Topic	*Discussion and preliminary decisions and next steps*	*Final decisions*
DBHDS Personnel Regulations	The Personnel Regulations are with the Governor for review. See Virginia Regulatory Town Hall to check status: http://www.townhall.virginia.gov/L/ViewAction.cfm?actionid=3065	
Rates for Dietitians and Audiologists	• The Part C Office has provided Part C rate information for dietitians and audiologists • See rate information in Billing and Reimbursement Information Sheet	
Status of Training Modules	• There are now 603 registered users for the training modules • 376 have successfully completed the child development module • 331 have successfully completed the family centered practices module • 9 local systems and 5 provider agencies have provided current provider lists o 260 providers are included on these updated lists o 140 providers are on the updated provider list and are registered training module users • The service pathway and the practitioner requirements modules are being loaded on the web	
DMAS Update: DMAS – DBHDS Data Exchange	• DMAS can run a match of all the children enrolled in Part C to the Medicaid eligibility file. The child's full legal name (not nicknames) from ITOTS and date of birth are required for this. Availability of the child's address and social security number would enable an accurate or exact match. Without addresses and social security numbers, a probably match can be provided. This match will be used to identify children who have Medicaid but for whom a Medicaid number is not entered in ITOTS. DMAS will provide the Medicaid number, the eligibility dates and MCO info. • Collection/recording of parent addresses is projected as one of the ITOTS enhancements, but the timeframe for this enhancement is not yet known. • A complete file match will be done rather running reports with just children new to Part C. DMAS and DBHDS can determine the frequency for the match report to be run. • Part C would provide names of all children for this match. **Next Steps:** • The DMAS-DBHDS Business Associates Agreement must be in place prior to exchange of data. • Mary Ann has called OSEP for guidance about whether individual parent releases are required to share the names of children enrolled in Part C with DMAS.	
Reimbursing Providers for Participation in Eligibility Determination	• Eligibility determination is not reimbursed by third party payors. • The process is expected to be implemented in a variety of ways across the state. • Local Systems are responsible for determining the rate they will pay to contractors to participate in eligibility determination, recognizing that this function is very different from early intervention services, and will not include the costs to the provider for travel, billing third party payors, etc.	

Topic	*Discussion and preliminary decisions and next steps*	*Final decisions*
DMAS Requirement for Physician Signature on IFSP	• Physician signature is required for IFSP. This can be accomplished through: o Signature directly on the IFSP o Signature on a separate plan of care (that includes the service information from the IFSP), or o Letter referencing the IFSP signed by the MD. • Physician signature is required anytime there is a change in services identified on the IFSP • Services provided without the physician signature within the required time-frame will not be reimbursed by Medicaid. This will be identified through the utilization review process. • The physician signing the IFSP should be the child's Medical Home or the physician who referred the child to early intervention or any physician involved in that child's care. o The group discussed challenges with getting signatures from some MDs. Strategies were discussed including keeping track of the physicians or practices where this is and issue – and identification now of specific physicians/practices who can be targeted for state level outreach. o Some local systems have arrangements with a physician to provide consultation in their system. While it is not prohibited for a physician who has not seen the child to sign the IFSP, it is not best practice. One suggestion was to have that physician be the one to communicate with the physicians who are not responding to the requests for signatures. o In rare instances where the child's physician refuses to sign the IFSP authorizing provision of services, that physician is not fulfilling their role as a Medical Home. Options include assisting the family with identifying another physician who will serve as the Medical Home. o Requests for MD signatures can be used as an opportunity to provide information about early intervention services. • Service coordinators are responsible for assuring that the physician signature is obtained, though how this is operationalized may vary. Currently in many or most systems, providers handle this responsibility. The group discussed the need to have a mechanism in place to assure that the signatures had been obtained. • The time frame for signatures was discussed. Currently, with rehab services, the physician signature is required within 21 days of the first visit. The group recommended that the start date for the time span continue to be the first visit and that consideration be given to 30 days. • A suggestion was made that other early childhood partners may be able to assist with the process through a training approach. **Next Steps:** • DMAS will determine the start date and the time span for the required physician signature • Task force members were asked to send Beth and Mary Ann the names and contact information for	

Topic	*Discussion and preliminary decisions and next steps*	*Final decisions*
	physicians who are not responsive to requests for signatures (for targeted state level outreach) • Mary Ann will communicate with Dr. Ann Kellum and Dr. Colleen Kraft about putting early intervention on the training calendar for MDs. • Mary Ann and Joanne will develop a template for the physician letter approving the IFSP services	

Topic	*Discussion and preliminary decisions and next steps*	*Final decisions*
Physician Order for Assessment	• Medicaid will not require a physician order for assessment for children in Part C. • A prescription is not required by Part C unless it is necessary for reimbursement or to meet discipline-specific requirements. • TRICARE does require a prescription for evaluation/assessment. • Discipline specific requirements apply regarding physician orders for evaluations or assessments. Except under certain conditions, a physician order is required for a physical therapy evaluation. **Note:** According to the Code of Virginia, Chapter 34.1 of Title 54.1 – Physical Therapy: *In addition, **after completing a three-year period of active practice** upon the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner as authorized in his practice protocol, or a licensed physician assistant acting under the supervision of a licensed physician, **a physical therapist may conduct a one-time evaluation, that does not include treatment,** of a patient who does not meet the conditions established in (i) through (iv) without the referral and direction of a licensed doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner as authorized in his practice protocol, or a licensed physician assistant acting under the supervision of a licensed physician; if appropriate, the physical therapist shall immediately refer such patient to the appropriate practitioner.* http://dhp.virginia.gov/PhysicalTherapy/leg/Chapter%2034.1%20Physical%20Therapy.doc	
DMAS Early Intervention Manual	• Brian reported that the DMAS Early Intervention Manual will be completed by date of first September Training. • The DMAS Early Intervention Services Manual and the Infant & Toddler Connection of Virginia Practice Manual will be in sync with each other with some of the same information contained in both documents. • Brian reviewed the chapters, including items to be contained in each: o Definitions o Eligibility – child must be enrolled in Medicaid or FAMIS. Utilization review will include checking to see if child whose services were reimbursed under the Medicaid Early Intervention Program met Part C eligibility criteria o Provider Enrollment Criteria – will include information about the certifications required and the requirement for an early intervention provider agreement with Medicaid o Covered Services and Limitations. This chapter will include information about what services are covered, the fact that all services must be on the IFSP and approved (via MD signature) within the required time span. o Process to request enrollment	**Children enrolled in FAMIS will have the same benefits under Medicaid Early Intervention Services as children enrolled in Medicaid, including reimbursement for Assessment.**

Topic	*Discussion and preliminary decisions and next steps*	*Final decisions*
	o Process to request authorization (MCO) o Billing Chapter o Documentation and utilization review • Discussion o The manual will include the local lead agency's responsibility for maintaining program eligibility information for each child, including the frequency requirement for updating eligibility information in ITOTS (discharging children from ITOTS when no longer eligible). Process to find child no longer eligible for services involves two disciplines making the determination. ▪ The manual will be consistent with the Part C requirements regarding discharge when eligibility requirements are no longer met or when the child is lost to follow up, including the Part C No-show policy. o Covered services and limitations ▪ The chapter will define what is covered ▪ Include information about the 9 service codes, services defined under each, and daily and annual limitations ▪ Service coordination requirements/roles ▪ Provider roles, including what services provided by each discipline ▪ What is DMAS will lay out what you bill when you use each code – what is covered under the particular code. List which providers can provide each service and that the service is named according to the provider providing the services ▪ The IFSP will list the services according to the discipline of the provider with the exception of developmental services (currently special instruction) as is currently the practice. The billing codes, with the exception of PT, OT, SLP and Nursing, are categorized according to a description of the service provided, and the same code is used by multiple disciplines. The contact note that will document what the service was when one of the T codes is used. Utilization Review will compare IFSP to billing document to contact notes to see if the discipline listed on the IFSP provided the services. ▪ PT, OT, SLP, and Nursing use G codes for intervention sessions and T codes for meetings. • Provider choice was discussed. According to DMAS, providers can't discriminate who they will accept, but they also can't accept someone they cannot serve. ▪ Guidance needs to be clear about reimbursement requirements when families select out of network providers (when there are in-network providers available) ▪ Provider choice will be implemented initially by local systems providing families with a	**The maximum daily units/per child/ per code/ per provider is <u>6 units</u> with a maximum of <u>18 units</u> (for any combination of codes) per day per child for all providers** **Services are listed on the IFSP according to the discipline of the provider with the exception of those disciplines which provide "developmental services" (which is currently called "special instruction")** **There is no change in the scope of services that can be provided by each**

Topic	*Discussion and preliminary decisions and next steps*	*Final decisions*
	list of certified providers in their network who provide services in their local area. • Information will be included regarding services that are billed outside of the Medicaid Early Intervention Program, such as audiology, assistive technology). • Billing chapter will include information about how to complete the claim form. Claims can be submitted electronically or via paper copies. o For services that are billed by an agency, using the agency NPI and EI taxonomy code, there will not be an automated mechanism to assure that the provider who provided the service is certified. Provider agencies are responsible for assuring that early intervention services that are provided and billed are provided by certified early intervention providers. Utilization review will be a mechanism to check on this. • Documentation and Utilization review – these chapters will mirror the Infant & Toddler Connection Practice Manual o Utilization review will be done for the system, not just for children who have Medicaid. This is in alignment with OSEP requirements. o The local system and state Part C staff must have access to billing records for utilization review o UR will include comparing services listed on the IFSP to delivered services. o Supervision requirements will be included o A list of actions that would result in pay back will be listed including lack of MD signature, lack of documentation, provider not certified, etc. o Some local systems/providers require parent signatures on the contact note. The value of this practice was discussed. This will not, however, be a DMAS requirement. o Criteria for when Medicaid would pay in situations where children also had commercial insurance were discussed, including situations where there are no in-network providers available for the family's commercial insurance. In order DMAS to process the claims, there must be documentation of efforts to bill the commercial insurance. The issue of the commercial insurance not paying for up to 6 months or longer (claims automatically sent to "Medical Review") was raised: at what point can Medicaid pay in these situations. DMAS will clarify the TPL issue. **Next Steps:** • Beth will email Brian the Infant & Toddler Connection Practice Manual, which includes sections on the procedures for determining when children no longer meet eligibility as well as the no-show procedures.	**discipline from current practices.** **The billing codes, with the exception of PT, OT, SLP and Nursing describe the service, not the discipline**

Topic	*Discussion and preliminary decisions and next steps*	*Final decisions*
	• DMAS and DBHDS will work out procedures for informing DMAS when children are put on inactive status and moved back to active status. • DMAS will clarify if family counseling or counseling services are covered if the child is not present. • Brian will send out components of the chapter to task force members between now and the next meeting for input. A quick turnaround with input will be requested.	

Topic	*Discussion and preliminary decisions and next steps*	*Final decisions*
Implementation of Medicaid Initiative by Medicaid MCOs	• Tammy asked for input from the task force members about whether they would anticipate any issues/problems if DMAS decided to carve out early intervention services (not children) from MCOs when the initiative is implemented October 1. Tammy indicated that if this would be temporary. • Task force members were receptive to the possibility. They indicated that not only did they not anticipate any issues or problems with carving out early intervention services, it would simplify the process.	
Local Contract	• The Local Contract for 10/1/09 through 6/20/10 needs to include the changes in ITOTS requirements required by this initiative. **Next Steps:** • Include draft contract language on the agenda for the next meeting.	
Billing Information: Finalization of Info to Send to Providers	• Input was provided on the Billing and Reimbursement Document. • Task force members recommended that this not be sent from the state to all providers because it would be confusing to those who do not bill. The group agreed that this document would be send to the local system managers with directions to send it to current and potential providers in their system. It will also be posted on the Infant & Toddler Connection of Virginia website in order to be available to all potential providers in the state. **Next Steps:** • Beth/Brian will correct the information on Table D concerning provider limits for billing per day. (It should be 6 units per day per billing code per provider). • DMAS will develop a sample CMS 1500 form to include as part of this document • The Part C Office will send the revised document to System Managers for dissemination.	
Provider Enrollment in Medicaid	• Provider Agencies or Individuals can enroll in Medicaid. • DMAS is looking into possibilities for an expedited process for enrollment of agencies who are currently enrolled as rehab providers • The process for individuals to enroll takes approximately two weeks. • DMAS will be addressing the enrollment process this week. **Next Steps:** • DMAS will provide an update (after internal meetings) about the process for enrollment as a Medicaid Early Intervention Provider (as an agency and as an individual)	
Finalization of Alert Memo	• The group provided suggestions for edits to the memo. • There was discussion about whether additional information should be finalized prior to sending the memo; the task force members requested that the memo go out now. **Next Steps:**	

Topic	*Discussion and preliminary decisions and next steps*	*Final decisions*
	• Beth will revise the memo based on the discussion as well as written input, then send to Mary Ann and Tammy for final review. • The finalized memo will be sent to Local System Managers and to the Executive Directors for each Local Lead Agency.	

Topic	*Discussion and preliminary decisions and next steps*	*Final decisions*
Finalize Agenda for September DMAS/DBHDS Provider Trainings	• Brian reported that they are working with the DMAS training unit to follow up on the suggestions from the last meeting including videotaping the training, moving one training to Tidewater and considering the possibility of a far SW Virginia site. • Beth distributed a draft agenda which included potential audiences for each topic and possible subtopics. The group was asked to let Brian and Beth know if additional topics needed to be included. No suggestions were made during the meeting. • Task Force Members asked if there was an expectation for all providers to attend. Clarification was provided that the training is <u>open</u> to all providers. Private Provider agencies and Local Lead Agencies can determine who they would like to send to the training. They will be responsible for ensuring that all of their employees receive information from the training relevant to their job. (For example, not all providers will need to know how to bill if their agency does the billing for them, but all providers need to know the requirements for documentation). The training will be especially useful for providers, including those who provide developmental services, who have not previously been Medicaid Providers. • The DMAS manual will be available prior to the training. Providers should be encouraged to read the manual before the training in order to identify where they have questions or a need for additional information. **Next Steps** • DMAS (with DMAS training unit) will finalize the agenda. Decisions will be made about which topics need to be addressed in the face-to-face training (core information) and what can be provided in follow up web-based trainings. • DMAS will disseminate the final agenda and training locations after the internal meetings. • Part C will include information about the trainings in the Transformation Update as well as general information in the "Alert" memo	
Communication Planning	• Phyllis sent information about the training modules to the Directors of Special Education. • Mary Ann and Joanne will talk about getting info out to MDs, nurses, members of the Home Visiting Consortium, etc.	
Provider Information Sheet	• The group discussed challenges associated with expecting providers to routinely confirm with families whether their insurance was the same or had changed. Discussion included: o Consider including a field for this (insurance the same/changed) on the contact note for each visit. o Whose responsibility it is to check on the insurance – provider, service coordinator, etc. o System work needed (practices, training) to implement responsibility at Local Lead Agency	

Topic	*Discussion and preliminary decisions and next steps*	*Final decisions*
	level o Frequency of checking – insurance coverage changes on a monthly basis – so once a month checks would probably suffice o A suggestion was mad to consider adding a field to the contact note: insurance – same or changed, including a place for new information. **Next Steps:** • The Provider Information Sheet will be finalized and sent from the Part C Office to Local System Managers as well as posted on the Infant & Toddler Connection of Virginia website	
Family Information Sheet	• Intent of the Family Information Sheet is to have a document that can be used statewide to provide consistent information about early intervention services, especially about those things that may change October 1, 2009. The Local System can determine how to disseminate the document in their system. **Next Steps:** • The group working on the Family Information sheet will finalize the draft document and send it to the group tomorrow for input.	
Information sheet for Referral Sources	• Task Force Members received a draft document developed by Terry. This was not discussed today. However, a comment was made that there may need to be two documents developed – one for physicians and one for non-physicians. **Next Steps:** • Task Force Members were asked to send suggestions/input to Terry Pasco and to let him know if they were willing to partner with him on this document.	
Private Insurance	To be addressed at future meeting.	

Next Meeting: **August 20, 2009**

Items for August Agenda:

o Language for Local Contract

September Teleconference meeting: **Wednesday, September 16 from 1:00 PM to 3:00 PM**