report.*

#### Monitoring and Quality Management Reviews:

93. When and where will Quality Management Reviews (QMR) occur?

*These reviews may occur anytime after 10/1/09 and can be announced or unannounced. QMR may be conducted on-site or through desk reviews. Please see Chapter VI of the Medicaid Early Intervention Service Manual (available at [www.dmas.virginia.gov](http://www.dmas.virginia.gov)) for more information.*

94. What is the expected cycle for QMR? How many days will the review take?

*We are still in the process of working out details around QMR and will provide additional information and training as those details are finalized.*

95. When we meet with families and providers (like child care providers) do we need to say that an audit may be conducted?

*It is not necessary to tell people routinely that they may be contacted as a part of an audit. When an audit is scheduled, you will have the opportunity to inform families or others who may be contacted.*

96. Does QMR apply to all children/families or only ones funded by Medicaid?

*All children*