

RESPONSES TO QUESTIONS FROM LOCAL SYSTEM MANAGERS January 2010

Questions about eligibility determination, assessment for service planning, and IFSP development and implementation:

1. If staff of the local lead agency is not 100% funded by their agency, can Part C dollars be used to pay for eligibility determination meetings?

Response: The information in this question is not clear enough to allow for a simple or complete response. If an individual is employed by the local lead agency, then Part C funds may not be used to reimburse that individual for her time in eligibility determination meetings. This is different from when you are buying a person's time for eligibility determination meetings through a contract. Please contact your technical assistance consultant if you need a more specific response to this question in relation to a particular funding/employment scenario.

2. We have a child referred who is two weeks old. She does not have a Medicaid number issued to her yet and we have been told that it can take 4 to 6 weeks for a child to be issued a number from the time of birth. How does this situation impact the 10-day requirement to get all information loaded into ITOTS after the IFSP?

Response: As long as the Medicaid number is entered by the local system as soon as it is available, the Part C Office will work with the Department of Medical Assistance Services (DMAS) to enter the start date for Medicaid EI Services to correspond with the start date for Medicaid coverage for the child. In such situations, the local system needs to email Tamara Wilder (tamara.wilder@dbhds.virginia.gov) and David Mills (david.mills@dbhds.virginia.gov) to alert them to this special situation.

3. What are some examples of what the team might write in the box at the bottom of the Eligibility Determination form (eligibility narrative)?

Response: We have consistently found that it is problematic to provide specific examples of how to write narratives. Local systems find that the example(s) does not apply to them for some reason, or the examples are taken as the only way to meet a given requirement when it is rare that one or even a few examples appropriately address all scenarios possible when working with children and families. As indicated on the Eligibility Determination form, the narrative should provide a summary of the information reviewed by the team and how the available information led the team to determine the child eligible or not eligible. When we request feedback on the Practice Manual and forms after 6 months of implementation, we will invite local system managers to submit examples of Eligibility Determination form narratives that we can review in order to identify the need for any further clarification in the revised Practice Manual.

4. A child is found eligible for Part C during eligibility determination at the desk (and an Eligibility Determination form completed and signed) and then is found not eligible when an Assessment for Service Planning is done. Is any part of the IFSP form

completed? Prior to October 1st, the first four pages were completed and given to the family when a child was found not eligible. What paperwork is completed? Just a second Eligibility Determination form? Is anything given to the family in terms of paperwork documenting their child's assessment results besides the Parental Prior Notice form?

Response: There is no longer a requirement to complete any part of the IFSP form if the child is not eligible for Part C. In the scenario described in the question, a new Eligibility Determination form is completed and the family receives a copy of the Eligibility Determination form, which will include documentation about the assessment results, and a Parental Prior Notice form indicating that their child is not eligible. When the Practice Manual is revised in the spring, language will be added on pages 39-40 clarifying the requirement to complete a new Eligibility Determination form.

5. What is the date to put on the first Eligibility Determination form? If you put the same date as the Assessment for Service Planning, will Medicaid cover the Assessment for Service Planning?

Response: You will use the date that eligibility was determined, even if that occurs on the same date as the assessment for service planning. Medicaid will still reimburse for the assessment for service planning.

6. Page 90 of the Practice Manual says that the Eligibility Determination form is completed if the family or another team member believes the child is no longer eligible. We understand this to mean that this form should be completed at discharge and we have been told to write in "discharge" at the top since it is currently not included on the form. Completing the Eligibility Determination form at discharge is not mentioned, however, on page 101 of the Practice Manual which discusses transitioning out; page 101 talks about completing the Parental Prior Notice form and documenting on that form that "ongoing assessment results indicate that the child no longer meets the eligibility criteria for Part C." We wonder if completing the Eligibility Determination form should be included at all discharges or just in certain circumstances. We have questions about what to do at discharge.

*Response: The requirement to complete the Eligibility Determination form if the family or another team member believes the child may no longer be eligible should **not** be interpreted to mean that the Eligibility Determination form must be completed as part of discharge.*

- Is the Eligibility Determination form completed when a child is transitioning to Part B? What about if the child transitions out to Part B at the third birthday? If this form is completed, is the date of the form the date the team meets to confirm continued eligibility?

Response: The Eligibility Determination form is not completed when the reason the child is no longer eligible for Part C is because of his/her age (3 years old) or because he/she has transitioned to Part B services.

- Is the Eligibility Determination form completed when a child turns three and is not transitioning to Part B but still has a delay or a disability? We know the child would no longer be age eligible for Part C, but the child may still have a delay. Is this documented somewhere in the record?

Response: The Eligibility Determination form is not completed when the reason the child is no longer eligible for Part C is because of his/her age (3 years old). Contact notes will document the child's developmental status based on ongoing assessment that occurs as part of service delivery. If the child has been receiving Part C services for more than 6 months, the child's record will also include exit assessment and child outcome progress information.

- Is the Eligibility Determination form completed at discharge when a parent declines further services for a child (for a child already found eligible and who has been receiving Part C services and is not yet three) in order to have documentation that the team, at discharge, finds the child still eligible?

Response: The Eligibility Determination form is not completed when the child is exiting Part C because the parent declines further services for their child. Contact notes will document the child's developmental status based on ongoing assessment that occurs as part of service delivery.

7. Can the total amount of minutes for a service be listed for the month on page 6 of the IFSP? For example, could an IFSP state "240 minutes a month" for a service and then could those minutes be divided in any way the provider and family agree during the month?

Response: The IFSP needs to give the family (and providers) a reasonable expectation as to frequency and intensity of services. The proposed "240 minutes a month" is too wide-open, giving no structure to scheduling and planning for the service that would ensure the service is reasonably designed to address the IFSP outcome(s). We see in this question a desire for flexibility, presumably to meet child and family needs, and a commitment to providing services at the frequency and intensity listed on the IFSP. While you are required to meet the frequency and intensity of services listed on the IFSP, this does not eliminate flexibility to meet child and family needs. For instance, the child's IFSP may list developmental services once a week for 60 minutes. If a particular visit needs to be cut short, maybe 45 minutes into the visit the family gets a phone call and needs to leave to handle an urgent family matter, then the remaining 15 minutes of that visit can be "made up" by adding 5 minutes each to the next 3 visits, or adding 15 minutes to the next visit, etc. The arrangements for making up the time must be documented in a contact note. If you consistently find that the planned frequency or intensity is not working, then it is time to hold an IFSP review or consider whether a different day or time of day would fit better in the child's and family's schedule and routine.

8. When a child still has a delay at their annual IFSP but it is not a 25% delay and so they are no longer eligible for Part C, will there be any impact on the local system's exit outcome data since the children in this situation will not score 7s on their ratings?

Response: (Presumably the child in this question also has no diagnosed condition or atypical development that would make him/her eligible.) A child with a delay of less than 25% may or may not be functioning at the level of same-aged peers depending on how discipline-specific skills are translating into the functional abilities measured by the child indicators. In addition, there will never be the expectation that all children exiting Part C will be at age level. We report on

child outcomes based on 2 summary statements. The first of these statements reports the percent of children who have increased their rate of growth by the time they leave the program, while the second statement accounts for children who leave the program functioning within age expectations. Chances are the progress of the child in this question will be reflected in the first summary statement, if not the second.

9. If a consultation is written as a service on the IFSP, is it reimbursable by DMAS if the consultation is done with the family over the phone?

Response: Services provided via phone are not reimbursable. See Medicaid Early Intervention Services; Chapter IV, page 9: Billable time consists of actual time spent with the child and family member or caregiver. The family member or caregiver must be present during the intervention session.

10. Is this the correct process for the following scenario? A child is due for their annual IFSP. They have only been getting service coordination so they need an updated assessment by two providers to determine continued eligibility. The service coordinator: 1) does an IFSP review to add the assessment (the review would state the two disciplines that would do the assessment); 2) gets an order from the primary care physician to do the assessment.

Response: As with the initial determination of eligibility, developmental screening results along with observation, parent report and current health information may be sufficient to make the annual determination of eligibility when ongoing assessment information is not available (as in the scenario described in the question). The service coordinator may conduct the developmental screening, if trained to do so. If the eligibility determination team finds that targeted assessment is necessary in order to confirm ongoing eligibility (i.e., the screening results and other available information were insufficient to determine eligibility) or if the child continues to be eligible and assessment is needed for service planning and IFSP development, then you would hold an IFSP review to add the assessment(s) and then secure a physician order for the assessment(s), if needed.

11. Before Oct 1, we always did an evaluation when we brought in a new therapy service. So, if a child was getting PT and the team decided there was a speech issue the physical therapist could not address OR if a physical therapist and educator did the initial eval and the team agreed, when writing the IFSP, that the child would benefit from seeing a speech therapist, we would put "speech eval" on page 6 of the IFSP and the speech therapist would go out and do an eval (even if we had recently had an educator evaluate speech for the IFSP report and the educator's evaluation results were still accurate). Then we would do an IFSP review after the speech eval, review what the speech therapist found, and, if the team agreed, write outcomes and add speech therapy. We had always understood that Medicaid (through outpatient rehab) wanted an eval (including a written report) from the therapist at the start of each therapy service. Now, after October 1st, do we do the same? Is DMAS or the Part C office going to be looking for a formal assessment when a new IFSP service begins/when a new discipline starts? So if an educator already assessed the area of communication for the IFSP report, does the service coordinator still have to first add "speech assessment" to page 6 of the IFSP or could "speech therapy" be added with

outcomes developed that the speech therapist could immediately begin to address at his/her first session with the family? In other words, at the start of each therapy service, must there be a formal assessment – with a written report of some sort completed by the therapist? If yes, 1) what kind of report is expected? 2) does this also include when Developmental Services are added; does a provider qualified to provide Developmental Services have to complete a formal assessment? 3) what developmental areas would be covered in an assessment by a provider for Developmental Services? (it is more obvious what areas of development an OT/PT/ST would cover) If no formal report is needed but an assessment is required when a new provider starts working with a child, how is that documented?

Response: Neither the Part C Office nor DMAS requires an assessment when services by new disciplines are added to the child's IFSP. However, providers must be aware of their discipline's licensure requirements. For example, physical therapists must evaluate (assess, in Part C terms) a client prior to providing services. When a new service is added to the IFSP, the provider will need to use his/her discipline-specific expertise to determine what strategies are needed to address the outcomes determined by the team. This type of assessment will occur during the first session(s) with the child and family. This session(s) should be documented in a contact note, just as ongoing assessments are documented. The provider may or may not determine that additional outcomes or short term goals are needed (in which case an IFSP review will be needed).

12. Page 90 of the Practice Manual talks about the 6 month review and says that it can be conducted before 6 months and then the 6 month review timeline is started again. If a service coordinator does a review at 3 months after the IFSP is signed and then again 6 months later (at the 9 month point following the IFSP), does the service coordinator check the 6 month review box at the top of the IFSP review form at the 3 month review or the 9 month review – or both – or never and just checks the “Upon request by _____” box for both reviews? Another way of asking this: Is the 6 month review box at the top of the IFSP review form only checked when the IFSP review occurs on or about the 6 month mark after the IFSP is signed?

Response: If the IFSP review is being held because it has been about 6 months since the IFSP was developed or reviewed, then check the “6 month review box” on page 9 of the IFSP form. If the review is being held because it was requested by the family or another team member and it is not near the 6-month mark, then check the “Upon request by ___” box. In the example given in the question, the review held at 3 months would be “Upon request by _____,” and the review held at 9 months would be marked “6 month review.”

13. Do service coordinators have to send the DMAS Right to Appeal letter to families each time an IFSP service is decreased or ended entirely? If no, in what situations would we use the DMAS Right to Appeal letter?

Response: Families must be notified of their right to appeal if the family disagrees with (1) the eligibility decision, or (2) decision about services, including which services are to be provided, frequency or intensity.

Questions about the early intervention record:

14. For the requirement of completing progress notes within three working days:

- Does day one start with the date of the service or the next day?
Response: Day one is the day of the service.
- Suppose a provider delivers a service today and then goes on annual leave or sick leave the next day for a number of days (exceeds the three working days) and does not get the note written until he/she returns to the office. Is this a violation of the three working days requirement?

Response: Yes. To be most accurate and helpful, the note should be completed at or immediately following the session. To complete it more than 3 working days later leaves too much opportunity for inaccuracy and means the information is not readily available to other providers. Please note that if a handwritten note (that is to be transcribed into the electronic health record) is completed within three working days, that meets the requirement even if the note is not entered electronically until after the 3-working day deadline.

- If we find that a provider has not completed a progress note for a billable service within the three working days, do we not bill Medicaid for that service? Who pays for that service? Does our local system just somehow cover the cost of that service? Do I need to go through notes not written within three working days in the past three months and return funds to the Department of Medical Assistance Services (DMAS) for those services?

Response: There is not a need at this point to go through notes to identify a need to return funds to DMAS. However, you do need to assure that you have set up your procedures so that you are not in a position of missing the deadline. Determination of whether the requirements are met will be done through retroactive record reviews as part of the Medicaid Quality Management Reviews that are the responsibility of the Part C Office.

15. In regards to the recent Financial files memo:

- What exactly should be included in the financial file that is kept separate from the clinical record? Many systems have the insurance information in the clinical record but keep the family's proof of income separate. Is this acceptable?

Response: As indicated in Chapter 9 of the Practice Manual, all documentation related to family cost share and billing including, but not limited to, the family cost share agreement form, billing documentation for Medicaid and private insurance, and all communication related to determination of family cost share or other financial matters must be maintained in the Financial Record. Insurance information belongs in the financial record.

- What about electronic health records systems? Depending on how electronic systems are organized, the requirement from the recent memo may be hard or even impossible to meet.

Response: We recognize that electronic health record systems present some unique challenges with regard to the requirement for a separate financial record. The October 29, 2009 memo related to separate

financial files encourages you to take note of any challenges that this particular requirement poses at the local level so that you may include those comments when we request feedback in the spring. All comments will be considered at that time, including those related to electronic records.

Question about outpatient rehab:

16. Can a child get outpatient rehab in addition to their Part C EI services? A related issue for families: some systems are not discharging children fast enough from Part C and there is a lapse in getting an outpatient rehab preauthorization.

Response: If a child needs Medicaid rehab services to meet medical needs (services that do not meet the definition of Part C early intervention services), the child can receive Medicaid EI services and Medicaid Rehab services simultaneously. If there are questions about specific situations, contact Brian Campbell at brian.campbell@dmas.virginia.gov and Beth Tolley at beth.tolley@dbhds.virginia.gov.