



# ***FIT Scenarios (Q & A)***

**FIT-KIDS:**

1.	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	<i>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.</i>
2.	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	<i>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.</i>
3.	Q	Is there a way to pull up a report showing which clients we have already entered Part B Eligibility Dates?
	A	<i>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.</i>

**Developmental Specialist Certification:**

4.	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	<i>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.</i>
5.	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	<i>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.</i>
6.	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	<i>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.</i>
7.	Q	Can I fax my DS information?
	A	<i>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.</i>  <i>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.</i>
8.	Q	How do we write a plan for mentorship if it is one of the strategies listed in the IDPD
	A	<i>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 <a href="http://www.fitprogram.org">www.fitprogram.org</a>)</i>

## FIT Scenarios (Q & A)

### Early Childhood Outcomes:

9.	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	<p><i>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.</i></p> <ul style="list-style-type: none"> <li>• <i>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.</i></li> <li>• <i>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.)</i></li> </ul>
10.	Q	Do parents have to be present for an exit ECO meeting?
	A	<i>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.</i>
11.	Q	I know that in some states, annual ECOs are not required. Why are we required to do them in New Mexico?
	A	<p><i>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.</i></p> <p><i>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.</i></p>
12.		Some other states have elected to not collect outcomes data on children under 4 months of age. Why does New Mexico?
		<i>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.</i>

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## Service Coordination:

13.	Q	What do I need to do to get a Service Coordinator Waiver for my Staff?
	A	<i>In accordance with DDS Service Definitions &amp; Standards, a Service Coordination exemption can be approved by DDS 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.</i>
14.	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?
	A	<i>Yes. In accordance with DDS Service Definitions &amp; 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.</i>
15.	Q	Is there a maximum number of cases for a service coordinator to carry?
	A	<p><i>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.</i></p> <p><i>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 Joicey Hurth may be helpful in determining these requirements for your agency.</i></p> <p><b>Dedicated SC:</b> . <i>The average caseload of a dedicated service coordinator of the states that responded was 35. Some went as high as 50 and others were as low as 20. <b>Dual Role:</b> NECTAC's survey turned up an average of 14 cases for those SC that work in a dual role. The range was from 8 to 16.</i></p> <ul style="list-style-type: none"> <li><i>• Caseloads must be low enough to allow a service coordinator to build a relationship with families and to understand their concerns, priorities, and resources. The service coordinator should be able to configure the IFSP process and to assist in the selection of providers and supports that meet the individual preferences and needs of each family.</i></li> <li><i>• Flexibility in caseloads is necessary to allow a range of support from intensive contacts to very few, depending on families' needs, desires, and location. Family needs for service coordination vary both among families and with any given family over time. Service coordination needs are likely to be greater at entry to the system, during transitions, (especially transitions at age 3 years), and at times of such acute or critical need as major changes in the health of a family member.</i></li> <li><i>• System evaluation, monitoring, and oversight are essential to maximize the system's strengths and correct for problems or inequities. Data is needed about the relationship of caseloads to family experience and outcomes, as well as provider satisfaction, within various system models. At this point there is insufficient empirical information to set an optimal or even a satisfactory caseload standard, although comparing averages and typical loads across states is valuable. We should continue to track and compare information and evaluations across states.</i></li> </ul>

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### Transition:

16.	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	<i>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.</i>

### Misc.

18.	Q	Do we need to get prescriptions for EI services from physicians?
	A	<p>The Special Rehab. Regulations, which govern early intervention services funded by Medicaid, state:</p> <p><b>8.320.4.13 A (1)</b> <i>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).</i></p> <p><b>8.320.4.13 A (2)</b> <i>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).</i></p> <p><b>8.320.4.13 A (3)</b> <i>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).</i></p> <p>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.</p> <p>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".</p>
19.	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.
20.	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	<p><i>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:</i></p> <ol style="list-style-type: none"> <li><i>1. Parent/Caregiver,</i></li> <li><i>2. Service Coordinator, and</i></li> <li><i>3. Someone from the evaluation team or someone who will be providing services to the child/family.</i></li> </ol>



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21. 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	<p><i>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. <b>In this situation, do not list this hearing screen on the supports and services page of the IFSP.</b></i></p> <p><i>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.</i></p>
22. Q	Can a COTA do an evaluation or assessment?
A	<p><i>No. A licensed OT (not OTA) must conduct an evaluation. The OTA can participate in the assessment activities.</i></p>
23. Q	How often do we need to get hearing screening equipment calibrated?
A	<p><i>The equipment needs to be calibrated annually.</i></p>
24. Q	How long do we need to save therapy notes before they can be shredded?
A	<p><i>Medicaid records (see below) state that records must be retained for 6 years.</i></p> <p><b>8.302.1.17 RECORD KEEPING AND DOCUMENTATION REQUIREMENTS:</b> 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, <i>Sanctions and Remedies</i>.</p> <p>A. <b>Detail required in records:</b> 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.</p> <p>(2) E. <b>Record retention:</b> 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:</p> <ul style="list-style-type: none"> <li>(1) treatment or care of any eligible recipient;</li> <li>(2) services or goods provided to any eligible recipient;</li> <li>(3) amounts paid by MAD on behalf of any eligible recipient; and</li> <li>(4) any records required by MAD for the administration of Medicaid.</li> </ul>
25. Q	<p>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.</p> <p>Since it has been less than 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.</p> <p>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?</p>



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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.*