NEW MEXICO
Family Infant Toddler Program

Family Infant Toddler

FIT Scenarios
A Handbook for Family Infant Toddler Providers

To Help with Issues Regarding Billing,
Service Definitions & Standards, and Regulations

FY 11

Hand book was developed on June 27, 2011 and compiled by Verna Trujillo, team leader and with the help of others

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FAMILY INFANT TODDLER

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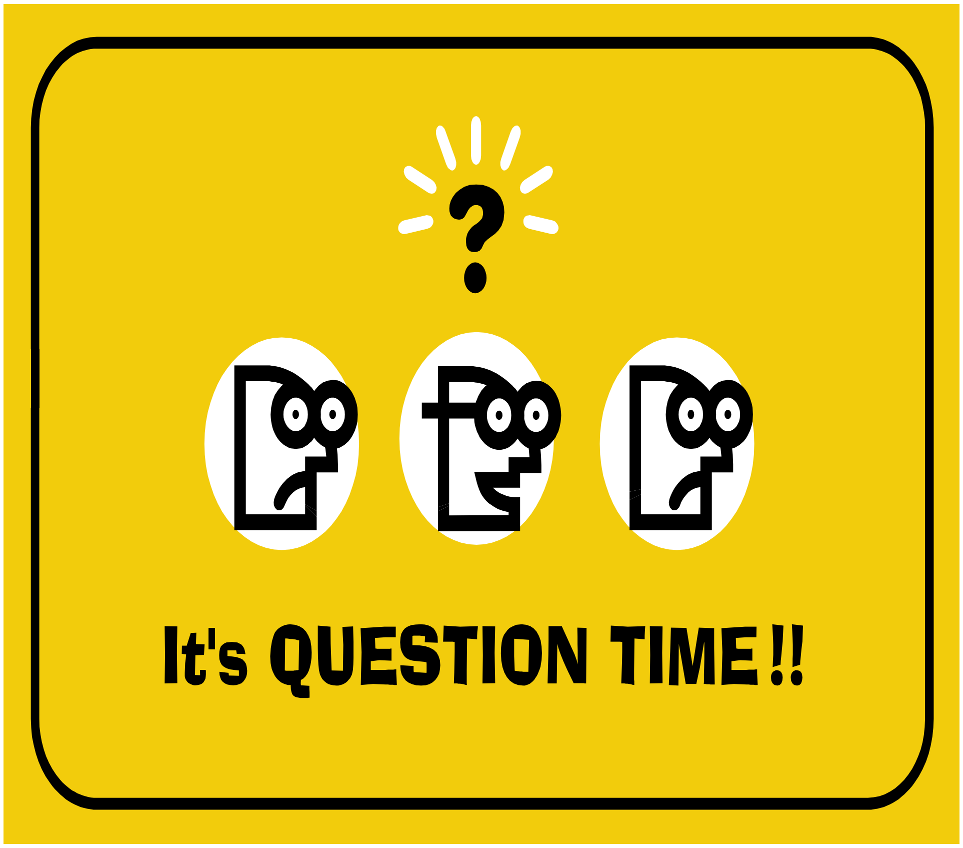


Over the several years, the FIT Program has compiled a list of scenarios to clarify areas where we frequently hear questions. Most often, these involve billing, but some involve service definitions and regulations.

By request, we have combined these scenarios and questions with answers that will help to clarify these issues.

During the intake process the service coordinator will have the family complete a Freedom of Choice Form. to select a FIT Provider in counties where there is more than one provider agency.

The Freedom of Choice Form will also be used when a family is transferring into a county where there is more than one FIT Provider agency.

Referral/Intake

Q If a child is referred shortly before their 3rd birthday, do we have to take them?

A If a child is referred to Part C fewer than 45 days prior to the child's third birthday an intake an intake or evaluation will not be conducted. The Service Coordinator will let the family know of preschool options in the community , e.g. Preschool, Special Education, Head Start, Early Head Start, private school etc.. And will assist with a referral to those entities.

Q Do we need to get prescriptions for EI services from physicians?

A The Special Rehab. Regulations, which govern early intervention services funded by Medicaid, state:

> ***8.320.4.13 A (1)*** *Speech, language and hearing services are provided by or under the direction of a speech pathologist or audiologist, as the result of a referral by a physician or primary care provider (PCP).*
>
> ***8.320.4.13 A (2)*** *Occupational therapy services are provided by or under the direction of a qualified occupational therapist as the result of a referral from a physician or primary care provider (PCP).*
>
> ***8.320.4.13 A (3)*** *Physical therapy services are provided by or under the direction of a qualified physical therapist as a result of a referral from a physician or primary care provider (PCP).*

So, Yes providers should still try to get the PCP referral. However, early intervention services should not be delayed while waiting for the PCP referral. The FIT Provider should document that they have sent / faxed a request for this referral from the PCP.

The key is that this is a "referral" not a "prescription" - something like "Darren could benefit for physical therapy" or "I am referring Brittany for speech". Not "OT 1x per week for 1 hour until August".

Q Do I need to give a Freedom of Choice to the family or is it an option?

A No, This is not an option. You are required to give the family the Freedom of Choice form in order for them to determine which provider they would like to work with.

Home & Community (Group)

"Home & Community (Group)" is defined as an inclusive service location away from the provider/contractor site (including, but not limited to a play area; swimming pool; park; Chapter House; community center; child care or a family's home), which involves travel for the early intervention personnel. Home & Community (Group) is provided to two or more eligible children/families at the same time. Services delivered in a Home & Community (Group) must be documented as a strategy to meet the individualized child/family's outcomes in their IFSP. The purpose of Home & Community groups is to 1) assist families in learning from and with other families in the community, or 2) facilitate integration/participation of children and families into inclusive community settings, or 3) provide consultation to parents and/or caregivers. **The ratio of staff to eligible children in Community Based (Group) will be no greater than 1:4 (one staff to four eligible children).**

Rate: $13:00 per 15 mins.

Q Tanya, a Developmental Specialist for "Good Start" Early intervention Agency, takes a group of 3 eligible children (with IFSPs stating that community based group will be part of their services) and their families to the play area in the local park (or McDonalds play area when it's cold!). She works with the children for 1 hour. How does she bill for this?

A She bills for 4 units of the Community Based Group rate for each of the three children.

Staff:	Kids:	Time:	Rate:	Amount:
1	3	4 units	$13.00	
Calculation 3 x 4 x 13				$156.00

Home & Community (Group)

Q What if, Tanya adds two children to her group? How does she bill?

A This is how Tanya would bill for two children:

Staff:	Kids:	Time:	Rate:	Amount:
1	4	4 units	$13.00	
1	1	4 units	$13.00	
Calculation (4 x 4 x 13)+(1 x 4 x 13)				$260.00

Q Do we need to tie staff to 4 kids in the FIT KIDS?

A Yes, each child in the group needs to be listed in the database as receiving services from the staff person responsible for them

Q Tanya realizes that in order to bill for additional children, she needs additional staff to accompany her on these outings. Her group just keeps growing. This week she is going to have 6 children in her group, so she asks Ernie, another staff person, to join them. The group lasts an hour and 15 minutes. Now, how do they bill.

A Each staff person can bill the units up to 4 children. So Tanya could bill for 4 children, and Ernie could bill for the other 2.

Staff:	Kids:	Time:	Rate:	Amount:
2	6	5 units	$13.00	
Calculation 6 x 5 x 13				$390.00

Q Let's throw a kink into this. Let's say that 1 of the children, Tyler, receives physical therapy, and the family decides that the PT could provide ideas for Tyler's motor development while in the group. So Tanya and Ernie are joined by the PT, Gail, for the last ½ hour (the group was 1 hr 15 min). Gail works exclusively with Tyler and his mom during this time. How does the billing work now?

Home & Community (Group)

A Answer: Gail bills Home & Community for time she spends with the one child and Family, while Tanya and Ernie utilize the home and community group rate to bill for the other children.

Staff:	Kids:	Time:	Rate:	Amount:
2	6	3 units	$13.00	$234.00
2	5	2 units	$13.00	$130.00
1	1	2 units	$25.50	51.00
				$415.00

Note: If Tyler continues to be part of the group and Gail facilitates his participation in the group (working on his positioning or balance as he participates in the group), then Tyler would continue to be included in the home and community group billing and Gail would bill her time with Tyler as Home and Community- Individual.

Q The parents in Tanya's group decide they'd like to have siblings come to the group. What happens to the staff ratio and how is this billed?

A It is still the same ratio of staff to eligible children and should be billed under the community group rate. If siblings are coming along they should be supervised by their own parents/caregivers.

Q When Tanya is not working with her group, she provides services to other families in their homes. One family she works with has twins, Joshua and Jessica, who are both eligible for FIT services, but whose developmental needs are quite different. Of course each child has a separate IFSP as their development and needs for intervention are individualized. If Tanya spends ½ hour with the twins and mom together and ½ hour with mom and each child separately - How is Tanya to bill?

A For the time that Tanya works with both children and the family the Home & Community (group) rate would be used. For the time focused on one child the home & community rate would be used.

Staff	Kids	Time:	Rate:	Amount:
1	2	2 units	$13.00	$52.00
1	1	2 units	$25.50	$51.00
1	1	2 units	$25.50	$51.00
				$154.00

Home & Community (Group)

Q Why would we use the group rate for twins?

A As described above, the Home and Community (Group) rate would only be used for the time when working with both twins at the same time – in effect this becomes a small group. More often, due to the individual needs of the twins, as documented in their IFSPs, the early intervention personnel would be working specifically with the family on the outcomes for one of the children (even though the other child is likely to want to join in!) Therefore, the Home and Community (Individual) rate would be used for that time period.

Q Tanya works with Bobby and his Grandma and Amy and her mom on the west side of town. Bobby and Amy have both recently turned two and the mom and Grandma agree to have one visit a month for an hour and ½ at each other's homes in order for Bobby and Amy to play and develop communication skills. How is this billed?

A Tanya bills the Home & Community (Group) rate for both children for the length of the session

Staff:	Kids:	Time:	Rate:	Amount:
1	2	6 units	$13.00	
Calculation 2 x 6 x 13				$156.00

Q Joan, a Developmental Specialist, serves 3 children at a child care program. She works with all three for a period. Then 2 of the 3 children in Joan's group are in circle time singing songs with the rest of the class and one child is left with the Joan to work on sensory issues. How would she bill for that period of time?

Home & Community (Group)

A

Service	Unit Price	Delivered	Billed
Home & Comm. **- Individual**	**$25.50**	**1 unit** **(10:30 to 10:45 with Tommy)**	**$25.50** **(1 child x 1 unit x $25.50)**
Community Based Group	**$13.00 per child**	**1 unit** **(10:45 to 11:00 with 3 kids**	**$39.00** **(3 kids x 1 unit x $13.00)**
		Total billing for the hour:	**$142.50**

During the time that she is working with only one child, she would stop billing for Community Based Group and start billing Home and Community (Individual). Then she may return to billing Community Based Group when the other children rejoin her group.

So, for example, she may begin working with all the children at 10:00 am, and at 10:30 two of the children join the rest of the daycare children as they sing songs. Joan works exclusively with one child, Tommy, for 15 minutes, then the other two children rejoin Tommy and Joan until 11:00.

Service	Unit Price	Delivered	Billed
Community Based Group	**$13.00 per child**	**2 units** **(10:00 to 10:30 with 3 kids**	**$78.00** **(3 kids x 2 units x $13.00)**

Q An EI program holds a play group for children who are at least 2 ½, in a community setting (a local church hall). There are 12 children in the group, 6 who are eligible for the FIT Program and 6 typically developing peers. The group staff include a DSII, a DSI and an OT (ratio 1 staff: 4 children). It is a two hour group that meets 1x/week.

All 6 children who are eligible for the FIT Program have an outcome related to preschool readiness (joint play, interaction, following instruction etc.) and have special instruction on their IFSP). 2 of these children have fine motor / visual perception outcomes and have Occupational therapy on their IFSP

During this group the OT conducts/leads activities for 30 minutes to support fine motor and sensory development. All children participate in these activities. How do we bill for this group?

Home & Community (Group)

A Of course – only the time of the FIT eligible children is billable. The home and community group rate is based on billing for each child in the group, i.e. the $13.00 / 15 mins is billed for each child at the same time. Here is how the billing would occur.

Service	Unit Price	Delivered	Billed
SI H/C (Group)	$13.00 per 15 mins	90 minutes = 6 units	(4 children x 8 units x $13.00) = **$416.00**
OT H/C (Group)	$13.00 per 15 mins	30 minutes = 2 units	(2 children x 2 units x $13.00 = **$52.00**
SI H/C (Group)	$13.00 per 15 mins	30 minutes = 2 units	(2 children x 2 units x $13.00 = **$52.00**
		Total billing for the 2 hours:	$ 520.00
If the OT were to work 1:1 with of the children in the group – this would be billed at the home and community based rate of $25.50 and this child would not be billed at the group rate for that ½ hour. Documentation of time in / time out and description of the service provided must be completed for each child in the group.			

Consultation between early intervention personnel allows for discussion (without the family present) for the purposes of planning effective early intervention strategies. This activity is reimbursable for up to twelve (12) hours a year for each service listed on the child's IFSP. Consultation time must be planned and documented in the IFSP as one of the strategies that will be used to meet the child/family outcome(s). For example, "the developmental specialist and the contracted physical therapist will meet one time per month to address issues related to the child's positioning." In this example both personnel may be reimbursed for their time. Consultation may be with a co-worker, sub-contractor or employee of another agency and may be in person or via the telephone. (Note: impromptu meetings about a child/family or general staff meetings are not billable). Consultation is reimbursed based on the location where the activity and documentation of consultation activities must be recorded in the progress notes.

Home & Community (Group)

Q Amanda, a service coordinator, is currently serving a child who is receiving both PT & SI. During the IFSP meeting, the team realizes that it would be helpful for the PT and the developmental specialist to consult from time to time to insure that services are coordinated and consistent with the outcomes. How should Amanda write this into the IFSP?

A This is listed as a strategy. An example that is taken from the service definitions is as follows: "The developmental specialist and the contracted physical therapist will meet one time per month to address issues related to the child's positioning." **It must be listed also on the supports and services page.**

Q What is the maximum number of times that consultation can be billed?

A Each service (discipline) can bill up to 12 hours a year for each eligible child. So if a PT consults with the OT for a ½ hr on a child with whom they are both serving, that PT and OT can each bill ½ hour.

Q What rate is used for billing consultation?

A Yes. You can bill for no more than 12 hours per year, but it need not be delivered in one hour a month increments. Example the DS may need intensive consultation from a mental health therapist for a 3-4 month period and then less regular consultation as things stabilize. Remember that it must be listed on the IFSP, with the frequency noted. Also, remember that consultation is included in the 19-hour service pre-authorization requirements. And, while we are on that point, remember that service coordination and respite are not included in the 19-hour service pre-authorization.

Q Regarding consultation, can you write "up to 12 hours per year" on the IFSP?

A It is not required to list consultation on the service page, however, it must be written as a strategy on the outcomes.

Q How would that be written into the IFSP as a strategy?

A See example below:

Strategy: DS & PT will consult 1 hour per month to address positioning
Service: PT & DS (location / 1 hour each service / month) .

Q Is consultation included in the 14-hour max before requiring prior approval?

A Yes

Home & Community (Group)

Q Follow up from ECEP team: Is this billable?

A No. Unless it is part of the IFSP meeting or part of a joint home visit by the provider staff, then it would be billed at the appropriate service location rate

Q Theresa, another service coordinator, has just enrolled a child, James, who is diagnosed with autism. She will need intensive intervention through her agency. Several of her staff who will be working with this child has asked to attend a workshop on working with kids with Autism Spectrum Disorder.

Can this training get written into the IFSP and can it be billed?

How do I write consultation on the services page?

A It is best to write any consultations on a separate line from the face to face service for the child. For example, if the speech therapist was providing services for 60 minutes a week, that would go on one line. Similarly, if the physical therapist were providing services twice a month for 60 minutes, that would go on another line. Now, if the speech therapist planned to consult with the physical therapist for 30 minutes every month, the consults would each go on another line, one for each discipline, with consult being checked off and the frequency noted. You don't have to say on the service page who is consulting with whom. But, it will be important to show on the outcome strategy who is consulting with whom and for what purpose

Q Theresa suggests to her supervisor that they bring aboard an autism specialist as a consultant to James' team. Is this billable?

A Yes. As long as it's written into the IFSP supports and services page and as a strategy to meet the outcomes on the IFSP, the autism specialist can bill for their time consulting with James' team and the team can bill for their time meeting with the autism specialist. In this case consultation will promote the skills and competencies of the team in serving James. Consultation may be billed for up to 12 units for each service on the IFSP.

Q Training and consultation with a child and family: Can you bill for this?

A This occurs very rarely. For example, Project SET will sometimes invite families in to training to enable "hands-on" training regarding intervention techniques. This time is not billable as consultation as the primary activity is training, even though the personnel may gain ideas about how to work particularly with that child and family.

Consultation

Q The consultation rate is based on the location – if staff meet in the community can they bill the Home and Community (individual) rate?

A Consultation should be billed at the Center Individual rate, even if it involves staff driving to community settings or having lunch in the community for the purpose of consultation. The exception to this would be if the staff travel to another program (e.g. a Head Start; private therapy center; child care etc.) to provide consultation. Then the Home and Community (individual) rate can be billed.

Q Sally, a developmental specialist from Super Agency, and Phil, a physical therapist from Fine Agency are consulting on a particular child with whom they both provide services. Sally phones Phil to develop strategies for interdisciplinary services for the child. If they talk for one hour, how do they bill their time?

A Both Sally and Phil would bill for 4 units of service based on where the meeting occurred. In this case, each would bill 4 units at a center-based rate.

Q When Sally and Phil are out in the community doing home visits, they have found it convenient to meet for consultation at a small restaurant in rural New Mexico. How do they bill for these consultations?

A If a meeting in the community is merely a matter of convenience for Sally and Phil, and they could have easily conducted their consultation over the phone, they would bill at the center-based rate.

Q If the Consultation rate is based on the location, can staff meet in the community and bill the Home and Community (individual) rate?

A No. Consultation should always be billed at the Center Individual rate, even if it involves staff driving to community settings or having lunch in the community for the purpose of consultation. The exception to this would be if it is necessary for staff to travel to another program (e.g. a Head Start; private therapy center; child care etc.) to provide consultation with the staff at that location, then the Home and Community (individual) rate can be billed.

Note: Service Coordination cannot bill Consultation.

Consultation can be via phone if it is planned and is billed at the Center/Individual rate.

Q Ellen, a speech therapist, has several children she serves who have autism. One of the common problems she faces when working with them is difficulty engaging them in order to provide them with their speech therapy. She goes to Project SET to ask for help with this issue. Project SET staff discuss different strategies that can be used to engage children with autism. Can Ellen bill this time as consultation?

Consultation

A No. Ellen's request is not child specific. It is more global to "children with autism." Her time would be considered "training."

Q Ellen is working with Tommy, who has autism, and his family. Today she is attending a videoconference with the family where project SET staff are at the other end of the videophone. Project SET staff give guidance on how to better engage Tommy. Would Ellen be able to bill her time as consultation?

A Yes. Ordinarily we think of consultation occurring when the family is not present, but in this case, clearly Ellen is receiving consultative services that are "child specific" from Project SET personnel, and she may bill accordingly so long as it is listed on the IFSP.

When deciding whether time is spent in training or in consultation, it is helpful to ask yourself these questions. Is it child specific? Is it on the IFSP? What is the intent (using a child as an example in a training does not make it direct service or a consultation).

Q Mark, a Developmental Specialist accompanied Joey and his family to Joey's pediatrician visit? Mark was with the doctor for 30 minutes discussing Joey's progress and gaining insight about how his health concerns are impacting his early intervention supports and services. How can this time be billed?

A Again, this is an example of a time when consultation occurs when the child and family are present. Mark can bill for two units of consultation at H/C individual rate.

Q Can consultation be billed if it occurred one time only, but was not listed on the IFSP?

A No, every service, even if it occurs only 1 time ever, must be listed on the IFSP.

Q Should consultation and direct service be listed separately on the service page. If they are listed separately, how do we enter that on the database?

A Yes, consultation and direct service must be listed separately on the service page. Usually, there is a difference in frequency, intensity and location of consultation vs. direct service.

In FIT KIDS, consultation and direct services are listed separately and specified under the "service type."

Also, it is clearer to the family to have services indicating what direct services versus consultative services are. Finally, it is good to delineate the services in order to ensure that everyone of the IFSP team is clear in fulfilling their roles/responsibilities.

Transition

> Transition is designed to support community providers in developing and/or improving their system of transitioning children and families from early intervention services to other services and supports.
>
> Transition includes collaboration with the receiving agency including Public Schools, Head Start, Early Head Start, Child care, and FACE programs to insure that children have all their needs met and are in an inclusive and appropriate setting conducive to their learning style.

Q How many times can a Service Coordinator bill for Service Coordination after a child have transitioned?

A A Service Coordinator can bill up to three times within a six-month period, after transition. In order to bill Service Coordination services there has to be at least an hour of service per billing.

Q George is a PT who has been working with Justin and his family for over two years. Justin starts at the local preschool next week, and even though the transition plan and IEP went well, George wants to make sure the staff are able to meet Justin's physical needs and can use his walker appropriately. Can George bill for a visit to the preschool after Justin transitions? How does this get documented?

A Yes. Up to four hours may be billed after transition in total across all services/disciplines. The need for this must be documented on the transition plan.

Q Medicaid will not pay for transition services past the 4th birthday. What do we do?

A A child whose 3rd birthday is in Sept or Oct, will turn 4 shortly after transition – in this case for Medicaid eligible children, the consultation after transition will, indeed, need to occur before they turn 4. Medicaid will not pay for this and it cannot to be billed to State General Funds.

Q Linda is a Service Coordinator working with a family whose child, Anna, has just transitioned to Head Start. Regardless, the family is quite anxious about transitioning and has continued to request service coordination activities from Linda until they get settled. At the end of each month, she reviews her service records and learns that the first month after Anna transitioned, Linda provided 45 minutes of service coordination. The second month after the transition, Linda provided 90 minutes of service coordination. How does she bill for these two months?

A Assuming this service has been documented as a need in the IFSP transition plan, the first month, she cannot bill anything for service coordination. However, the second month, she can bill $155.00 for service coordination. Linda can bill up to three times for this service (assuming she provides at least an hour of service per month) until 6 months after Anna transitioned.

Transition

Q Joe is a physical therapist who was working with Molly and her family for the last two years. Molly just transitioned and now has a new physical therapist through Alpine school district. The new physical therapist has called Joe several times for consultation since Molly transitioned and has requested he also come to the classroom to get some ideas on positioning. Can Joe bill for his time?

A Joe can continue to consult about Molly for up to four hours for 4 months after transition, so long as it has been documented in the IFSP transition plan. Note: each child / family is limited to 4 hours total of consultation after transition. So, if another member of the IFSP is also consulting with the classroom staff, the 4 hrs must be shared between them.

Q Can a therapist consult with parents in the home after transition, e.g. discuss how things are going specific to the transition process?

A No, The service standards state that consultation is to be provided to the "LEA, Head Start or other early childhood staff regarding the child's intervention needs". Families can be present during the consultation with the other staff, but the consultation for which you are billing is between disciplines.

Please refer to your service definitions and standards for information on this issue

Q If a child is transitioning from Part C to Part B and the school states the child needs another evaluation, who is responsible to do the new evaluation?

A Part C is responsible to give the schools (with parent permission) the updated assessments and other needed information to transition the child. Part C is not responsible for doing a new evaluation. In this case, Part B would be responsible.

Also, schools will often request EI Providers to do a current hearing screening on the child at transition. Certainly, EI Providers can do that if they are willing; however the responsibility for that lies with Part B.

Q Do we have to fill out the Transition Assessment Summary Form since we're attaching copies of the latest evaluation? Our school stated that the form was not that helpful.

A Yes. The Transition Assessment Summary form must be completed. It may be helpful for discussion to occur with the LEA on how this form could be completed in a way that would prove helpful to most school districts. Recommended future changes to the form can be brought to the FIT Program.

Q Billie is transitioning from part C to a private developmental center that her parents have chosen. This will occur next fall. Does Billie need a 90-conference meeting and a transition plan?

A Yes, all children exiting Part C need to have a 90-day conference and a transition plan in place, which is a part of the IFSP.

Transition

Q Betty is an Occupational Therapist who served Cameron in the FIT program. Cameron has just transitioned to part B. Cameron has a new Occupational Therapist in the part B program and has requested Betty to come and consult with her regarding Cameron.

A Yes, Betty can consult with the new Occupational Therapist for up to four hours in a four-month period after transition. It does have to be documented in the IFSP transition plan. Also, remember that a child is only able to have four hours of consultation across all disciplines, except Service Coordination. So remember, if there are several staff members providing consultative services, four hours must be shared between the staff.

Q Tommy will be 2 ½ and will begin Preschool in August with an IEP. Can Tommy leave the Preschool & return to the FIT EI Program if the parents feel the he is not adjusting to the Preschool.

A Yes, provided the child has not turned three years of age. By IDEA law, the early intervention system is responsible to provide services until the child turns three years of age. If the child's third birthday has occurred then the child must remain in the Part B system.

The practice of "switching" back and forth is not encouraged and should only occur in unusual circumstances. During the "planning" for transition, emphasis is placed on ensuring that each family has adequate information to make informed decisions. T

he transition plan should include visits to the new setting, interviews with prospective teachers/staff and preparation for the changes that will occur. The service coordinator assists the family with these activities and facilitates on-going communication between the family and preschool program.

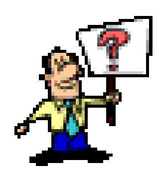
The family should be comfortable with their placement decision and the need to switch back to early intervention should be a rare occurrence.

Q Do You need to document transition follow-ups?

A Yes. The need for Post Transition activities must be written on the transition plan in the IFSP and documentation on case notes / contact must be made.

Q Does every child need transition planning and a 90 day transition conference even if they are not exiting to Part B special education?

A Yes. The regulations specify that the child shall have a smooth and effective transition wherever that may be.



Transition

Q What happens to a referral form that was sent to the LEA and then child does not qualify and does not transition – what happens to the referral form? (Parent does not want paper work around that might result in child getting labeled)

A The LEA is bound by the Family Education Rights and Privacy Act (FERPA) with regards to confidentiality.

Q Is it a FIT mandate that each child be evaluated with an assessment tool annually? Do we bill for that annually?

A Yes. All children must receive an annual assessment of their development, both to determine the child's continued eligibility for the FIT Program and to document the child's present levels of development in the IFSP. See the following regulations:

> **G. Assessment**
>
> **(1)** Each eligible child shall receive an initial and ongoing assessment to determine the child's unique strengths and needs and to recommend to the interdisciplinary team services and supports to address IFSP outcomes… Assessments may include a variety methods and procedures including family report and clinical opinion. Any assessment instruments or tools used shall be valid, reliable and used only for their intended purpose…

Billing for ongoing assessment activities is on fee-for-service basis.

Q Can there be a portion added to the Assessment Summary form that provides space for documenting parent refusal or consent on the form?

A If the parent(s) has consented to the referral to the LEA – they cannot refuse consent to the Assessment Summery Form. Use a Prior Written Notice Form to document that the parent(s) refuse for the Assessment Summary Form to go to the LEA and that therefore their early intervention services through Part C would end at the time of the child's third birthday.

Q What do we do if we can't complete assessments before child is ready to transition?

A Ongoing assessments must be completed on all children in the FIT program. If for some reason an assessment has not been completed the transition conference should not be delayed. The need for assessment information in order for the LEA to determine eligibility for Part B would be addressed at the transition conference.

Q How do we update developmental levels without doing a complete new evaluation?

Transition

A Again, ongoing assessment of the child's development is required for all children in the FIT Program and the child's developmental levels are to be documented in the IFSP. An evaluation is only completed at the time of intake to determine the child's initial eligibility for the FIT Program, or a diagnostic evaluation through the Early Childhood Evaluation Program (ECEP).

Q If a child is age appropriate in all areas except speech, do we still need updated (within 6 months) information for the other domains?

A Yes. Again ongoing assessment of the child's development is required for all children in the FIT Program. This requires assessment of all developmental domains.

Q What happens when the Transition Conference keeps getting postponed? (Referral has been consented to but family keeps canceling conference and child is already 3.)

A The Service Coordinator should discuss with the family the requirement to have the transition conference with the LEA and if they refuse they should be provided with Prior Written Notice that early intervention services through the FIT Program will end at the child's third birthday.

Q What if family doesn't want a Transition Conference?

A See previous question

Q What if Part B says they cannot attend Transition Conference after school hours or beyond the regular school schedule?

A There is no requirement that the LEA attend meeting beyond the school day. However this should be discuss at the community transition team meeting to see if they will willing to accommodate families who work during the day.

Q What If consent is not obtained at Transition Conference?

A Service Coordinators should assist families to determine if they will sign consent for the evaluation to determine eligibility within one month of the transition conference.

Q Does the LEA test kids transitioning from Head Start to school?

A Yes. If the child was served in Early Head Start the child will receive an evaluation to determine eligibility for preschool special education.

Transition

Q Children who are medically fragile – do they automatically qualify for Part B?

A No children automatically qualify for IDEA Part B. All children must receive an evaluation from the LEA to determine eligibility for IDEA Part B.

Q Can the eligibility determination meeting and an IEP be done at the same time?

A It is unlikely that the LEA and the IEP to occur at the same time. Firstly the child must be determined eligible in order for the IEP meeting to be held. If the meetings are combined – the parent(s) must receive Prior Written Notice from the LEA that the eligibility determination and the IEP will occur.

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Q Part C needs date of eligibility determination meeting in order to continue Part C services right? Does this information need to be entered into data base?

A The documentation of the child's eligibility determination for IDEA Part B should include a date that the determination was made. If a date is not indicated on the documentation, the FIT Provider should use the date that documentation was received. The need for this date should be raised at the community transition team meeting.

Q What happens at the eligibility determination meeting if the LEA decides that more testing is needed and LEA has used up their 60 days – is there another timeline to conduct additional testing? How long?

A The child must be determined eligible by the child's third birthday.

Q Judy turns 3 on June 10 and must transition to Part B. Judy lives in a very rural community; the closest preschool program is an hour and fifteen minute bus ride each way for a half day program. This child would be eligible for the kindergarten program at the local school in the Fall of 08. The family said, if they keep her in the home, the school district services would be one time a month. Although the full assessment is not complete, it appears there are two or more areas of delay.

1) Can this child stay in early intervention until she enters a school near their home?

2) Can the school district determine services before the full assessment is completed?

Transition

A If a new service needs to be added to the IFSP, is the following process proper and efficient? “Add a line to the existing supports and services page with the update, have the parent initial and date it. This would be supported by the parents’ signature on the PWN form.”

Q Who is the contact at the LEA who receives notification?

A The notification should be sent to the Local Education Agency – Special Education Director, unless otherwise specified in the local transition Memorandum of Understanding (MOU).

Q Does BIE get included in the Notification?

A No. The Bureau of Indian Education is not responsible under the Individuals with Disabilities Education to provider preschool special education. BIE funded tribal programs are funded through IDEA to “assist the state in child find, screening, and other procedures for the early identification” The LEA has responsibility to provide special education and related services to children eligible for Part B §619. These special education and related services can occur at an inclusive Head Start or FACE program for Native American children.

Q Do we include the disability on the notification as outlined in our local MOU?

A No. The child’s disability or eligibility category is not needed at the time of the notification.

Q What if parents do not want their information released to LEA?

A There is not a way for the family to “opt out” of this notification. Of course the parent(s) can choose for there to be no referral that goes to the LEA

Q Can programs modify the referral form to include the age of the child at evaluation and the dates of the evaluation?

A No. Changes to the statewide referral form can not be made. Providers and LEAs can make recommendations regarding enhancements to the forms

Q Will there be a statewide form used for when a family refuses referral?

A No Service Coordinator should use a Prior Written Notice form to document that the parent

- Refuses services for their child to be referred to the LEA and that their early intervention
- Service through Part c would end at the time the child’s third birthday.

Transition

Q Will parents and FIT receive the evaluation report prior to the IEP?

A Yes. The family and FIT provider (with consent from the parent(s)) must receive documentation of the child's eligible for IDEA Part B before the child's third birthday and before the IEP is held.

Q If a child is determined eligible mid year, does Part C have to provide preschool readiness?

A The preschool readiness outcomes and strategies need to be added to the IFSP once the child turns 3, irrespective of when this occurs during the year.

Q If a child is not part of the extended Part C option and is not determined eligible for Part B, do we update IFSP to include preschool readiness?

A Yes. Preschool readiness outcomes and strategies need to be added to the IFSP once the child turns 3 for all children, even if they don't qualify for IDEA Part B.

Q In adding preschool readiness to the IFSP, do we do it immediately or at 6 month review or annual?

A Preschool readiness outcomes and strategies need to be added to the IFSP by the time the child turns three. If the Annual or 6 month review occur at this time the preschool readiness outcomes and strategies can be added at that time of that meeting, or it can be a separate meeting.

Q If IFSP expires 7/1/2010 and school doesn't start till 8/1/2010 does there need to be a new IFSP? (yr round vs. traditional school yr restrictions may apply).

A Yes. There needs to be an active IFSP for all children receiving services through the FIT Program. If the new IFSP will only be active for a month or so – much of the previous IFSP information can be carried forward to the new one.

Q Do post service coordination hours need to be added to the IFSP as a plan for billing purposes? Do we leave the IFSP open?

A Yes. The plan for service coordination follow-up needs to be added to transition plan in the IFSP. Once the child transitions the exit is recorded in FIT-KIDS. Providers can still enter delivered services and approve for billing services provided after the exit date.

Q Is there a comparable IEP invitation and corresponding timeline for Part B inviting Part C and family to the IEP meeting?

A Parent(s) must receive 5 days Prior Written Notice of the IEP meeting.

Transition

Q Who is responsible for sending the invitations for the IEP?

A The LEA is responsible for inviting all participants to the IEP meeting.

Q What is the process for filing a grievance regarding the IEP?

A The "Parent and Child Rights in Special Education: Procedural Safeguards Notice" must be shared with the parents by the LEA. This notice can be downloaded from the PED website www.ped.state.nm.us/SEB/index.html.

Q What if the IEP date comes and goes and no IEP has been held?

A The service coordinator should help the family contact the LEA to ensure the IEP is held at least 15 days prior to the child's transition to preschool.

Q Can LEA write IEP in May prior to transition in august but start date for IEP in August?

A Yes

Q If a child goes to school but decides that they don't like it, may they come back to FIT if it is before the child's 3rd birthday?

A Yes. As long the child is not yet age 3 they can return to the FIT Program. However, this should not be encouraged and with good transition planning this should be able to be avoided.

Q What information on the Evaluation Report is needed for documentation by the Service Coordinator?

A The documentation of the child's eligibility for Part B from the LEA needs to include that the child is eligible for IDEA Part B and the date that determination.

Q IN FIT KIDS, when asked to enter date of eligibility meeting, the system will only let you enter meeting date if answer is yes to eligible for Part B. Had an eligibility meeting where the child was not eligible for B so could not enter date of meeting. How do we enter the information?

A At this time FIT-KIDS only allows the user to enter the date of eligibility determination if the was determined eligibility. The ability to enter that the child was not determined eligible may be added to FIT-KIDS at a later date.

Transition

Q What if a child comes into the program late? (ex. 28 months old) How is it entered as code so that we are not at fault for late reporting?

A In the Annual Performance Report (APR) or the Community Based Assessment (CBA) the fact the transition conference could not be scheduled 90 days prior to the child's third birthday will not count against the agency.

Q If a child transitions to Part B and it is agreed upon that the child needs an extended school year, is it guaranteed that the child will receive this extended service?

A The child's need for Extended School Year (ESY) should be brought up at the initial IEP meeting. The need for ESY is decided upon on a case by case basis and is not guaranteed.

Q What if the parents want a inclusive classroom and the schools only offer a classroom with other children eligible for Special Ed?

A The service coordinator should help the family advocate for services to be provided in the Least Restrictive Environment. Parents Reaching Out (PRO) and EPICS may be able to help the parent(s) advocate for an inclusive environment (at least 50% children without special needs) for their child. The family has rights and procedural safeguards under IDEA Part B that can be used if the LEA does not provide services in the LRE.

Social work services includes--

(i) Making home visits to evaluate a child's living conditions and patterns of parent-child interaction;
(ii) Preparing a social or emotional developmental assessment of the child within the family context;
(iii) Providing individual and family-group counseling with parents and other family members, and appropriate social skill-building activities with the child and parents;
(iv) Working with those problems in a child's and family's living situation (home, community, and any center where early intervention services are provided) that affect the child's maximum utilization of early intervention services; and
(v) Identifying, mobilizing, and coordinating community resources and services to enable the child and family to receive maximum benefit from early intervention services.

Service coordination means the activities carried out by a service coordinator to assist and enable a child eligible under this part and the child's family to receive the rights, procedural safeguards, and services that are authorized to be provided under the State's early intervention program.

(2) Each child eligible under this part and the child's family must be provided with one service coordinator who is responsible for--
  (i) Coordinating all services across agency lines; and
  (ii) Serving as the single point of contact in helping parents to obtain the services and assistance they need.
(3) Service coordination is an active, ongoing process that involves--
  (i) Assisting parents of eligible children in gaining access to the early intervention services and other services identified in the individualized family service plan;
  (ii) Coordinating the provision of early intervention services and other services (such as medical services for other than diagnostic and evaluation purposes) that the child needs or is being provided;
  (iii) Facilitating the timely delivery of available services; and
  (iv) Continuously seeking the appropriate services and situations necessary to benefit the development of each child being served for the duration of the child's eligibility.
    (b) Specific service coordination activities. Service coordination activities include--
      (1) Coordinating the performance of evaluations and assessments;
      (2) Facilitating and participating in the development, review, and evaluation of individualized family service plans;
      (3) Assisting families in identifying available service providers;
      (4) Coordinating and monitoring the delivery of available services;
      (5) Informing families of the availability of advocacy services;
      (6) Coordinating with medical and health providers; and
      (7) Facilitating the development of a transition plan to preschool services, if appropriate.

Service Coordination vs. Social Work

Q Joan, an EC Coordinator (manager), has noticed that over a period of time, one of her service coordinators, Allison (who is a social worker), has been logging about 8 to 10 hours of service coordination each month on several of her families. She is pretty concerned, as reimbursement rate is only $155.00 a month for this service, but understands that Allison is serving some of the most challenging families, as she does well in this area. What might Joan look at to alleviate this concern?

A Joan might want to take a closer look at what is actually being provided under “service coordination.” It is possible that when hours become excessive, it is actually “social work” that is being provided. Social Work does, at times, require some brokerage of services. Service coordination is based on an average of 2-3 hours per month.

Service Coordination vs. Social Work

Obviously, in order to bill for "social work" one needs a licensed social worker to provide the service, and it needs to be written into the IFSP to address particular outcomes. For example: "Nancy will work with the social worker in order to find more permanent/stable housing for her family."

The language from the box entitled "**Social work services**" above describes the regulations may be useful in helping to distinguish these services

Q Can a family have multiple service coordinators working on their case as long as they are all working for the same agency?

A The service standards state that "A family will have only one service coordinator, designated on the IFSP." While the intention is that they would have only one individual, not one agency, doing service coordination, we will make that clarification in the SD & S stronger. The new wording will read, "Whenever the service coordinator changes (the original SC is no longer employed, is taking a leave of absence, etc) the family must be informed and agree to the new individual assuming the service coordination."

Q Our agency received a transfer of a child last month. We provided well over the minimum hour of service coordination, but when we tried to bill for it, FIT KIDS would not let us.

A This is due to the timing of the transfer of the child. When the service coordinating provider changes during the month, if it occurs after the 15th of the month, the "original" service coordinator is authorized to bill for that month. If it occurs before the 15th of the month, then the new service coordinator bills for the entire month. Providers shall not postpone the transfer of a child until after the 15th of the month in order to bill

Q What do I need to do to get a Service Coordinator Waiver for my Staff?

A In accordance with DDSD Service Definitions & Standards, a Service Coordination exemption can be approved by DDSD when an agency has not been able to hire a staff person with the required qualifications but who meet the cultural or linguistic needs of the population served or if the applicant is a parent of a child with special needs (NOTE a parent cannot be paid to provide service coordination to their own family). The agency should submit a letter to the FIT Program requesting an exemption. The letter should outline the specific requirements prompting the exemption request. Upon approval, the FIT Program will issue an exemption letter exempting which should be kept on file for billing purposes.

Q Can an EI program bill for service coordination activities, such as completing the Exit ECO and the Discharge Summary, the same day (or after) the child begins services on an IEP with the public schools?

Service Coordination vs. Social Work

A Yes. In accordance with DDSD Service Definitions & Standards, Service coordination may be reimbursed for up to three (3) months after the child has successfully transitioned to preschool or another appropriate setting. This option is available to ensure that the transition process is smooth and effective and must be agreed upon by the family and documented in the IFSP transition plan. In order to be reimbursed a minimum of one hour per month must be provided.

Q Is there a maximum number of cases for a service coordinator to carry?

A The FIT Program does not currently have a maximum case load requirement for service coordinators. Neither the federal nor state regulations offer guidance on what constitutes a maximum, minimum, or typical caseload for a service coordinator. However, the National Early Childhood Technical Assistance Center (NECTAC) surveyed a number of states to learn about case loads. Information and excerpts from their article, "Service Coordination Caseloads in State Early Intervention Systems" by Jocey Hurth may be helpful in determining these requirements for your agency.

> **Co-treatment** where more than one early intervention personnel provides intervention to the child/family at the same time is reimbursable if it is documented in the IFSP as one of the strategies to be used to meet the child/family outcome(s). This approach allows for transdisciplinary and interdisciplinary practice to occur, enhances the integration of services and promotes a primary service provider model. Co-treatment is reimbursed based on the location where the activity occurred

Co-Treatment

Q Eliza, a SLP, sees a benefit to providing treatment along with the OT at the same time, in order to address the swallowing and sensorimotor needs of a young child, Robert. How does she bill for co-treatment? What documentation is needed in the IFSP?

A Co-treatment is reimbursed based on the location where the activity occurred. Each EI discipline bills for their own time spent providing their service with the family.

It needs to be documented in the IFSP as a strategy to meet the child/family's outcome. It should also state that co-treatment will enhance the integration of services. It does not need to be listed on the services page as a separate service.

Q Does co-treatment have to be provided by separate disciplines?

Co-Treatment

A It would be rare that two people from the same discipline would provide co-treatment. There are cases where it could happen, in which case it must be well justified as a strategy in the IFSP as a way to meet a particular outcome. (see the question below as an example)

Note: This should not be used to bill for the supervision of a PT assistant or COTA.

Q Tammy, a speech therapist, is seeing Joseph for speech therapy. Tammy would like another speech therapist to see Joseph for his feeding issues. Tammy and the new speech therapist do a home visit with Joseph. Can both speech therapists bill for the same home visit?

A Yes, because both therapists are working with Joseph at the same time. Both services are written on Joseph's IFSP and co-treatment is listed as one of the strategies to be used to meet the child/family outcomes. One therapist is working on speech concerns and the other on feeding issues.

Q How do 2 different agencies bill for co-treatment?

A Assuming they are both listed on the child's IFSP, each agency bills for their staff's time.

Q If two different Programs bill the same code for the same child on the same day, why does the program who bills first get paid and the other claim gets denied?

A This depends on which code you are referring to. For example Service Coordination can only be paid once per month, and whoever bills first on this will get paid. More guidelines on SC transfers can be found in the section of "Transfer of Services" of this document.

However, if you are referring to co-treatment, you should be able to bill the same code for the same child for the same day. Medicaid has an report that is generated when two providers bill for the same child on the same day – however they will typically allow both claims to be paid.

Q Can an SLP and a DS each bill for 1 hour of direct service provided to a child (joint visit, each service is written into IFSP)?

A Both the SLP and the DS can bill for their co-treatment so long as it has been documented in the IFSP as one of the strategies to be used to meet the child/family outcomes.One point of clarification on co-treatment vs. joint visit. If a "joint visit" simply refers to the SLP and the DS driving to the visit together and being present while each is providing service – that is not co-treatment. If they are car-pooling to the visit, then the DS would need to provide those units of service and the SLP would provide those units of service-one after the other.Again, Co-treatment needs to be documented in the IFSP and means that both the SLP and the DS have a purpose in working together in order to meet the child/family outcomes. Please refer to your service definitions and standards for information on this issue.

The Comprehensive Multidisciplinary Evaluation is designed to inform the eligibility determination process through a timely, non-discriminatory, comprehensive and interdisciplinary approach. The evaluation is designed to determine the developmental status of the child and must cover the following developmental areas:

- Cognitive
- Physical/ motor (including vision and hearing)
- Communication
- Social or emotional
- Adaptive behavior

This service includes activities provided by early intervention personnel in order to complete an initial comprehensive multidisciplinary developmental evaluation (in accordance with 7.30.8 NMAC) for children who are referred to the FIT Program. Evaluation personnel should have a background in child development and be trained in the tool they are administering.

Evaluation

Q Maria, a Service Coordinator with EVR agency, has been referred a child who appears to be eligible for FIT services in the environmental risk category. Does she still need to do a comprehensive multidisciplinary evaluation before the family's IFSP is conducted

A Yes, all children, regardless of their eligibility category, must have a Comprehensive Multidisciplinary Evaluation (CME) prior to doing the IFSP

Q With the number of children Maria is being referred from CYFD due to CAPTA, she is really

struggling with getting all the evals done. Is it okay to send the child for an ECEP eval?

A No. ECEP evals are quite expensive and should be reserved for children where there are complex medical / developmental issues, a need for a diagnostic evaluation that involves a physician or diagnostician (such as Autism) or where a specialty role is not available in the local community

Evaluation

Q Fred is a Service Coordinator who has worked with 16-month-old Bart and his family, who were referred because they had concerns about their son's development. The comprehensive multidisciplinary evaluation that Fred arranged showed that Bart had a very slight delay, but not enough to make him eligible for the FIT Program. Fred feels pretty certain that if they monitor Bart, he will eventually show enough of a delay that he will be eligible, so he is reluctant to close Bart's case. Should he keep Bart and his family enrolled in the program and continue to monitor Bart, or should he close them and tell them to come back later if they have a concern about Bart's development at a later date?

A Definitely, Fred should close Bart and his family from the FIT Program. However, he may wish to contact the family from time to time to see how Bart is doing. Fred could send the family an Ages and Stages Questionnaire (ASQ) or PEDS screening tool periodically for the family to complete. If at least 6 months have passed from the last evaluation, Bart can be re-evaluated (assuming he is still under the age of 3) and the evaluation can be billed again.

Q If a parent withdraws their child from the FIT Program and later is re-referred for concerns about development – can we do another Comprehensive Developmental Evaluation and how do we bill for this?

A As long as the child has been out of the FIT Program for at least 6 months, a full Comprehensive Developmental Evaluation can be completed (if it was less than 6 months an updated assessment would be completed). The CME can be billed through FIT-KIDS after the child is re-enrolled.

Q Can we re-evaluate a child that was recently evaluated at another EI agency?

A No. A child and family should have only one comprehensive multidisciplinary evaluation to determine eligibility. If a family is asking to be re-evaluated after disagreeing with a previous eval, they should be informed of their rights so they can request a hearing. If a provider agency becomes aware that the child has already been evaluated by another provider agency, it is recommended they contact that other agency to get a copy of that evaluation.

Q If a child is evaluated and determined not eligible, could we do an evaluation every 6 months until the child is eligible or turns 3 years and bill the full amount?

A When determining whether to re-evaluate a child, you should use some professional judgment and/or developmental screening results to influence your decision. It is not appropriate to simply re-evaluate every 6 months automatically. If the child is referred back to you because there are concerns, you should re-evaluate.

Evaluation

Q When ECEP does an eval, the report doesn't come until 1 to 2 months later, which impacts the 45-day timeline. Is that justification for delaying the IFSP?

A This is not justification for delaying the 45 day timeline. Even if the written report is not done within the time period, the eval team can usually provide preliminary results (a draft of recommendations can be requested from ECEP) to inform IFSP team members in determining eligibility. This is particularly true if members from the evaluation team are present at the IFSP.

Q How long are evals good for?

A It would be pretty difficult to say "how long an eval is good for", when children grow and change at such a rapid rate. Once a child has had a comprehensive multidisciplinary evaluation, we require regular assessments throughout their service period.

If a child is found ineligible for services, s/he can be re-evaluated in 6 months

If this is a transition question, schools require that the assessment is less than a year old.

Q Billy needs to have a hearing screening for the Comprehensive Multidisciplinary Evaluation (CME). Can we bill for this in addition to the CME?

A No. Assessment of a child's hearing and vision are part of the CME and cannot be billed separate from the $625.00 for evaluations. Note: ongoing vision and hearing screening / assessment can be billed separately.

Q Can Billy's provider bill for a subsequent hearing screening at Center-Individual, if it's listed on the IFSP?

A Yes. If there are flags for the child around hearing, you can bill under the location code for where the screening occurred. The service would be coded as Eval. & Assessment in the database.

Q Can the DS, SC, and therapist's bill for the write up of an evaluation or assessment?

A No. The writing of the evaluation is included in the Comprehensive Multidisciplinary Evaluation (CME) rate. Also, the write up of an ongoing assessment is included in the rate of the direct service provided.

Q Is it appropriate to bill when participating in an ECEP evaluation?

Evaluation

A Only if you are contributing to the evaluation, not as an observer.

Q Can I do an evaluation even if I haven't been trained in the instrument being used?

A No, you must be trained to use the tool and to score it appropriately.

Q When can CME be repeated?

A If a child is evaluated and determined not eligible, or exits the FIT Program and, due to concerns is referred again to the FIT Program at least 6 months after the previous evaluation, the provider may bill for an additional comprehensive multidisciplinary evaluation.

If the CME cannot be completed before the child moves to another community e.g. they are in temporary housing (Shelter, foster home etc.) time spent conducting the evaluation can be billed as ongoing assessment under Early Intervention.

Q Can a COTA do an evaluation or assessment?

A No. A licensed OT (not OTA) must conduct an evaluation. The OTA can participate in the assessment activities.

Q Can I bill Evaluation for Therapists or Developmental Specialist assessment separate from the CME rate of 625.00?

A No, This rate covers the work of multidisciplinary evaluation team members in conducting direct assessment activities, administering instruments and tools with child and family, reviewing records and/ or reports, and writing the comprehensive developmental evaluation report.

Q Can I bill the CME even if the reports is not compete yet?

A While the Evaluation Summary Form. may be used, this unit cannot be billed until the full report has been written.

> Supports and services should be incorporated into the family's everyday routines, activities and places. The Contractor must ensure that all services must be provided in natural environments, defined as places that are natural or normal for
>
> children of the same age who have no apparent developmental delay.
>
> All services must be delivered in accordance with the frequency and intensity indicated on the IFSP.

Individual Family Support Plan (IFSP)

Q	When we are writing services on the IFSP, is there a preference for writing the frequency in weekly, monthly or quarterly terms? It is more responsive to the families if we can allow more flexibility and write services in monthly or quarterly terms, but we are told in service coordination training that it has to be written in weekly terms. Also, the regulations don't say anywhere that it must be written in weekly terms.

A	While most services on an IFSP should be listed in the amount that they will receive weekly, the service may be written in terms of the monthly amount, but it needs to have the intensity listed clearly. For example, instead of writing "60 minutes, once a week," you could write "60 minutes, 4 times a month". This is still clear to the family regarding what they are receiving. **Avoid rolling up services into a quarterly or annual basis.**

Q	How can we update an IFSP to be responsive to crises that arise requiring immediate change? Must we have prior notice?

A	The IFSP is not a static document, and changes will be required, sometimes on short notice, to respond to the family's needs. If the crisis involves a one-time visit (e.g. a social work assessment or counseling visit) a change to the IFSP can be made simply by adding a line on the supports and services page of the IFSP, reflecting the start and end date for this brief period and must be added to FIT-KIDS as a 1 X year. It does not require an entire team meeting, but may involve only the parents and the service coordinator. Prior Written Notice must always be given to the family to ensure they are informed of the service, and to get their consent to the service.

Q	Is attendance at an IEP meeting considered direct service or consultation?

A	The IFSP is not a static document, and changes will be required, sometimes on short notice, to respond to the family's needs. If the crisis involves a one-time visit (e.g. a social work assessment or counseling visit) a change to the IFSP can be made simply by adding a line on the supports and services page of the IFSP, reflecting the start and end date for this brief period and must be added to FIT-KIDS as a 1 X year. It does not require an entire team meeting, but may involve only the parents and the service coordinator. Prior Written Notice must always be given to the family to ensure they are informed of the service, and to get their consent to the service.

Q	Is attendance at an IEP meeting considered direct service or consultation?

A	Attendance at an IEP or an IFSP meeting does not need to be written into the services page of the IFSP and therefore the team does not have to predict how many hours of attendance at IFSP or at the child's initial IEP would occur in the year. Attendance at the IEP meeting should however be written into the transition plan.

In terms of billing, a Service Coordinator can count that time toward the monthly minimum of 1 hour. Other EI staff should bill for their time as direct service based on the location of the IFSP or IEP meeting.

Individual Family Support Plan (IFSP)

Q When a child is not eligible for services, can the IFSP team still conduct a meeting with the family and review information, make referrals as appropriate, and fill out the first page of the IFSP and mark ineligible?

A The service coordinator can meet with family to explain the results of the evaluation and that their child does not meet the eligibility criteria for the FIT Program. The SC must explain the family's rights to due process under IDEA Part C and State regulation. The SC can help the family with referrals to other service systems. An IFSP must not be opened for a child who is determined to not be eligible for the FIT Program. SC and the Comprehensive Multidisciplinary Evaluation (CME) are the only services that can be provided to a child who is determined not be eligible for the FIT Program.

Q Billy who is 3, is in our EI program; his Annual IFSP expires shortly before he is scheduled to transition. Can we continue to bill with the same IFSP?

A No. You must generate a new Annual IFSP; however, outcomes and strategies may be revised and/or forwarded from the old IFSP if the child will soon transition out of the FIT Program.

Q If a new service needs to be added to the IFSP, is the following process proper and efficient? "Add a line to the existing supports and services page with the update, have the parent initial and date it. This would be supported by the parents' signature on the PWN form."

A Yes, this was decided when FIT KIDS came online, as it forced the issue that every service, even if offered only once, had to be on the IFSP. Programs were advised to handle minor changes in this way versus constantly trying to create addendums and keep track of them.

Q When we get a new family from another EI program, do we use the existing IFSP? The referral date and the IFSP date won't match? Do we need to re-do the IFSP or use the original referral date?

A Best practice would indicate that families, whether they are coming from another agency in New Mexico or coming from out of state, would have no gap in services during their transfer. If a family has an existing IFSP, they will bring it to the new agency or their current service coordinator may send it ahead of time. The receiving provider agency will update it with their own service coordinator and begin providing services immediately. If the transfer is occurring within New Mexico, the "transferring" agency would not close the family from their services until the day of the new updated IFSP from the "receiving" agency. At the very least, the receiving agency should be helping the family to transfer as soon as they get the referral and not make the family wait until services have been discontinued from their previous provider. Once the family has settled into their new home the team may decide to develop a new IFSP to look at the mix of supports and services the child now needs or they may decide to wait until the next annual IFSP date

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Individual Family Support Plan (IFSP)

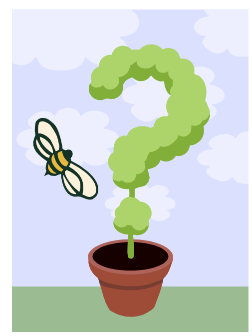
Unfortunately, the current set-up of the FIT Database software does not allow for electronic data to be transferred from one agency to another. The receiving agency will need to re-enter all the eligibility, IFSP and demographic information into the database. In addition, if the IFSP in question is an "Initial" IFSP or the child has not yet had their initial IFSP but has been determined eligible by the transferring agency, the receiving agency should enter the date the child starts with their agency as the Date of Referral rather than the original date of referral to the FIT Program. The Eligibility Date and the Start Date of the Initial IFSP should be the same date as well. This will avoid having the receiving agency appear to have not met the 45-day timeline.

Q If a new service needs to be added to the IFSP, is the following process proper and efficient? "Add a line to the existing supports and services page with the update, have the parent initial and date it. This would be supported by the parents' signature on the PWN form."

A Yes, this was decided when FIT KIDS came online, as it forced the issue that every service, even if offered only once, had to be on the IFSP. Programs were advised to handle minor changes in this way versus constantly trying to create addendums and keep track of them.

Q What is the nature of the changes in the IFSP – how many changes have to occur to make a new IFSP? Family moves to a different program. The IFSP's don't transfer in the data system. The ECO will stay the same. On a re-enrollment the ECO would stay the same.

A If the family moves out of the community and then returns (6 weeks later)? There has already been a CME and an initial. There is an annual IFSP issued. May use the same pages, but will reset the dates. IFSP dates have to be continuous. There can be no gaps or overlaps in the dates. If the family moves from another state and wants to continue. Each state has their own eligibility so they would need an initial IFSP to determine NM eligibility. If the family moves and has a new address there is a change to the cover sheet.



Q If we have a service that we don't want to begin before 90 days on the IFSP, how do count that toward our compliance on the 30 day timely delivery.

A Indicator 1 is based on "start dates" for each individual service on the IFSP. When planning services for the IFSP, it is important to record on the supports and services page when services are planned to begin. Most services have start dates that begin on the day of the IFSP meeting. However, if you don't want a service to begin until 90 days later, use 90 days later as the start date for that particular service. Then, when calculating compliance for Indicator 1 on the APR, the agency would always work off of the "start date" and determine if services were delivered within 30 days of the start date, whenever that is.

Individual Family Support Plan (IFSP)

Q Does the IFSP have to remain stapled and intact in the child's file? (meaning that, for example, the transition pages cannot be in a separate section of the file)

A The transition pages are part of the IFSP, therefore they must be included in the IFSP in the child's record. If the agency has a transition section of the child's record a copy of the transition pages can be included there also.

Q Can the requirement for the number of IFSP meeting participants be met by counting the 3rd person as participating by phone or contributing a report?

A There always has to be that 3rd person present (face to face) at an initial or annual IFSP. Even if there is participation from team members in other forms, such as a phone call or a written report, the minimum number of people present is as follows:

1. Parent/Caregiver;
2. Service Coordinator; and
3. Someone from the evaluation team or someone who will be providing services to the child/family.

Q If, for some reason we do not get the hearing screening done at the time of the CME, do we need to list it on the IFSP supports and services page?

A A hearing screening must be included as part of the CME. On rare occasions, there may be a delay in getting the hearing screening conducted for the CME, and rather than hold up the IFSP waiting for this to occur, a decision may be made to go ahead with the IFSP meeting. **In this situation, do not list this hearing screen on the supports and services page of the IFSP.**

However, if you are planning ongoing annual hearing screenings, they need to be listed on the supports and services page with the service provider who is actually performing the screenings and the frequency, the outcome it addresses, etc.

Early Childhood Outcomes (ECO)

Early intervention services include the ongoing delivery of support provided to families in order to enhance their ability to meet their child's development. Early intervention services are provided within everyday routines, activities and places of the child and family. Early intervention services are selected in order to meet the child/ family outcomes that are decided on by the IFSP team.

Ongoing assessment of the child includes the ongoing procedures used throughout the child's eligibility for the FIT Program to identify the unique strengths, needs, and developmental functioning, including assessments conducted for the NM - **Early Childhood Outcomes (ECO)** reporting.

Q IF Part B doesn't want our exit ECO, why are we doing it?

A The exit ECO data is used to compare to entry data in Part C and will help determine the effectiveness of Part C services.

Q If a child stopped services and already had an initial and exit ECO entered and decides to come back into the program, how do we enter the ECO information?

A At this point (June 2010) it is a rather cumbersome process in FIT-KIDS, but we hope to have this changed soon. Until that change occurs though, you must do the following:

- If the child has been out of the program less than 6 months, use the original entry ECO rating with the original date. When they exit again, you will have to edit the original exit date and rating.
- If the child has been out of services for over 6 months, when the child re-enters the program edit the entry ECO date and rating also (and of course, the exit rating and date when they exit again.)

Q Do parents have to be present for an exit ECO meeting?

A If the parent is still available at the time of the exit, then yes. Unfortunately, there are times when families exit the program without notice to the provider agency. In those instances, an exit ECO still must be conducted, but the parent will obviously not be present. The rest of the team should convene to determine an exit rating prior to closing the case in FIT-KIDS.

Q I know that in some states, annual ECOs are not required. Why are we required to do them in New Mexico?

Early Childhood Outcomes (ECO)

A When OSEP mandated that we start collecting outcome data, we pulled together a large stakeholder group to shape how our data collection system in New Mexico would work. This group was made up largely of FIT Providers. It was this group's decision to collect outcome data at times that aligned with activities that were already occurring – hence the data is collected at every IFSP.

Additionally, we intended to use the data collected for other methods besides just satisfying the OSEP mandate. By reviewing and recording outcomes annually, we could analyze that data to learn more about how children progress in our system in relation to a number of other factors that we currently have available, e.g. ICD9 codes, types of service, number of services, etc. Finally, the annual data collection has been a lifesaver, as we have discovered over the last two years. So many families are exited from the program unexpectedly, and no exit ECO data is collected. Very often, we can use the last annual ECO data as exit data, if it was collected within 6 months of the child's exit.

Q Some other states have elected to not collect outcomes data on children under 4 months of age. Why does New Mexico?

A Similar to the answer above. This was a decision of the stakeholder group, made up largely of FIT Providers. The belief at the time was that if we started collecting data at different points for different children, it would get too complicated. Providers would forget to collect the data on that 4 month old child that has been in the program since birth.

Infant Mental Health

> Family training and counseling for child development, including Infant Mental Health (IMH) and early intervention, provided for the bio-psychosocial and emotional well-being of infants, toddlers and children in relationship with their caregivers, environment and culture, and with respect for each child's uniqueness.

Q What type of certification does staff need in order to bill for mental health or behavioral health services?

A A person may bill for psychological service, social work, family training and counseling, as long as they work under the scope of practice outlined in the rules & laws of their specified licensure.

Q Can a Developmental Specialist (DS) bill for mental health services?

Child Abuse Protection and Treatment Act (CAPTA)

A While Infant Mental Health (IMH) is not an EI service, promotion, prevention and intervention practices are strategies a DS may utilize when working with a family. (Refer to IMH & IDEA Part C Position Paper by Infant Toddler Coordinators Association for IMH approaches in early intervention) However, IMH treatment may only be provided by a licensed Mental Health professional.

Q What if the DS is not licensed, but has expertise and training in the Infant Mental Health field?

A If the DS is not a licensed Mental Health professional, but has training & expertise in attachment and bonding, he/she may be listed as additional Special Instruction in this area on the IFSP service page, with separate frequency and intensity. However, as stated above IMH treatment (such as family therapy) may only be provided by a licensed Mental Health professional.

Q Jane, a service coordinator, received a referral from CYFD. The child referred does qualify for the FIT program. The CYFD worker explains that she can sign for all the paperwork that the FIT Program needs.

Can the CYFD worker sign the paperwork for the FIT program?

A No. Under the IDEA guidelines, a surrogate parent has to be assigned for the child. A state worker cannot sign as a surrogate parent. The assigned surrogate parent should sign the paperwork for the FIT program. There are several E.I. agencies that have both the assigned surrogate parent and the CYFD worker sign needed paperwork.

Q Are early Intervention services mandated through CAPTA?

A No, only the referral. All services are voluntary and the families have the choice to accept services or decline them.

Q Following an evaluation, it is determined the child does not qualify for services, therefore there is no IFSP written. Two months later the child is referred by CYFD. A number of life changes have occurred since the original referral was made. Since it has been less then six months the program is aware they can not bill for a new CME. Therefore, the program reviews the original evaluation and updates the Environmental Risk Assessment (ERA) tool. The child now meets the eligibility of Environmentally at Risk.

How is this documented in the file? Also, what would be billable prior to the development of the IFSP, and how is this entered into the data base?

Prior-Approval to Exceed 14 Hours Monthly

A The provider should write an amendment to the first CME, and keep that filed with the original CME for auditing purposes. Supporting documentation would go in the provider notes.

Billing, of course, depends on who is completing the ERA. If it is the service coordinator, it just gets counted as time toward the month's hourly rate of service coordination. However, if someone else completes the ERA, this can be billed and entered in FIT-KIDS as Evaluation and Assessment.

Q Karen, a service coordinator, is working with Kate and her family. Kate is a child that has Autism and the IFSP Team has decided that she needs services that will add up to be over 14 hours a month.

Does the Service Coordinator need to fill out a prior approval form since services offered will be over 14 hours per month? Do the services need to be listed on the IFSP? Can the services be listed on the IFSP in quarterly time?

A Services over 14 hours per month do need to be approved by a Regional Manager of the FIT program. The Service Coordinator would just need to fill out a prior authorization form and send it in with the current diagnosis, current IFSP, current evaluation, therapy reports, and any other information that would show why there needs to be more that 14 hours of service per month.

Services need to be listed on the IFSP as monthly or weekly so that the hours reflect the services that will be given on an on going basis. Prior authorization requests that have monthly or weekly services listed in quarterly time will be denied.

Q Karen has submitted all of the above information correctly and received approval from her regional manager to provide more than 14 hours of service for Kate and her family. After the approval expires (usually in 6 to 12 months), she needs to request approval again to continue services at this level.

Is it necessary for her to provide the evaluation and current IFSP with each request, since it has already been sent previously?

How do I add the hours on the services page to know whether I need prior approval?

A Convert the time planned for each service into hourly units. If it is a weekly service, multiply that times 4; if it is a twice monthly service, multiply by 2, etc. Then, add them all up (except for service coordination & respite). If the hours exceed 14, then a prior authorization is required.

Q When do we change over from 19 hours to 14 hours to the Prior Approval?

A It is expected that you would do this at the time of the Annual IFSP. This will give time for parent discussion as well as preparation for chanfes to service.

Discharge & Re-Enrollment

Q Kylie has been receiving services from her local E.I. agency for a developmental delay. The IFSP team has found that Kylie is now not showing any delays in her development and is now ineligible for the FIT program. Should Kylie be discharged from the FIT program? Can Kylie ever have another evaluation if she starts showing signs of a delay?

A If Kylie was eligible for the FIT program due to a developmental delay, and she is no longer delayed, she should be discharged and her file would be closed. As long as the child is under three, there could be another evaluation (at least 6 months later) if the child is again referred due to concerns.

Prep Time

Q Angie, a DSII finds that when she is about to conduct a home visit with Gina and her family, she needs a great deal of preparation time due to the complexities of Gina's condition. She often spends an hour a week researching methods for working with Gina. Can Angie bill for this prep time?

A No. When the rates were created, prep time was bundled into the cost of the face-to-face encounter. While Angie is spending a great deal of time on her research, it is assumed that there are other cases that require much less prep time so that it evens out

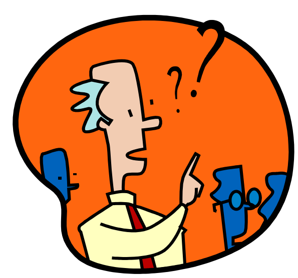
Q Can we bill for prep time for assistive technology or for prep time to develop a family plan to help families provide support to their child (i.e., child with ASD-part of 25 recommended hours of service is provided by parents) i.e., prep time that results in a "product"

A At this time, no, you cannot bill for prep time for assistive technology or to develop a family plan. However, This is something that we will be looking at in the future. Remember, if you are doing your prep with the family present (example developing a picture board), and it is on the IFSP, then it is billable.

Q Can a provider bill for new staff to review children's records prior to providing services?

A No. This is part of new staff orientation and training and is consider prep time which is not billable.

Transportation



Q Can Early Intervention providers bill for Transportation services?

A Transportation can be provided to assist the family to receive an early intervention service provided outside

The agency such as; Audiologist, WIC (nutrition), wheelchair clinic (PT), family therapy, etc. The provider may bill for the time spent transporting the child and family to that service. This would be billed at the Home/Community (Individual) rate. Transportation is included in the 14 hrs for prior authorization.

The provider may not bill for transportation to get families to EI services provided at their center. If the agency is requiring that the family come to the center to receive an EI service – the agency must offer to reimburse the family so that they do not incur travel costs.

Respite

Q Jenny, a service coordinator, is working with a family that is requesting respite services for their child. The family wants respite at least three times a week.

Can the family solely choose how many hours of respite their child will receive?

A No, the IFSP team (the parents are a part of this team) will decide the needed respite services for the child. The respite services have to be listed on the IFSP and there has to be a strategy written for respite services used to meet the child/family outcomes.

Transfer of Service

Q If a child moves from one EI agency to another and Service Coordinators from both programs consult regarding the child, can both service coordinators bill for services? If not, who bills?

A There can only be one service coordinator at a time, so whoever is listed as the SC on the IFSP will do the billing. Also, there is no "consultative fee" for service coordination, as the service coordinator listed on the IFSP is the only one who could bill.

If service coordination switches during the month, the general guideline has been that if it occurs after the 15th of the month, the "original" SC bills for that month. If it occurs before the 15th of the month, then the new service coordinator bills for the entire month.

Therapy Services

Q Do OT's need to sign off on the work of a COTA

Therapy Services

A Yes "Supervision" according to licensing and regulations, means the typical oversight required for individuals at the various levels of role performance. Supervision is a shared responsibility. The supervising occupational therapist (OT) has a responsibility to provide supervision to occupational therapy assistants (OTAs), persons practicing on a provisional permit, and occupational therapy aides/technicians. The supervisee has a responsibility to obtain supervision.

"On-site supervision" means a minimum of daily direct contact at the site of work with the licensed supervisor physically present within the facility when the supervisee renders care.

The supervising occupational therapist shall co-sign any and all patient treatment notes while the Supervisee is practicing on a provisional permit.

[NMAC - 16 NMAC 15.3.10, 06-29-00; A, 04-03-03]

Note: This applies to PTA's as specified under the licensing and regulations of the PT Board.

16 NMAC 20.7, 10-15-97; 16.20.6.8 NMAC - Rn, 16 NMAC 20.6.8, 08-31-00; A, 03-02-06]

Q Can a therapist provide services if they only have a provisional license?

A Yes, therapists can provide services using a provisional license number.

Billing Verification

Q Why do we have to verify client eligibility for our children who have private insurance? When I call to verify eligibility they do not have our tax ID number on file and cannot give me the information due to HIPAA privacy laws.

A The FIT Program bills health plans for up to $3,500 per year for children who are covered under private insurance. This means that it is important that the insurance information collected from the family is accurate. Calling the health plan helps verify that the information collected from the family correct (i.e. that the numbers were written down accurately) and that the child is still covered by that health plan.

When calling the health plan, please identify yourself s an out of network provider. You do not need a tax ID to obtain this information.

Q What about using professional ethics in using diagnostic codes when personnel are not medical professionals.

Billing Verification

A These are codes that are used for billing. COTA does procedure code. They cannot diagnosis. Therapists can diagnosis within their practice.

Once you have done a multidisciplinary evaluation you can diagnosis from Dev. Delay categories. (315 series) It has to be in writing. If it is not in writing to use 315.9 (unspecified delayed) for billing purposes. It can be changed later. If staff member is uncomfortable don't assign a code.

Q How do you bill for children who do not have Medicaid, or private insurance and need to see an Audiologist, or other ancillary service?

A The provider may sub-contract with an Audiologist or other ancillary service, and bill under the location code for where the screening occurred.

FIT-KIDS Database

Q I can't make a former staff member inactive in the FIT-KIDS database because she is listed as a Provider Manager. She is no longer with our agency. How would I inactivate her or who would I need to talk to do this?

A Only the FIT Data Manager (Albert) can add or inactivate Provider Managers in FIT-KIDS. Please send him the name of the individual and he will inactivate him/her.

Q We enrolled a child who is on Medicaid. Her Medicaid card has her last name spelled incorrectly. Mother will be trying to get it corrected. In the meantime, our experience with FIT-KIDS and Medicaid is that we need to spell the name as Medicaid shows it or Medicaid will not pay. When and if it is corrected, we then go in and change it in FITKIDS. Is that the understanding that you have?

A Yes, that is correct. Put whatever name Medicaid has into FIT-KIDS until it gets corrected in the Medicaid system – this includes incorrect DOB, SSN, and Name.

Q Is there a way to pull up a report showing which clients we have already entered Part B Eligibility Dates?

A No - not at this time. I would pull a Active Caseload by SC - then export to Excel - sort by DOB - then you can look up those kids over age three.

Sending Confidential Information

Q What is the FTP Site and How do I get there?

A The FTP site is a secure method of send and receiving data that can not be sent via email. The URL address for the FTP website is: ftp://164.64.82.115/

Records - Equipment

Q How often do we need to get hearing screening equipment calibrated?

A The equipment needs to be calibrated annually.

Q How long do we need to save therapy notes before they can be shredded?

A Medicaid records (see below) state that records must be retained for 6 years.

8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS: A provider must maintain all the records necessary to fully disclose the nature, quality, amount and medical necessity of services furnished to an eligible recipient who is currently receiving or who has received services in the past. [42 CFR 431.107(b)]. Services billed to MAD not substantiated in the eligible recipient's records are subject to recoupment. Failure to maintain records for the required time period is a violation of the Medicaid Provider Act. NMSA 1978 section 27-11-1, et. seq., and a crime punishable under the Medicaid Fraud Act, NMSA, section 30.44-5. See 8.351.2 NMAC, Sanctions and Remedies.

A. Detail required in records: Provider records must be sufficiently detailed to substantiate the date, time, eligible recipient name, rendering, attending, ordering or prescribing provider; level and quantity of services; length of a session of service billed, diagnosis and medical necessity of any service.

Record retention: A provider who receives payment for treatment, services, or goods must retain all medical and business records relating to any of the following for a period of at least six years from the payment date:

(1) treatment or care of any eligible recipient;

(2) services or goods provided to any eligible recipient;

(3) amounts paid by MAD on behalf of any eligible recipient; and

(4) any records required by MAD for the administration of Medicaid.

Clinical Opinion/Professional Judgment

The State Eligibility Committee defines "Informed Clinical Opinion" as:

The knowledgeable perceptions of the evaluation team who use qualitative and quantitative information regarding aspects of a child's development that are difficult to measure in order to make a decision about the child's eligibility for the FIT Program. Informed Clinical Opinion may be used to determine eligibility under the following criteria:

1. when results from the tools could not be used to determine 25% developmental delay; or
2. when there are inconstancies in the results of the evaluation; or
3. For children under 4 months of age

Informed clinical opinion shall not be used to override the developmental levels obtained through the approved state tool(s).

Q When is it appropriate to use clinical opinion ?

A "Informed clinical opinion is especially important if there are no standardized measures, or if the standardized procedures are not appropriate for a given age or developmental area."

1) A comprehensive developmental evaluation (all developmental areas, review of relevant records, at least two professionals representing 2 disciplines with the parents) <u>is required for ALL children who are referred, regardless of age</u>; and

2) ONLY for the developmental delay category and ONLY for children under 12 months of age, if the "multiple and appropriate procedures and activities" that are used do not show a clear 25% delay AND it is the professional judgment/clinical opinion of the team that the child's delays are significant enough to make him eligible under this category, then you can write that in the report and recommend that the child be considered eligible as developmentally delayed.

<u>**Professional judgment/clinical opinion of an interdisciplinary team is not to be used in lieu of the above evaluation process, to interpret and document evidence of delay significant enough for eligibility."**</u>

DS Certification/IDPD

Q Can a DS I determine whether a child has met their IFSP goals and are they qualified to document that in writing in the files?

A Since a DS I cannot develop the IFSP, including writing outcomes and strategies, they cannot determine whether a child has met their IFSP goals. However, the DS I should provide input to the IFSP team regarding his/her observations of the child's progress and abilities.

Q Can I still renew my DS certification even if it has lapsed/expired, or I have not worked in EI for a time?

A Yes, You can still renew, however if it has expired and you are still working with EI, you can be suspended until it is renewed with required documentation. It will also be "back-dated" to reflect the gap. If you have not worked in EI for 6 months or longer, we would consider this an initial application, so that the 75 hours of CEU would not count against you.

Q What if my required documentation is submitted to the FIT Program at different times? Will this take a longer amount of time to certify?

A According to the DS Policy, all documentation must be received before we can proceed with the DS process. We have 30 days from the receipt of all required documentation to certify an applicant.

Q Can I fax my DS information?

A For Re-Certification, Faxed information is fine; we do not need original transcripts, since this is already in your file. You must have a) the Re-Certification Application; and b) the tracking forms completed with 75 hours of documented training with supervisor initials.

However, for Initial Certification, You must submit a) Official Transcripts, (these can not be copies and the envelope for the University should be unopened) b) initial application.

Q How do we write a plan for mentorship if it is one of the strategies listed in the IDPD?

A A plan for mentorship is included in Appendix D of the DS Certification manual that all agencies have a copy of (Note: this will soon be available online at www.fitprogram.org

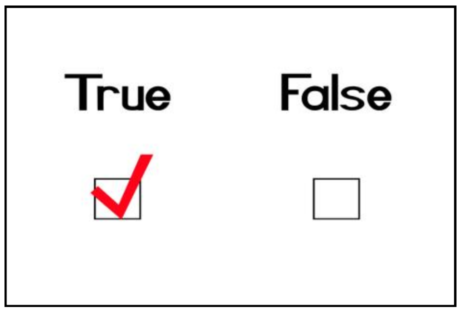
Q How do you calculate college credit into contact hours?

A One college credit is equal to 10 contact hours. Therefore a 3 credit college course would be equal to 30 contact hours.

DS Certification/IDPD

Q Does a therapist have to be a DS to provide EI? What if they bill only for their discipline?

A Anyone, who is billing for Special Instruction, is required to hold a current DS certificate (except licensed professionals who bill for less than 40% of their time as a DS). This includes DS sub-contractors, as well.



NEW MEXICO DEPARTMENT OF HEALTH

NEW MEXICO Family Infant Toddler Program