Early Intervention
Provider and Invoicing Manual

RMHS
Rocky Mountain Human Services

Revised November 2019

Welcome to the Rocky Mountain Human Services (RMHS) provider network. This manual is an extension of your contract and is a resource about the RMHS continuum of services. It will also provide you with guidelines for doing business with RMHS, including policies and procedures. Throughout this manual and the contract you receive from RMHS, individuals who provide services may also be called Subcontractors. Both the term “provider” and “subcontractor” may be used at different places in the manual. We use the term “Subcontractor” in the contract because RMHS is considered by Medicaid, insurance companies and EI Colorado as the “provider” when we are invoicing for EI services, and RMHS is considered the “contractor” for EI Colorado services. If an individual therapist is directly invoicing Medicaid or an insurance company for the services they provide, they are considered the “provider.”

Rocky Mountain Human Services is a 501(c)3 nonprofit organization that serves clients in a variety of programs. In our Early Intervention program, we serve over 1000 children and families at any point in time, and we consider all of our subcontractor providers an integral part of ensuring that we can meet the needs of the people we serve.

Rocky Mountain Human Services is committed to ensuring that everyone who interfaces with our organization is provided with an experience that is helpful, meaningful and individualized. We strive to ensure that our values of respect, integrity, courage, excellence, and dynamism are present in all of our interactions. In our Early Intervention program, we operate from a family-centered philosophy: the child, family, service providers and service coordinators all make a team to support the development of infants and toddlers in the context of their family.

The information in this manual will provide you with a better understanding of what to expect while doing business with RMHS, but it should not be relied upon for your own company’s business, financial or legal advice. If you have any questions about the information contained in this manual, our staff welcome your call. Our goal is for this manual to facilitate a better understanding of the requirements for providers, and we will update it frequently as substantive changes are made to information, processes, etc. You can find the most current version of this manual on the RMHS website at www.rmhumanservices.org/ei-providers. We welcome you to RMHS and thank you for your commitment to working together with us to offer a great start to infants, toddlers and their families!

Jodi K. Dooling-Litfin, Ph.D., Director of Developmental & Behavioral Health

Contents

EI Provider and Invoicing Manual

The provider shall comply with all portions of the Early Intervention Provider & Invoicing Manual, which may be amended from time to time. The provider understands that RMHS has the sole discretion to amend such manual. The provider shall comply with any amended provisions of the Early Intervention Provider & Invoicing Manual within a reasonable time after notice is given to the provider of any amendment. The provider understands the provider is responsible for reading the Early Intervention Provider & Invoicing Manual and contacting RMHS if any current provisions or amendments are unclear to the provider.

Provider Requirements

Minimum Provider Qualifications to Deliver Early Intervention Services

Providers are responsible for ensuring they have the appropriate qualifications and licensure to provide Early Intervention (EI) services. If a service requires licensure, the provider must have a valid license and provide a copy of that license to RMHS. The provider is responsible for notifying RMHS within five (5) business days if their license is revoked or suspended, or they have had a malpractice claim filed against them.

The link below outlines the qualifications required to provide various allowable EI services. Provider qualifications link: https://dcfs.my.salesforce.com/sfc/p/#410000012srR/a/41000000CgNP/nqH0WiTYgXeFCBbQrkTuWwgc_m.Esi5fO81OvXL4N4A

Early Intervention Colorado

Provider Portal

Please log in to the EI Colorado Provider Portal as soon as possible at www.eicolorado.org. Click on "For EI Professionals," then click on the link to the Early Intervention Provider Portal. All providers and employees must be entered in the database prior to providing EI services and profiles must be updated annually.

Requirements

All EI providers and Community Centered Board users must complete and maintain a current record in the Provider Portal Provider Registration screen. Instructions can be found at www.eicolorado.org. The Provider Portal Support contact is Tracy Sperry. She can be reached at 303-866-5916 Tracy.Sperry@state.co.us.

Obtaining an NPI Number

Providers of health care services are required to have a National Provider Identifier (NPI) number. NPI is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use NPI#s in the administrative and financial transactions adopted under HIPAA.

As outlined in the Federal Regulation, HIPAA-covered providers must also share their NPI with other providers, health plans, clearinghouses and any entity that may need it for invoicing purposes. Providers should apply for an NPI number at https://nppes.cms.hhs.gov/#/

Becoming a Medicaid Provider

The State of Colorado requires all licensed providers to become an approved Health First Colorado Medicaid provider to treat Medicaid patients and invoice Medicaid for payment. This includes allowable Early Intervention Physical Therapy, Occupational Therapy and Speech/Language services that are **funded by the Medicaid State Plan and for which RMHS or the provider is going to invoice Medicaid for payment**. RMHS contracts with Denver Health and Colorado CHP+ plans, which are both Medicaid-funded; thus, all EI subcontracted providers are required to be approved by Medicaid prior to billing.

To become a Medicaid provider, you must submit an application through the Health First Colorado Provider Enrollment page at www.colorado.gov/hcpf/provider-enrollment.

Information helpful in completing the process:

Enrollment Type – you must choose an Enrollment Type based on how you plan to bill Medicaid.

1. **Billing Individual** – If an individual provider who wants to bill Medicaid directly does not have a company to bill under, billing and payments will be made under the individual's social security number. This is the only application needed.
2. **Individual Within a Group** – An individual provider who performs services (rendering provider) but does not bill directly using their social security number must register as an Individual within a Group and associate themselves with a Medicaid-approved Group, identified in the system by the Group's Type 2 NPI#. This type of provider's billing is processed through his/her Company, or a Trading Partner/Billing Agent such as RMHS. Individuals within a Group still need to use their own social security number in the first part of the application, because the application is for the individual provider. The Group's Type 2 NPI and Tax ID will be required in the next section.
3. **Group** – Bills on behalf of rendering providers under the Company's Tax ID. If you are the sole proprietor or owner of a company/corporation with its own Tax ID and Type 2 NPI, you need to submit your company's Group application first and receive approval before submitting your own Individual Within a Group application.

Provider Type for Individuals – depends on the Provider's specialty; Speech Therapy, Physical Therapist, Occupational Therapist, etc.

Provider Type for Groups – most used for EI provider groups is **Non-Physician Practitioner - Group**

Provider Taxonomy – Your taxonomy must match the primary taxonomy registered to your NPI number.

- If you are not sure what your registered taxonomy is, you can find that information at https://npiregistry.cms.hhs.gov/registry/.
- If your taxonomy listed with your NPI is incorrect or has changed, you should correct that first before submitting your Medicaid application. Changes to your NPI are done through the NPPES at https://nppes.cms.hhs.gov/NPPES/Login.do?subAction=LoginA list of all taxonomies can be found at Certification/MedicareProviderSupEnroll/Downloads/TaxonomyCrosswalk.pdf

DORA License – Providers are required to upload a copy of their current DORA license; if you recently changed your name make sure your DORA license has been updated first before submitting your Medicaid application.
Your NPI registry needs to be updated as well. – everything must match, or your application will be returned. Further instructions for completing a Medicaid application can be found at www.colorado.gov/hcpf/provider- enrollment. Contact the Health First Colorado (Medicaid) Provider Services Call Center at 844-235-2387 to request guidance or assistance with your application, as well ask as claims questions.

Requirements for Provider Credentialing

RMHS abides by the state and federal regulations requiring formal credentialing of Practitioners/Providers licensed by the state to practice independently and without supervision. Credentialing of these provider types must be completed before seeing patients:

- MD
- DO
- PT
- OT
- SLP
- Psychiatrist
- Doctoral or master's level Psychologists (PhD, CP, LP))
- LPC
- Master's Level Social Worker (MSW, LCSW)
- BCBA; RBT

RMHS utilizes the Council for Affordable Quality Healthcare (CAQH) ProView system for credentialing purposes. CAQH ProView, Provider, is an online, safe and secure, nationally recognized database, which allows providers to enter their credentialing information in one location; upload and store necessary documentation and update as needed; and authorize payers to access their information - at no cost to the provider.

Each provider who requires credentialing, within a contracted group or as an individual, must set up and maintain an active up-to-date CAQH profile. If you do not have a current CAQH account, you need to register as soon as possible so you can become credentialed and receive referrals through RMHS. New users may self-register through the CAQH ProView portal at https://proview.caqh.org/pr.

EI Subcontracted Providers are not employed by RMHS but need to list their relationship with RMHS for credentialing and billing purposes. Providers should list Rocky Mountain Human Services as an **additional practice location to their primary location in the Location Section of their CAQH profile; do not list RMHS as an employer in the Employment History Section**. Use the following information for the RMHS additional practice location.

Rocky Mountain Human Services
9900 E Iliff Ave, Denver CO 80231
303-247-8423 (EI Appointment Line)
303-636-5614 fax
Tax ID: 841182143
Type 2 NPI for EI Services: 1316291040
Office Manager and Credentialing Contact: Sharry DiQuinzio, 202-636-5762, sdiquinzio@rmhumanservices.org
Start Date: Use your individual contract date or the date you began with your contracted agency. Include 0-3 age restrictions if applicable.

Providers must complete the CAQH application and upload the required documents before their information can be released to any credentialing bodies. Required documents are a Provider's DORA license, copy of personal or company professional liability insurance face sheet showing effective dates and amounts per occurrence and aggregate (minimum of 1m occurrence, and 3m aggregate). If you are a provider whose liability insurance is through a group policy, your name must appear on the policy face sheet, letter or roster indicating the providers covered under that policy. CAQH allows only one document to be loaded for insurance purposes; the letter/roster should be attached to the end of the policy face sheet as one document. If you are unable to attach your letter/roster, please contract Credentialing for assistance.

List at least the most recent five years of work history. Include start and end dates in Month/Year format. If there is a gap of 30 days or more (required by the state of Colorado), you must include an explanation (i.e., leave of absence, maternity leave, active duty, illness, relocation, stayed home with children; in between jobs. Credentialers will verify that your time has been accounted for.

CAQH is designed to meet the needs of many different specialties and provider types which means not all questions are applicable to all providers. If you believe a section does not apply to you, indicate so by N/A and skip it. CAQH will prompt you if you attempt to skip a question that is required for your provider type.

All providers should answer YES to having a Specialty; then a further YES or NO to being Board Certified. List your board certification with expiration dates if applicable. ASHA, NBCOT and BACB are considered board certifications, not licenses

If you have already created your CAQH ProView account, please be sure your information

and all necessary expiring documentation, is current. When you replace a document that has expired, be sure to update the information in your data profile as well; if the data in your profile and the information appearing on the document do not match, the document will be rejected. CAQH requires re-attestation on a continuous quarterly basis and will email reminders. CAQH requires re-attestation after making any edits or adding information/documents; if you don't re-attest, your changes will not appear to the requesting agency.

Providers control which organizations may receive their profile information. To eliminate delays, RMHS advises providers to authorize any organization that requests to add you to their roster by pre-selecting **ALL**. Providers will receive an email from CAQH notifying that XYZ plan has added them to their roster or is requesting to do so.

A variety of resources, including short how-to videos and a Quick Reference Guide, to help providers and their practice managers use CAQH ProView is available at www.caqh.org/solutions/caqh-proview. The CAQH Help Desk (888-599-1771) is available Monday through Friday, 7 a.m. to -7 p.m., Eastern Time; online Live Chat is also available.

If you are not sure that your specific provider type requires credentialing, or have any questions regarding credentialing, please contact the RMHS Credentialing Department at sdiquinzio@rmhumanservices.org or 303-636- 5762.

Credentialing Forms are available for download from the RMHS Webpage.
Provider Group changes (Adds/Terms) should be submitted using either the **Early Intervention Program – Provider Update Form for Opt-In Providers/Organizations; or the Opt-Out Provider Update Form** depending upon your contractual billing choices.

Practitioner Rights

Practitioners applying to become part of the RMHS EI Provider Network have the right to:

- Review information submitted to support their credentialing application.
- Be informed of and correct erroneous information.
- Request review of their credentialing information by contacting the credentialing specialist by phone or email.
- Receive the status of their credentialing or recredentialing application.
- Receive notification of their credentialing approval/denial within 30-days of the decision.
- If denied, reapply after a 60-day waiting period.

Therapy Assistants

RMHS may utilize therapy assistants to deliver Individual Family Service Plan (IFSP) services when there is a shortage of licensed professionals within a specific discipline. RMHS may utilize Physical Therapy Assistants, Certified Occupational Therapy Assistants, Speech Language Pathology Assistants and Paraprofessionals providing Behavioral Intervention. All assistants must be employees of subcontracted agencies and may not be independent providers with RMHS. It is the responsibility of the provider to inform families of their professional status prior to initiating services. Therapy Assistants are reimbursed at a

lower rate. When submitting billing, please include the word “Therapy Assistant” next to the provider name on each progress note. This will notify RMHS to reimburse providers at the appropriate rate. Also, a signature of the supervising staff member and date of supervision must be included on each progress note. The following requirements are in the Early Intervention Colorado State Plan (Rule 12CCR 2509-10, 7.951).

Use of paraprofessional is permitted if the following occurs:

- Ongoing supervision is provided by a qualified professional to assure that the paraprofessional understands the intervention plan and all procedures to be followed; and
- When a paraprofessional is providing Early Intervention services:
    - The Individualized Family Service Plan strategies are developed by a qualified professional; and
    - The qualified professional trains the paraprofessional to implement the plan; and
    - The qualified professional providers supervision through ongoing and periodic discussions and face- to-face or videotaped observations at least monthly and in accordance with the guideline of the affiliated professional organization, if appropriate; and
    - All supervision of Developmental Intervention Assistants must complete the Department-approved Developmental Intervention Supervisor Academy prior to assignment of supervisory responsibilities.

Clinical Fellows for Speech Language Pathologists (SLPs)

EI agencies shall be allowed to utilize clinical fellows to serve people accepting services from RMHS. In accordance with Colorado Medicaid guidelines, billing will be submitted by the SLP supervising provider of the clinical fellow. When submitting billing, please include the words “Clinical Fellow” next to the provider name on each progress note. Progress notes should contain the signatures of both the supervising SLP and the Clinical Fellow for all billable services, regardless of the child’s funding source. Agencies utilizing clinical fellows will be expected to comply with the Division of Professions and Occupations Office of Speech Language Pathology Certification requirements.

Telehealth Services

RMHS recognizes Telehealth as an Early Intervention service-delivery method available to providers who service Early Intervention Colorado clients.

To provide telehealth services, providers must demonstrate compliance with all requirements from Early Intervention Colorado and RMHS as described below:

a. Be licensed in the State of Colorado.
b. Be an approved Medicaid provider through Health First Colorado (as required).
c. Complete required Telehealth training or present a waiver from Early Intervention Colorado.
d. Update the Unified Child Outcomes Reporting Network (UNICORN) EI Colorado Provider Portal with your Telehealth designation. (Check the telehealth box under service model and specialty areas and upload your training certificate.)

e. Request approval from RMHS prior to providing Telehealth services for RMHS clients.
f. Complete the Early Intervention Colorado ***HOME – Telehealth Checklist***.
g. Complete the Early Intervention Colorado ***Family Technology Checklist for Telehealth***.

Providers must obtain all required consents/authorizations and provide Telehealth services through HIPAA- compliant, interactive audio-visual communications.

Provider must indicate that Telehealth services were provided by including the appropriate service CPT code with a "TH" clearly indicated for each date of service described on the progress note. Progress note documentation must also clearly indicate that services were provided via Telehealth. An additional Telehealth fee will be paid to providers on the usual payment schedule when appropriate documentation is received. Forms, checklists and brochures are available at www.eicolorado.org. (For EI Professionals/Training/Telehealth)

Telehealth Fee

RMHS will reimburse providers at $10 telehealth fee for each date of services provided to a child and family. Telehealth must be clearly documented on the progress note for payment. This can be indicated by a check box or as the service-delivery method. Telehealth fee is not reimbursed for "no-show" sessions.

Training Requirements

Global Outcome

Child Outcome Rating – Initial Rating

Providers can participate in Initial IFSP meetings based on a set schedule that RMHS establishes. Service Coordinators (SC) will schedule a child and family for an initial IFSP based on the provider's regional preference and availability. The SC will notify the provider of a scheduled Initial IFSP meeting by sending a secure email with a draft of IFSP, and/or evaluation report and the date, time and location of the IFSP meeting. Initial IFSP meetings are discipline-free and the provider will likely not continue as the ongoing service provider.

During the Initial IFSP meeting, the provider is age-anchoring the child's strengths and needs in the three global outcome areas by reviewing evaluation information, listening to skills discussed during SAFER, and listening for foundational, immediately foundational and age-expected skills. The provider will age-anchor the child's developmental skills and will have the primary role in determining the Initial Rating. The decision tree must be used when determining a Rating.

If the child is under 6 months of age at the Initial IFSP, the Global Outcome Rating is determined at the Periodic Review.

To participate in the Initial IFSP, you must have attended an RMHS training on roles and responsibilities during IFSP meetings, as well as writing functional IFSP outcomes.

Cancelations of Initial IFSP
If either party will not be able to attend due to illness, contact the SC/Provider directly to inform the other party of the cancelation. The SC is responsible for contacting the family and for rescheduling the Initial IFSP. If the IFSP slot is not scheduled within 48 hours of the start time, the slot is forfeited, and the provider is released of the responsibility of participating in an IFSP meeting during this time.

Child Outcome Rating – Annual Rating
Prior to the Annual IFSP meeting, the provider and family will discuss the child's recent developmental progress. The provider is responsible for providing age equivalencies within the five developmental domains at the Annual IFSP meeting. The family and provider will complete the "Annual Report" in preparation for the Annual IFSP meeting. This report is sent securely to the SC 48 hours prior to the IFSP meeting. The provider is age-anchoring the child's strengths and needs in the three global outcome areas during family assessment discussion, and listening for foundational, immediately foundational and age-expected skills. The provider will age-anchor the child's developmental skills and will have the primary role in determining the Annual Rating. The decision tree must be used when determining a Rating.

Child Outcome Rating – Exit Rating
Graduation or Moving Out of State – The IFSP team, including the family, provider(s) and SC, discuss the child's progress toward IFSP outcomes. The team determines that EI services are no longer needed for the child to make developmental progress, and the child and family graduate from EI services. Exit Rating is determined by the provider with input from the other IFSP team members. The decision tree must be used when determining a Rating.

Exiting EI at Age 3 – The SC schedules the Transition Conference with Denver Public Schools if applicable and notifies the provider that the "Transition Report" is due. The provider and family complete the Transition Report and the completed report is sent to the SC at least 48 hours prior to the Transition Conference. The SC will share information from the Transition Report with Denver Public Schools at the time of the Transition Conference. Prior to the child's third birthday, the SC will finalize the Exit Rating with the family and provider(s).

Referrals

Referrals will be sent to all providers who can independently bill the child's funding source and who have the appropriate skills to fit the needs of the child and family. If you are interested in accepting the referral, please reply to the email with your availability to see the child. Referrals will be assigned after 48 hours. Referrals are placed based on the following criteria:

1. Does the provider have the appropriate skill set to help the child and family meet the goals addressed in the IFSP?
2. Can the provider bill appropriately and follow the funding hierarchy?
3. Is the provider part of a transdisciplinary team?

4. What availability matches best with the family's needs?
5. Which provider has gone the longest without a referral?

Delivery of Early Intervention Services

By becoming an Early Intervention Provider with RMHS, you are agreeing to promote the Primary Service Provider Model. The designation of a primary service provider maintains the integrity of the team interaction while minimizing the number of professionals that families and child care providers are required to interact with on a regular basis. A primary service provider model uses a trans-disciplinary process but details the role of this primary service provider team member.

Primary Service Provider Model

The Primary Service Provider Model is a transdisciplinary, home-based service delivery approach. One provider of the program acts as the primary service provider to the parents or other caregivers and is selected based on expertise in child development, family support and coaching. The primary service provider has awareness of and access to other providers with a variety of knowledge, skills and experiences. The primary service provider is seen as a coach, and reciprocal coaching and learning occur between the primary service provider and caregivers and between the primary service provider and other providers. The primary service provider receives coaching from other providers through ongoing interactions and promotes a parent's or other caregiver's ability to support a child's participation in everyday experiences and interactions with family members and peers across settings.

Joint visits should occur at the same place and time whenever possible with other providers to support the primary service provider as often as deemed appropriate by the PSP and IFSP. When visits occur at separate times, the primary service provider and other program staff must inform the care providers that the purpose of the visit is to gain information that will be shared with the primary service provider for his or her continued work with the family. Ongoing interaction provides opportunities for reflection and information sharing. Other providers providing coaching to the primary service provider may vary depending on the need or desire for timely ideas and feedback.

It is critical for providers to promote the Primary Service Provider Model with families. All providers will have the opportunity to be a member of a trans-disciplinary team where they are able to use their expertise to jointly evaluate, assess and plan to best meet the needs of the child and the family in a cohesive way. Teaming through regularly scheduled meetings offers a formal time for provider-to-provider information sharing and support, so the team can develop strategies designed to build the capacity of parents and other caregivers to meet child and family outcomes.

RMHS offers monthly meetings for many different transdisciplinary teams to meet and lend their expertise to give strategies to best meet the needs of the child and family. These teams meet at various times and locations in Denver County. We can assist you in joining a transdisciplinary team. Please contact our EI Operations Manager Beth Scully at BScully@rmhumanservices.org.

Early Intervention Allowable Service Definitions

Please see Appendix A for a listing of allowable Early Intervention Services. RMHS cannot pay for services that are not on the list.

Parent Education or Teaming Strategies

Maximum One Unit of State General Funds Definition

1. Can be used for ongoing assessment and treatment time that doesn't meet CPT code definitions.
2. Parent education.
    a. Family training, education and support provided to assist a parent or other caregivers in understanding the special needs of the child related to enhancing the skill development of the child.
3. Making of session supports, such as PECS, visual schedules, etc.
    a. Adaptation of learning environments, activities and materials to enhance developmental and learning opportunities that promote the infant's or toddler's acquisition of skills in all developmental areas.
4. The State General Fund Unit is associated with a date of service: In the event that session supports are utilized, the documentation of such activities will correspond with the date of service the information was shared with the family.

Teaming strategies shared by the Primary Service Provider outside of their discipline.
Parent Education/Teaming Strategies is a billable service for all Early Intervention Providers. This is intended to cover the time and cost of additional activities in which a provider participates that are not billable to public or commercial insurance but are part of Early Intervention. Providers who have opted-out of RMHS billing will be reimbursed for the Parent Education/Teaming Strategies unit when those activities are documented. Be aware that for those opted out providers who are billing RMHS for any reason will not receive an additional unit of reimbursement for those unique clients. Providers who have opted in for RMHS billing should still document those activities, but reimbursement is included in their contracted rate, which was developed in part with the assumption that care coordination would be provided. Parent Education/Teaming Strategy activities are to be documented in progress notes and coded as "Parent Education/Teaming Strategies." This is a per session code so the number of units documented is "1."

When Providers Should Use 'Parent Education/Teaming Strategies'
When billing for additional services that are performed or utilized ***with*** a CPT service that is either outside the session or is unrelated to the provider discipline and are therefore not billable activities. These services can be reimbursed for one unit of State General Funding.

"OOOOO" Miscellaneous Code

When providers Should Use "00000" Miscellaneous Code
When billing for additional services that are performed ***without*** a CPT service that lasts for the entire session duration. These are services for which Early Intervention can reimburse providers.

For example, the following table outlines examples of when to use 00000 or Parent Education and how to document:

00000	Parent Education/Teaming Strategies
Parent education is provided in the family's home while child is asleep for the entire session	Parent education is provided that is unrelated to the provider discipline, so it is not covered under any CPT code. Child is present during
Assisting a family with obtaining a library card and buying books for the child for the entire session duration.	Creating handout aides before meeting with the family.
Assisting the family locate alternative housing for the entire session duration.	Spending the last 10 minutes of a session coaching the family on behavioral strategies that are outside the provider's discipline.
Participating in an IFSP meeting when the assigned provider is not delivering direct services to the child and a CPT code cannot	n/a
How to Document 00000 on Progress Notes	**How to Document Parent Education on Progress Notes**
Providers should ensure the following elements are present on each progress note when billing "00000." • The EI Allowable Service • "00000" as the CPT code • The unit amount • "No CPT code associated with service" in the narrative section • Duration of session	Providers should ensure the following elements are present on each progress note when billing Parent Education. • The EI Allowable Service • Parent Ed as the CPT code • 1 as the unit amount

Individual Family Service Plan

The Individual Family Service Plan (IFSP) documents the treatment plan for the child and family. The IFSP outlines the types of services needed by the child as well as the frequency, scope and duration of those services. Services should be provided in accordance with the IFSP. Providers need to be cognizant of amount of services authorized for each child they serve; providers who are not invoicing through RMHS should track their utilization of units authorized in the IFSP.

If the provider believes that additional units of service or a different service is needed that is not listed on the IFSP, the following process shall be followed:

1. When appropriate, the provider shall discuss the area of concern with their transdisciplinary team and obtain recommendations and strategies from their team to support the child and family.

2. The provider shall notify the RMHS Service Coordinator of the new developmental concern that is outside of provider's area of expertise.
3. The provider shall implement strategies provided by transdisciplinary team member(s).
4. The provider shall notify the RMHS Service Coordinator if there is a need for a provider of another discipline to attend an upcoming visit with provider to gather information on the child's current skill level and provide targeted strategies to both provider and the family. Do not state to the family that a child "requires" an additional service or discipline.
5. The RMHS Service Coordinator will talk with the family about their concerns and discuss when they feel it would be appropriate to have another therapist meet their child.
6. If the family would like to make changes to the IFSP, the RMHS Service Coordinator will notify the provider. A determination will be made if a provider from the primary provider's team is available to meet the child and determine if there is a need to change the services provided. If the team cannot provide this visit, the RMHS Service Coordinator will locate a provider.
7. IFSP Review will be held with the family, current provider and possibly the provider of the new area of concern to add a visit (or multiple if determined necessary) in the area of concern and obtain the parent/guardians consent. The provider should not provide additional services until the IFSP has been reviewed; doing so would put the provider at risk of nonpayment of the services provided prior the review of the plan.

IFSP Meeting Participation

Providers are expected to attend and participate in all IFSP meetings for children receiving services. If, for any reason, a provider is unable to attend in person, the provider may attend via phone, web conference or submit a written report to the RMHS Service Coordinator prior to the IFSP meeting. Annual IFSP meetings require face-to- face participation. Providers are responsible for providing age equivalences during Annual IFSPs in all areas of development (Adaptive, Cognitive, Communication, Physical and Social & Emotional) regardless of provider's discipline.

Annual IFSP Gaps

The provider and service coordinator have a shared responsibility for knowing when an IFSP will expire. If an IFSP expires prior to a new Annual IFSP being complete no services may occur during this Annual gap. If a provider selects to provide services prior to the IFSP Annual, the provider will not be paid for those services.

Informing RMHS Service Coordinator of Start Date

When starting with a new family, providers are required to inform service coordinators within 24 hours of their initial visit or start date.

Exiting a Child from Services

When a child is making gains in development and the provider suspects that ongoing intervention may no longer be needed for the child to continue to make progress, the provider shall notify the RMHS Service Coordinator. The RMHS Service Coordinator will contact the

family to discuss the child's progress and how the family feels about exiting services (with a single discipline or from all EI services). The family may request an IFSP meeting to update the IFSP and graduate the child from service(s). If the child is exiting from Early Intervention services, the provider and IFSP team shall complete the Exit Global Outcome Rating.

Change in Provider

If the current provider is no longer able to work with the family, the provider shall inform the RMHS Service Coordinator, providing as much warning as possible, to allow the RMHS Service Coordinator to locate a new provider to minimize the impact on the family.

Change in Insurance

Providers will notify RMHS if they become aware of family insurance changes. Please notify the RMHS Service Coordinator as soon as possible so that RMHS has ample time to collect new insurance information for billing purposes. Providers should verify insurance eligibility prior to each session.

Play and Learn Library (PAL)

The RMHS Play & Learn Library offers therapists and families a variety of innovative toys to help children learn and grow. A provider who is contracted with RMHS can make loans from the Play & Learn Library when they are working with any children birth through age 6 enrolled in the Early Intervention, CES and Family Support Services Program. Providers are responsible for checking out and returning items that are loaned, informing families of the purpose and correct use of the item, and agree to return the item clean and in the same condition as when it was loaned out.

Guidelines for Medical Record Documentation

https://www.colorado.gov/pacific/hcpf/billing-manuals

As per Health First Colorado Medicaid's documentation requirements for therapy services; Rendering providers must document all evaluations, re-evaluations, services provided, member progress, attendance records, and discharge plans. All documentation must be kept in the member's records along with a copy of the referral or prescribing provider's order. Documentation must support both the medical necessity of services and the need for the level of skill provided. Rendering providers must copy the member's primary care provider (PCP), prescribing provider and/or medical home on all relevant records.

All documentation must include the following:

1. The member's name and date of birth
2. The date and type of service provided to the member
3. A description of each service provided during the encounter including procedure codes and time spent on each (including start and stop times)
4. The total duration of the encounter
5. The name or names and titles of the persons providing each service and the name and title of the therapist supervising or directing the services.

Health first Colorado requires the following types of documentation as a record of services provided within an episode of care: initial evaluation, re-evaluation, visit/encounter notes and a discharge summary.

Initial Evaluation

Written documentation of the initial evaluation must include the following:

1. **Referral Information:** Reason for referral and referral source.
2. **History:** Must include diagnoses pertinent to the reason for referral, including date of onset; cognitive, emotional, and/or physical loss necessitating referral, and the date of onset, if different from the onset of the relevant diagnoses; current functional limitation or disability as a result of the above loss, and the onset of the disability; pre-morbid functional status, including any pre-existing loss or disabilities; review of available test results; review of previous therapies/interventions for the presenting diagnoses, and the functional changes (or lack thereof) as a result of previous therapies or interventions.
3. **Assessment:** The assessment section must include a summary of the member's impairments, functional limitations and disabilities, based on a synthesis of all data/findings gathered from the evaluation procedures. Pertinent factors which influence the treatment diagnosis and prognosis must be highlighted, and the inter-relationship between the diagnoses and disabilities for which the referral was made must be discussed.
4. **Plan of Care:** A detailed Plan of Care must be included in the documentation of an initial evaluation. This care plan must include the following:
    a. Specific treatment goals for the entire episode of care which are functionally-based and objectively measured
    b. Proposed interventions/treatments to be provided during the episode of care
    c. Proposed duration and frequency of services to be provided
    d. Estimated duration of episode of care.
        i. An episode of outpatient therapy is defined as the period of time from the first day the member is under the care of the clinician for the current condition(s) being treated by one therapy discipline until the last date of service for that plan of care for that discipline in that setting.
        ii. The therapist's plan of care must be reviewed, revised if necessary, and signed, as medically necessary by the member's physician, or other licensed practitioner of the healing arts within the practitioner's scope of practice under state law at least once every 90 days.
        iii. The care plan may not cover more than a 90-day period, or the time frame documented in the approved IFSP.
        iv. A plan of care must be certified. Certification is the physician's, physician's assistant or nurse practitioner's approval of the plan of care. Certification requires a dated signature on the plan of care or some other document that indicates approval of the plan of care. If the service is a Medicare covered service and is provided to a member who is eligible for Medicare, the plan of care must be reviewed at the intervals required by Medicare.

Re-Evaluation
A re-evaluation must occur whenever there is an unanticipated change in the member's status, a failure to respond to interventions as expected or there is a need for a new plan of care based on new problems and outcomes requiring a significant modification of treatment plan. The documentation for a re-evaluation need not be as comprehensive as the initial evaluation, but must include at least the following:

1. Reason for re-evaluation
2. Member's health and functional status reflecting any changes
3. Findings from any repeated or new examination elements
4. Changes to plan of care

Visit/Encounter Notes
Written documentation of each encounter must be in the member's record of service. These visit notes document the implementation of the plan of care established by the therapist at the initial evaluation.

Each visit note must include the following:

1. The total duration of the encounter
2. The type and scope of treatment provided, including procedure codes and modifiers used.
3. The time spent providing each service, including start and stop times. The number of units billed/requested must match the documentation.
4. Identification of the short or long-term goals being addressed during the encounter.

Colorado Medicaid requires that documentation follow the Subjective, Objective, Assessment and Plan (SOAP) format. In addition to the above required information, the visit note must include:

1. A subjective element which includes the reason for the visit, the member/caregiver's report of current status relative to treatment goals, and any changes in member's status since the last visit;
2. An objective element which includes the practitioner's findings, including abnormal and pertinent normal
3. findings from any procedures or tests performed;
4. An assessment component which includes the practitioner's assessment of the member's response to interventions provided, specific progress made toward treatment goals, and any factors affecting the intervention or progression of goals, and
5. A plan component which states the plan for next visit(s).

Discharge Summary
At the conclusion of therapy services, a discharge summary must be included in the documentation of the final visit in an episode of care. This must include the following:

1. Highlights of a member's progress or lack of progress towards treatment goals.
2. Summary of the outcome of services provided during the episode of care.

Progress Note Requirements

Progress notes are required on all children enrolled in the RMHS Early Intervention Program,

regardless of funding source or invoicing method. This includes progress notes for services paid by Medicaid, Private Insurance or the State General Fund. All documents must be submitted in a timely manner and be of high quality. They must include complete, accurate and legible information. Any of the requirements listed below need to be written in English; no other languages will be accepted.

Industry standards and best practices are that progress notes should be completed within 24 hours of service provision.

Providers may use the progress note template on the following page and on the website at www.rmhumanservices.org/ei-providers, or they may use their own program note style, as long as it contains the below information.

Please note: if you are using the RMHS template, convert each note to a PDF before sending to invoices@rmhumanservices.org to limit delays in payment.

If a provider is using his or her own progress note template, the progress note must include:

- The provider's agency name.
- The first and last name of the individual provider performing the service (i.e. in addition to signature).
- The full legal name of the child as written on the IFSP.
- The child's date of birth.
- The name of the RMHS Service Coordinator for the child.
- The IFSP service that was provided.
- If billing other than a therapy service, please specify the type of IFSP by indicating whether it was an IFSP Review, IFSP Annual or an Initial Assessment.
- A check mark or description of who is responsible for billing each service type (RMHS to bill or Provider to bill).
- The diagnosis of the child or treating diagnosis. A diagnosis is required if a provider is invoicing for a service that has a CPT code.
- The funding for the service (e.g., Medicaid, Denver Health Medicaid Choice, Kaiser, etc.).
- All dates of service.
- The word "Therapy Assistant" or "Clinical Fellow" next to the provider name, when applicable.
- A supervisor signature for any billing documentation submitted for Therapy Assistants or Clinical Fellows.
- The CPT code, if applicable, for a particular service. Some Early Intervention services, such as Developmental Intervention and Vision, do not have CPT codes and therefore the provider does not have to include a CPT code for these types of services. Providers are responsible for knowing what services require a CPT code.
- If the service you have provided is invoiced under a CPT code, an ICD-10 diagnosis code is required on the progress note or the note is considered incomplete.
- The duration of the service should be entered in minutes per CPT code. If there is no CPT code for the service, then enter duration but leave the units field blank.

Please see Appendix B for more specific information about counting minutes for timed codes.

- The total number of units per CPT code.
- Providers may not submit billing that contains more units than the intensity listed on the IFSP. In the event the intensity of a session does not match the IFSP, the provider must notify the Service Coordinator within 48 hours to ensure appropriate payment and document the reason on the Progress Note. If the intensity of sessions does not match the IFSP for two visits within a six-month period, the IFSP team may be reconvened to determine what changes need to be made on the plan.
    - Progress notes must document the reason for exceeding intensity from the following picklist:
        - Makeup Visit - Time added to session
        - Time Exceeded - Community Partner Involvement
        - Family Circumstance Req'd Additional Support
        - Accompany Family to Appt or Outing
- A narrative including any progress toward the stated goals on the IFSP, the start and end time of that activity, as well as current techniques and activities used to help the child achieve outcomes.
- Each progress note must be signed and dated.
- For providers on transdisciplinary teams who invoice for DI-Teaming during a team meeting, a separate progress note documenting the activity must be submitted for each child discussed each month that includes the child's full name and the amount of time the child was discussed. Additionally, a separate attendance note is required for the amount of time spent at the meeting overall. See below for additional information.
- Providers should note on progress notes whether interpretation was used and include the name of the agency, the name of the individual provider who interpreted for the meeting, and the type of service (i.e. OT, PT, ST, etc.).
- Progress notes should include any no-shows. After a no-show, the provider should notify the Service Coordinator before going out to the home for a second visit. ***Provider should also notify the service coordinator within 48 hours for each no show. "No Show" payment will be limited to only two in a six-month period.***
- Separate progress notes must be completed for each child.
- Progress notes must be typed. Progress notes that are not typed will be returned to the provider for resubmission, which may delay payment.

All progress notes must be sent electronically to invoices@rmhumanservices.org in an encrypted, HIPAA- compliant manner and unalterable format, such as PDF. Please see later in the manual for specific instructions on deadlines for submission.

Transdisciplinary Team Meeting and Developmental Intervention Teaming

Billing for Transdisciplinary Team Meeting and DI Teaming requires less narrative than a therapy session.

- If you attended a transdisciplinary team and did not discuss a specific child on your caseload, then you will only submit a Transdisciplinary Team Meeting note with the following information: date of meeting, duration of meeting (up to two-hour maximum), provider agency and provider name. Indicate "Trans Teaming" as the

non-CPT Code.

- If you attended a transdisciplinary team and discussed a specific child on your caseload, then you will submit a short narrative about discussion and strategies. This narrative is a separate note from the Transdisciplinary Team Meeting note and should include the following: a short narrative documenting the discussion, child's legal name, child's date of birth, date of meeting, provider agency name, provider name, unit(s) - minimum of one unit, and provider signature and date. Indicate DI-Teaming as the non-CPT Code.

Documenting Participation in an IFSP Meeting, IFSP Review (Service) and IFSP (Annual) Service

Participating in an IFSP Meeting

To be utilized when a provider attends an IFSP review or annual meeting for a child when the provider is also the service provider listed on the IFSP and services will continue after completion of the current IFSP.

IFSP Review

To be utilized when a provider participates in the IFSP six-month/Periodic Review Meeting.

IFSP Annual

To be utilized when a provider participates in the Annual IFSP and determines current levels of development in all domains at the annual IFSP meeting.

Client Name:_____ **DOB:**_____ **ICD10:**_____

Service Coordinator:_____ **EI Service:**_____

Provider Name:_____ **Provider Agency:** _____

IFSP Service Frequency:_____ **Service Location:** _____

Telehealth: □ Reason for additional units, if applicable:_____

Date of Service:_____ **Start Time:**_____ **End Time:** _____

Funding Source:

Medicaid □ State General □ Denver Health □ Trust Fund □ CHP+ □ Private Insurance: _____

Key for services with no CPT code: NS=No show PE=Parent Education 00000=Misc. Code

Units	CPT Code	Outcomes/Session Plan	RMHS or Provider to bill	Total Session Duration
			□ RMHS □ Provider	

Observations/Progress toward IFSP Goal(s):

Recommendations/Strategies:

Provider Signature:_____ **Date:**_____

Supervising Staff Signature (if applicable):_____ **Date:** _____

Please convert this document to a PDF format before submitting securely to invoices@rmhumanservices.org

Sample Progress Note

Client Name: Mary Smith **DOB:**_____ **ICD10:**_____

Service Coordinator:_____ **EI Service:** _____

Provider Name:_____ **Provider Agency:** _____

IFSP Service Frequency:_____ **Service Location:** _____

Telehealth: □ Reason for additional units, if applicable: _____

Date of Service:_____ **Start Time:**_____ **End Time:** _____

Funding Source:

Medicaid □ State General □ Denver Health □ Trust Fund □ CHP+ □ Private Insurance: _____

Key for services with no CPT code: NS=No show PE=Parent Education 00000=Misc. Code

Units	CPT Code	Outcomes/Session Plan	RMHS or Provider to bill	Total Session Duration (mins.)
4 1	97530 PE	Mary made good progress this week. She was able to bend down from a standing position to pick up objects placed on the floor around her. She was able to imitate games such as "Spring like a kangaroo". She was able to catch a small ball when it was gently thrown to her. See description of Parent Ed/Teaming Strategies.	X RMHS □ Provider	60

Observations/Progress toward IFSP Goal(s):

Mary is making significant progress toward meeting her IFSP outcome around engaging in various gross motor activities to increase her upper body strength, balance and coordination.

Recommendations/Strategies:

Continue with Physical Therapy on a weekly basis until the IFSP team meets in October at Mary's annual review to discuss her progress and any possible changes regarding her therapy and services.

Provider Signature:_____ **Date:**_____

Supervising Staff Signature (if applicable):_____ **Date:** _____

No-Show

A "no-show" is when the provider makes a good faith attempt to provide services (i.e., the provider is en route to the family's home) and the family is unavailable for a scheduled therapy session when the provider arrives to the place of the visit.

The provider will be reimbursed for their time at one unit per no show. This payment is contingent upon the provider notifying the Service Coordinator immediately after the service provider is aware of the missed appointment.

The service provider must document the missed appointment on the progress note. No CPT code should be included on the documentation for the no-show. (For example, the service provider should not be invoicing for OT for the service date; it should be invoiced as a no-show.)

A provider will only be reimbursed for two no-shows in a six-month period per child. After the first no-show, the service coordinator will contact the family. After the second no-show, the Service Coordinator will set up a meeting with the family to review the IFSP services and ensure all needs are being met.

Incident Reporting

Our early intervention providers work very hard to build solid and trusting relationships with the families of children for whom they are providing therapy. It is often very difficult when a therapist, either directly or indirectly, becomes aware of the possible abuse or neglect of a child. (Abuse may be emotional, physical, sexual or institutional.) **All RMHS contracted providers are mandated reporters** and therefore have the responsibility to keep all children safe and to prevent harm. A report must be made when a reporter, in his or her official capacity, suspects or has reasons to believe that a child has been abused or neglected. Another standard frequently used is in situations in which the reporter has knowledge of or observes a child being subjected to conditions that would reasonably result in harm to the child.

Providers should review the State of Colorado website, which has information about mandated reporters, definitions of abuse and neglect, and phone numbers to report abuse and neglect. The website is www.colorado.gov/pacific/cdhs/report-abuse.

As a mandated reporter, if you become aware of a situation where a child's physical and or emotional well-being is at risk, you are required to call the following phone number for reporting abuse and neglect:

1-844-CO-4-Kids or 1-844-264-5437 to report all concerns for a child's safety and well-being

Remember

- If a child is in imminent danger, please contact the local police immediately.
- Suspicion of abuse is all that is necessary to report.
- Reports are confidential.

- Caller must know where the child lives.
- You will be asked to describe your concerns about the child and it will be helpful if you can provide the child's name, age, address, gender, school attended (if possible) and parents' names.

Please contact the Service Coordinator immediately after you report the suspected abuse/neglect to the proper authorities to inform him or her of the situation. If the Service Coordinator is not available, please contact his or her supervisor, or another member of the management team in the Developmental & Behavioral Health Department.

If RMHS becomes aware of an allegation of abuse/neglect involving a child in our program and it is discovered that one of our contracted providers had knowledge of but failed to make a report, that provider may be subject to a full investigation and the following may occur:

1. At a minimum, a hold may be placed on any new referrals to the provider.
2. Current services being provided by the therapist may be suspended. The arrangement for coverage of those services to customers will be made by the Developmental & Behavioral Health Department.
3. Termination of his/her contract with RMHS.

Immunity from Liability – Person's Reporting *(Taken from the Colorado Code State Statute 19-3-309)*
Any person, other than the perpetrator, complicitor, coconspirator, or accessory, participating in good faith in the making of a report, in the facilitation of the investigation of such report, or in a judicial proceeding held pursuant to this title, the taking of photographs or X-rays, or the placing in temporary custody of a child pursuant to section 19- 3-405 or otherwise performing his duties or acting pursuant to this part 3 shall be immune from liability, civil or criminal, or termination of employment that otherwise might result by reason of such acts of participation, unless a court of competent jurisdiction determines that such person's behavior was willful, wanton, and malicious. For the purpose of any proceedings, civil or criminal, the good faith of any such person reporting child abuse, any such person taking photographs or X- rays, and any such person who has legal authority to place a child in protective custody shall be presumed.

Billing and Payment

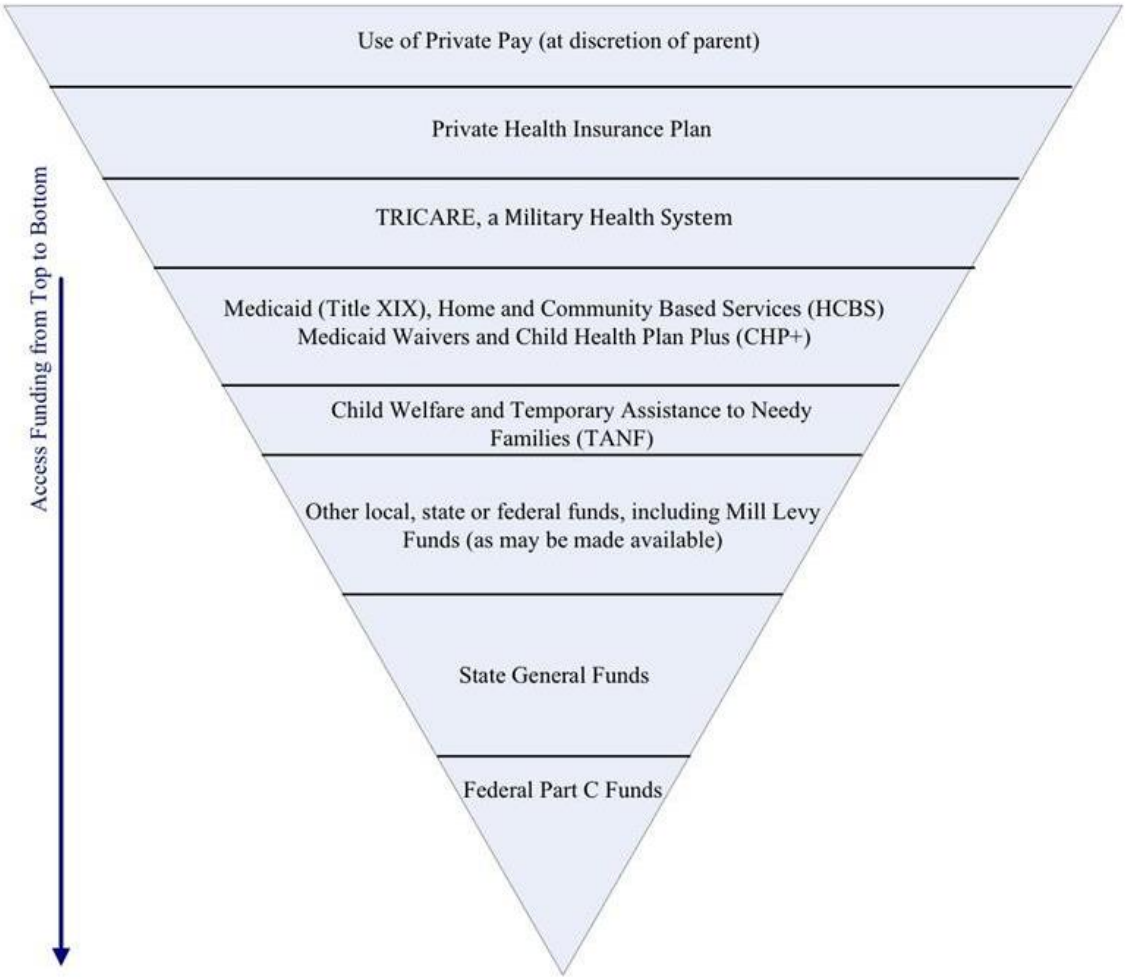
Funding Hierarchy

RMHS is required through Early Intervention Colorado to use the funding hierarchy. This means we must have providers in our network who accept reimbursement from private health insurance and Medicaid. We must always access these funding sources prior to using EI State or Federal funding. We will send referrals with information about the child's funding source, and if you agree to take the referral, we will expect that you are prepared to either invoice that funding source yourself, or to submit invoicing through RMHS for that funding source.

If you are invoicing your own services for a child with commercial insurance or Medicaid, you may only submit that child's invoicing for reimbursement by State General Fund if it is

accompanied by an Explanation of Benefit (EOB) that addresses the payment status from the funding source on the referral.

COORDINATED SYSTEM OF PAYMENT: FUNDING HIERARCHY



Progress Note Submission Requirements

If you are invoicing any services through RMHS, your progress notes serve as your invoice for payment. Provider shall electronically submit contact notes at least monthly, no later than 5 p.m. on the third (3rd) business day following the end of the month in which Services have been provided. If progress notes are not received by the invoicing deadline, payment will occur the following month. However, if notes are submitted beyond the 30-day deadline and RMHS is unable to recoup payment from outside sources, there is a risk of non- payment to the provider.

- Progress notes should be submitted electronically to invoices@rmhumanservices.org. Progress notes should be submitted in an encrypted or HIPAA-compliant manner.
- If progress notes are incomplete, have inaccuracies or are attempting to invoice for unallowable services, the progress note will be returned to the provider and payment

could be delayed. An example of an incomplete progress note is if a CPT code is listed but there is no diagnosis listed.
- We encourage you to submit your invoicing/progress notes on a weekly basis; this will allow us to review whether anything is missing with enough time for you to fix and resubmit and still be reimbursed for each service within the appropriate time frame.

Submitting Invoicing to RMHS

- Progress notes (which are your invoice) should be sent electronically to invoices@rmhumanservices.org. Emails must be sent as protected documents per HIPAA regulations.
- Providers can expect to receive an email confirmation within 72 hours of progress note submission. If you do not receive an email confirmation within this timeframe, it is likely RMHS did not receive your progress notes. Feel free to inquire at billingquestions@rmhumanservices.org.
- The files that contain progress notes should be saved and submitted by child name rather than by date of service.
- RMHS encourages you to utilize the following naming convention for each progress note uploaded to your email: “Agency Name_date sent to RMHS_child name_month of service.” For example, “ABC Provider_07.01.19_John Doe_July2019.”
- Progress notes must be accurate. If a progress note contains incorrect hours, charges for an unallowable service or a service that has not been approved on the child’s IFSP, or is missing information, providers will be notified of the problem hindering payment. Any handwritten corrections made to customer-related documents must be initialed by the provider. Payment will be based only upon receipt of the corrected progress note prior to the deadline. Payment for any corrected, resubmitted invoices will be processed within 30 days from the date of receipt.
- Providers submitting invoices with consistent issues, HIPAA violations and/or any other issues identified will have to be addressed in person at RHMS. If problems continue after the meeting, RMHS has the right terminate the provider’s contract at any time.
- Provider understands and agrees that RMHS may charge a $5.00 billing correction fee for each invoice that does not comply with the invoicing procedures set forth in the Manual.

Email Security and HIPAA

- All documents sent to RMHS must comply with HIPAA standards. (Please see the HIPAA agreement in the EI contract.) Documents must be sent to RMHS through a secured email service. RMHS sends all HIPAA- sensitive documents through encrypted email and all providers must have a personal encrypted email account to retrieve these documents. Providers may also send documents to RMHS through this secured email service.
- If providers experience problems accessing the secure email portal, we recommend emailing helpdesk@rmhumanservices.org with a detailed description of the problem. RMHS may be able to provide limited technical support or refer you to another troubleshooting resource. To limit delays in payment, feel free to submit invoices via fax to 303-636-5800, however, please be aware that providers will not receive an email confirmation to verify receipt when submitting through fax.

- Please ensure that no protected health information is included in the subject line of the email or in documents that are in an alterable format. All customer-related documents should be sent in a non-alterable format. For example, a Word or Excel document can be altered by the recipient. Examples of documents covered by this policy are progress notes, invoices, incident reports and protocols. This is not an exhaustive list. All documents should be submitted in a PDF format. Please refer to PDF instructions on the website for help with converting documents.

Prior Authorizations for Service Delivery

Medicaid and commercial payers require a Prior Authorization Record (PAR) for many of Early Intervention services.

If a provider is invoicing directly to Medicaid or another insurance company, the provider is responsible for obtaining any needed Medicaid or insurance prior authorizations. **According to Health First Colorado Program Early Intervention Billing Manual, please remember to bill EI services with the TL Modifier.**

According to the Health First Colorado Physical and Occupational Therapy Billing Manual, PARs for medically necessary services must be submitted after a certain number of units have been exceeded. For more information please visit https://www.colorado.gov/pacific/hcpf/billing-manuals

For providers with an RMHS Billing Agent agreement, RMHS will be submitting PARs on behalf of the providers in order to receive approval for services. Information will be required from the provider for approval to be received. That means that any opt-in provider for Medicaid and/or commercial insurance will need to send RMHS a PAR request form. A PAR request form will need to be completed for each individual child for any CPT codes at the following times: after every IFSP, as authorizations expire, or as providers gain credentialing-approval status with different payers. Please do not submit PAR request forms when no CPT codes are being billed for that child. It is the provider's responsibility to review this PAR authorization and to track their own billed units.

PAR Requests

1. At the time of the IFSP meeting, the ongoing provider will need to complete the Prior Authorization Request Form required by RMHS. (See Form located below or on the RMHS website.) This form includes:
    a. The patient name, member ID (if applicable), date of birth, diagnosis and place of service.
    b. The service start dates.
    c. The requested CPT codes and modifiers for the services needed by the child and the number of units that are needed for the entire length of the PAR. Please use one unit for any untimed codes.
    d. A description of the service (i.e., Speech Sound & Language Comprehension).
    e. Individual provider name and NPI.
    f. Provider signature.

2. The completed form will be sent to RMHS for submission. If a PAR is not received, RMHS will contact providers directly to request submission. If RMHS does not receive this form after three attempts to collect, RMHS reserves the right to solicit another provider.
    a. Providers can send all forms to eligibility@rmhumanservices.org or fax to 303-636-5627.
    b. RMHS will submit the PAR to the appropriate payer for approval.
3. RMHS will send the provider an updated PAR Coversheet that will include all services and unit amounts approved.
4. Providers will monitor their own individual billing and comply with their individual PAR Authorization. If changes are needed to the PAR Authorization, please see the process for PAR Amendments below.

PAR Amendments

For changes in services, provider, or to request additional units before the end of the existing PAR period, an Amendment Request (a new PAR form) must be submitted to RMHS. It is the provider's responsibility to review the Prior Authorization, track billed units and comply with individual PAR Authorization.

1. A new PAR form must be completed with all of the above information included when changes in the child's service, frequency or provider occurs.
2. The completed form will be sent to RMHS for submission.
    a. Send all requests to eligibility@rmhumanservices.org or fax to 303-636-5627.
    b. RMHS will submit the PAR to the appropriate payer for approval.
3. RMHS will send the provider an updated PAR Coversheet that will include all services and unit amounts approved.

Example of Completed PAR Request Form

Patient Name: Jane Doe
Patient Member ID: O123456
DOB: 11/3/16
Diagnosis: F80.1
Place of Service: Home
Provider Medicaid ID: 123456
Provider NPI: 12345678

Tax ID: 841182143

Email: eligibility@rmhumanservices.org

Fax: (303) 636-5627

Service Date Range	CPT Code(s)	Modifier(s)	Service Type Description	Units (for length of PAR)	Provider/NPI
09/15/16-09/14/17	92507	GN, TL	Treatment of speech, language, articulation	52*	Jane Doe
09/15/16-09/14/17	92523	GN, TL	Evaluation of speech, language, articulation	8	Jane Doe

**note: encounter-based (non-timed) CPT codes are billed at 1 unit per session.*

Prior Authorization Form Template

RMHS
Developmental & Behavioral Health
Rocky Mountain Human Services
9900 Iliff Ave. Denver CO 80022

Prior Authorization Request

Patient Name:
Patient Member ID:
DOB:
Diagnosis:

Tax ID: 841182143

Email: eligibility@rmhumanservices.org

Fax: (303) 636-5627

Place of Service:
Provider Medicaid ID:
Provider NPI:

Service Date Range	CPT Code	Modifier(s)	Service Description	Units *(for length of PAR)*	Provider Name

Comments *(for office use only):* Early Intervention Services, please see attached IFSP.

Submitting Medicaid or Insurance Denials to RMHS

Denials from Medicaid or other insurance companies may be sent to RMHS for reimbursement through the State General fund. Providers are responsible for researching and resubmitting Medicaid denied claims. The only denial code that will be accepted by RMHS include code 271 (child is no longer Medicaid eligible) and 0308 (child is eligible for Denver Health Medicaid). Questions about denials can be sent to billingquestions@rmhumanservices.org.

To be reimbursed for denials through the State General Fund, the following must be submitted to invoices@rmhumanservices.org within 30 days of receiving the explanation of benefits (EOB):

1. A copy of the EOB.
2. The progress note corresponding to the date listed on the EOB.
    a. The progress note must contain the following information: child's full name, diagnosis code, date(s) of service, CPT code(s) and unit amounts.
3. If a service is not covered by a child's insurance plan, only one denial is needed per benefit period. However, the EOB from the original denial must be submitted with each billing. The CPT code(s) on the EOB must match the billing that is being submitted. Providers are responsible for knowing when a child's insurance plan benefit renews and submitting a new claim to insurance for a denial.

After RMHS has received proper denial documentation, payment for services rendered within the timely filing period will be sent to providers within 30 days.

Process for EOBs, Co-Pays, Co-Insurance and Deductibles

For any provider who is not billing through RMHS, please be aware that any co-pays, co-insurance and deductibles cannot be charged to families receiving services. To be reimbursed for co-pays, co-insurance and deductibles through the State General Fund, the following must be submitted to invoices@rmhumanservices.org within 30 days of receiving the EOB:

1. A copy of the EOB
2. Patient name
3. DOB
4. Payor name
5. CPT code(s)
6. Allowed amount
7. Paid amount
8. Amount to be paid by State General Fund

Billing may be submitted directly to RMHS for reimbursement if the child's deductible amount is greater than $2,500 and the family is not likely to meet this deductible during their benefit period. Progress notes must document that the insurance coverage is a high deductible plan. Providers are responsible for periodically verifying that the deductible amount will not be met. Documentation of the deductible must be submitted with the initial billing, with each IFSP progress note, and at each benefit renewal.

Payment

For providers invoicing through RMHS, clean claims (complete progress notes) will be paid for claims received no later than 5 p.m. on the third (3rd) business day following the end of the

month in which Services have been provided.

RMHS reserves the right to process progress notes and pay providers prior to the 30-day deadline. For example, if a provider invoices weekly, RMHS may choose (but is not contractually required) to process the invoices and pay the provider on a weekly or bi-weekly basis. In these situations, checks remitted to providers may appear to be "short."

- Providers need to be aware that the payment for complete progress notes may be variable but will not exceed 30 days after the established billing date. If RMHS issues checks on a bi-weekly basis for three months, providers should not expect that this has suddenly become the payment policy and RMHS will continue to do this every month. Providers should not count on checks coming before the contractually agreed upon timeframe of 30 days after the invoicing deadline. RMHS reserves the right to not respond to provider inquiries about lacking payment if the inquiry is received before the 30-day deadline has occurred.
- Providers will receive a remittance statement along with their checks.
- If you do not receive full payment within the 30-day deadline, please specify the problem you are having and attach any corresponding documentation (i.e. progress notes) to billingquestions@rmhumanservices.org. We appreciate your patience as we are processing a high volume of questions and you can expect a response within 72 hours or as soon as possible.

Provider Update Form

Provider organizations shall provide notification of any new or terming employees to RMHS within 15 days of the date of hire; new-employee notification is required if they will be available to provide services to RMHS clients. Managers need to submit a completed Provider Update form and send it to the appropriate department determined by the organizations opt-in status. Providers will need to know their opt-in status for invoicing RMHS in order to complete the correct form. If you have questions regarding the opt-in status, please contact providersupport@rmhumanservices.org. Both Provider Update forms are available on the RMHS web page.

Complaint and Grievance Procedures

Complaint procedures: A complaint is defined as an oral expression of dissatisfaction.

1. Providers shall file a complaint regarding a specific process or procedure of the agency with the department designee to which it pertains.
    a. Early Intervention: Beth Scully 303-636-5978 or bscully@rmhumanservices.org.
    b. Contracts: Keelyn Hutchison 303-636-5734 or khutchison@rmhumanservices.org
    c. Compliance & Quality: Dianne Clarke 303-636-5819 or dianneclarke@rmhumanservices.org.
    d. Revenue Cycle (invoices and billing): Billingquestions@rmhumanservice.org
    e. Credentialing: Sharry DiQuinzio 303-636-5762 or sdiquinzio@rmhumanservices.org.
2. If the matter is not resolved to the satisfaction of the provider at the department designee level, the provider is encouraged to discuss the complaint with the department

director.
   a. Early Intervention Director: Jodi Dooling-Litfin 303-636-5979 or jlitfin@rmhumanservices.org.
   b. Contracts and Compliance Director: John Wetherington 303-636-5796 or jwetherington@rmhumanservices.org.
   c. Revenue Cycle & Credentialing Director: Dianne Clarke 303 636-5819 or dianneclarke@rmhumanservices.org.
3. If the matter is unable to be resolved at the director level, the provider shall contact the Executive Director Shari Repinski at 303-636-3833 or srepinski@rmhumanservices.org.
4. Should the matter be unresolved by the Executive Director, the provider shall contact the Board of Directors by obtaining contact information from the RMHS Executive Assistant.

Grievance Procedures: A grievance is defined as a written expression of dissatisfaction. If the provider is not satisfied with attempts at resolving a complaint and would like to file a grievance, the provider may do so by putting concerns in writing. Written grievances should include the following:

- A thorough and compete written explanation of the grievance and the desired outcome.
- The date the grievance is submitted.
- The individual's signature. RMHS staff will not follow up on anonymous grievances.

1. Providers who choose to file a grievance regarding a specific process or procedure of the agency shall do so with the department director to which it pertains.
   a. Early Intervention: Jodi Dooling-Litfin 303-636-5979 or jlitfin@rmhumanservices.org.
   b. Contracts and Compliance: John Wetherington 303-636-5796 or jwetherington@rmhumanservices.org.
   c. Revenue Cycle & Credentialing: Dianne Clarke 303-636-5819 or dianneclarke@rmhumanservices.org.
2. A meeting shall be held to discuss the grievance within 10 working days of receipt of the grievance and may include the use of mediation if both parties voluntarily agree to this process.
   a. If mutually agreed upon, the meeting can be conducted by phone.
   b. If the department director has made good faith efforts to contact the provider and schedule the meeting within the 10-day timeframe and is unable to do so, then the grievance will be dropped unless there are extenuating circumstances to warrant an extension.
3. The department director shall provide a written response identifying the relevant issues and discussing the outcome of the meeting within five days of the meeting.
4. If after discussing all the facts with the department director, the individual continues to be dissatisfied, he or she may request a meeting with the Executive Director.
   a. This request must be made in writing by the individual and be signed and dated by the individual.
5. The Executive Director shall meet with the individual and any other involved RMHS staff to discuss the grievance. This meeting shall be scheduled within 10days of receipt of the grievance.

6. The Executive Director shall provide a written response identifying the relevant issues and outcome of the meeting. Most decisions shall be rendered within five working days of the meeting with the individual. If more time is needed, the individual will be notified.
7. Should the outcome not satisfy the individual, he/she shall contact the Board of Directors by obtaining contact information from the RMHS Executive Assistant.

A log shall be maintained that documents all complaints and grievances received by RMHS. Information shall be reviewed by the Compliance Committee and recommendations will be made to the RMHS Leadership Team to be used in the overall improvement of agency processes and stakeholder relations, as well as strategic-planning purposes.

Contact Information

Trans-Disciplinary Questions:
EI Provider Referral, EI-Provider-Referral@rmhumanservices.org

Child Outcomes Summary, PAL Questions and Initial Set-Up in EI Database:
Ann Howell, AHowell@rmhumanservices.org

Progress Notes:
Send secure (i.e., fuse mail) and stable (i.e., PDF format) progress notes to invoices@rmhumanservices.org

Prior Authorization Request Forms:
Send secure (i.e., fuse mail) and stable (i.e., PDF format) forms to eligibility@rmhumanservices.org, or fax to 303- 636-5627.

Provider Relations:
Dulce Thompson, 303-636-5895 dthompson@rmhumanservices.org

Appendix A

Source:
https://dcfs.my.salesforce.com/sfc/p/#410000012srR/a/41000000Cg4I/oZfiCvVWB_VK4cB71wbKI5pdYwjRB NtFN24QOpeWNx0

EARLY INTERVENTION SERVICES RULE 12 CCR 2509-10

7.950 EARLY INTERVENTION SERVICES

A. Early Intervention Services shall be:
   1. Provided only after the development of an Individualized Family Service Plan and written parental consent is obtained for those services identified in the Individualized Family Service Plan; and,
   2. Provided to meet the developmental needs of an eligible infant or toddler, and the needs of a parent or other caregivers, to achieve the outcomes identified in the Individualized Family Service Plan; and,
   3. Based on appropriate peer-reviewed, evidence-based practices, to the extent which is practical; and,
   4. Related to functional outcomes and developmentally appropriate practices to support participation in everyday routines, activities and places; and,
   5. Provided by qualified providers who meet the state personnel standards for each early intervention service; and,
   6. Provided in a culturally relevant matter, including use of an interpreter, if needed; and,
   7. Provided in the natural environments of the child and family to the maximum extent appropriate. If there is a dete1mination that an early intervention service cannot be provided in a natural environment, written justification shall be provided in the Individualized Family Service Plan; and,
   8. Provided in physical settings where community-based early intervention services are accessed that meet all fire, building, licensing and health regulations, as applicable.

B. Early intervention services shall include the following:
   1. Assistive Technology Services"
      a. Means the direct selection, acquisition or use of assistive technology devices and includes:
         i. Functional evaluation of the developmental needs of the infant or toddler in his or her usual environments; and,
         ii. Selection, acquisition, modification or customization and maintenance of assistive technology devices; and,
         iii. Coordinating and using other therapies, interventions or services with assistive technology devices, such as those associated with existing intervention plans and programs; and,
         iv. Training or technical assistance for professionals providing early intervention services or other individuals identified as providing early intervention services to, or are otherwise substantially involved in the major life functions of, an infant or toddler on the use of assistive

technology devices; and,

v. Training or technical assistance for an infant or toddler receiving early intervention services or, if appropriate, the child 's family; and,

vi. Any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified or customized, that is used to increase, maintain, or improve the functional, developmental capabilities of an infant or toddler in his or her usual environments.

1. The device must be identified in the Individualized Family Service Plan; and,
2. Prior to purchase or lease of an assistive technology device, an assessment shall be conducted by a qualified early intervention provider to assure that the device is appropriate for the child and family's needs.

b. Does not mean, a device that is primarily intended to treat a medical condition, to meet life- sustaining needs, or a medical device that is surgically implanted, including a cochlear implant. It also does not mean the optimization, maintenance or the replacement of such a device.

2. “Audiology Services”

a. Means, services for the identification of an infant or toddler with an auditory impairment, using at- risk criteria and appropriate audiologic screening techniques, and includes:

i. Loss and communication functions, by use of audiological evaluation procedures; and;

ii. Auditory training, aural rehabilitation, speech reading and listening devices, orientation, and other training to increase functional communication skills; and,

iii. The determination of the need for individual amplification, including selecting, fitting and dispensing an approp1iate listening and vibrotactile device, and evaluating the effectiveness of the device; and,

iv. Referral for medical and other services necessary for the habilitation or rehabilitation of an infant or toddler with a disability which is an auditory impairment; and,

v. Family training, education, and support provided to assist a parent or other caregivers of a child eligible for services in understanding the special needs of the infant or toddler as related to audiology and aural rehabilitation services; and,

vi. The provision of services for prevention of hearing loss.

b. Does not mean, therapeutic services required for an infant or toddler to recover from medical procedures such as surgery, etc., or pre-surgery therapeutic services required by a physician to prepare a child for surgery and that are beyond the scope of the early intervention services identified in the child's Individualized Family Service Plan as being needed to meet the child's developmental outcomes.

3. “Developmental Intervention Services” in this section of the rules means developmental

assessment and special instruction to address the functional developmental needs of an infant or toddler and includes:

a. The design or adaptation of learning environments, activities and mate1ials to enhance developmental and learning opportunities that promote the infant's or toddler's acquisition of skills in a variety of developmental areas, including cognitive processes and social interaction; and,
b. Curriculum planning, including the planned interaction of personnel, materials, and time and space, that leads to achieving the outcomes in the child's Individualized Family Service Plan; and,
c. Working with the child to enhance the child 's development; and,
d. Family training, education and support provided to assist a parent or other caregivers in understanding the special needs of the child related to enhancing the skill development of the child.

4. “Health Services”
    a. Means services by a licensed health care professional that enable an eligible infant or toddler to benefit from other allowable early intervention services and includes:
        i. Assessment to determine the health status and special health care needs that will impact the provision of other early intervention services; and,
        ii. Services such as clean intermittent catheterization, tracheostomy care, tube feeding, the changing of dressings or colostomy bags, and other health services; and,
        iii. Consultation by a health care professional with a parent or other service provider regarding the impact of the infant or toddler's health status on the provision of other early intervention services.
    b. Does not mean:
        i. Services that are:
            1. Purely medical in nature, such as hospitalization, or the prescribing of medicine or other drugs for any purpose; or,
            2. Surgical in nature, such as cleft palate surgery or shunting for hydrocephalus; or,
            3. Medical diagnostic procedures, services that are primarily intended to treat a medical condition; or,
            4. Related to the implementation, optimization, maintenance, or replacement of a medical device that is surgically implanted.
        ii. Devices necessary to control or treat a medical condition or that are medical or health services routinely recommended for all infants and toddlers.
    c. Nothing in this section of the rules limits the rights of an infant or toddler with a disability, that has a surgically implanted device, to receive the early intervention services identified in the child's Individualized Family Service Plan as being needed to meet the child's developmental outcomes.
    d. Nothing in this section of the rules prevents the early intervention services provider from routinely checking that either the hearing aid or the external components of a surgically implanted device, such as a cochlear implant, used by

an infant or toddler with a disability are functioning properly.

5. “Medical Services” means services provided by a licensed physician for diagnostic or evaluation purposes, to determine a child's developmental status and need for early intervention services.

6. “Nursing Services” means:
    a. Assessment of health status for the purpose of providing nursing care, including the identification of patterns of human response to actual or potential health problems; and,
    b. Nursing care to prevent health problems, restore or improve functioning, and promote health and development; and,
    c. The administration of medications, treatments, and regimens prescribed by a licensed physician.

7. “Nutrition Services” means development of a plan to address the nutritional and feeding needs of an infant or toddler related to his or her development, and includes:
    a. The assessment of the nutritional history, dietary intake, body measurements such as height and weight, and feeding status; and,
    b. Consultation to develop, implement and monitor appropriate plans to address the nutritional needs; and,
    c. Referral to appropriate community resources to carry out nutritional plans; and,
    d. Family training, education and support provided to assist a parent or other caregivers in understanding the special needs of the child related to nutrition and feeding and enhancing the child's development.

8. “Occupational Therapy Services” means:
    a. Assessment and intervention services with an emphasis on adaptive skills, motor and sensory development, mobility, play and oral-motor functioning and includes:
        i. Intervention strategies to address the functional developmental needs, including oral motor functioning of an infant or toddler, minimizing the impact of initial or future impai1ment, and delay in development or loss of functional ability; and,
        ii. Consultation to adapt the environment to promote development, access and participation in everyday routines, activities and places; and,
        iii. The selection, design or fabrication of assistive and orthotic devices to promote mobility or pai1icipation in everyday routines, activities and places; and,
        iv. Family training, education, and suppo11provided to assist a parent or other caregivers in understanding the special needs of the child as related to occupational therapy strategies and enhancing the child's motor development.
    b. Does not include therapeutic services required due to, or as part of, a medical procedure, a medical intervention or an injury that is expected to heal without a long-term impact to child development and that are beyond the scope of the early intervention services identified in the child's Individualized Family Service Plan as

being needed to meet the child' developmental outcomes.

9. “Physical Therapy Services” means:
    a. Assessment and intervention services with an emphasis on mobility, positioning, motor development, and both strength and endurance and includes:
        i. Intervention strategies to address the functional developmental needs of an infant or toddler; and,
        ii. Through individual or group services, to obtain, interpret and integrate information for program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems; and,
        iii. The design or acquisition of assistive and orthotic devices and effective adaptation of the child's environment to promote mobility and participation in everyday routines, activities and places, and minimize the impact of initial or future impairment, delay in development or loss of functional ability; and,
        iv. Family training, education, and support provided to assist a parent or other caregivers in understanding the special needs of the child as related to physical therapy strategies and enhancing the child's motor development.
    b. Does not include therapeutic services required due to, or as part of, a medical procedure, a medical intervention or an injury that is expected to heal without a long-term impact to child development and that are beyond the scope of the early intervention services identified in the child's Individualized Family Service Plan as being needed to meet the child's developmental outcomes.

10. “Psychological Services” means assessment and intervention services that address the development, cognition, behavior and social or emotional development of an infant or toddler and includes:
    a. The administration of psychological and developmental tests and other assessment procedures to identify the developmental, cognitive, behavioral and social emotional status;
    b. The acquisition, integration and interpretation of test results, other information about development and behavior and the family and living situation related to learning, social or emotional development and behavior; and,
    c. The provision of individual or parent counseling, activities; and,
    d. Planning and managing a child's program of psychological services; and,
    e. Consultation on child behavior, child and family conditions related to learning, mental health, and development to a parent, other caregivers and other service providers; and,
    f. Family training, education, and support provided to assist a parent or other caregivers in understanding the special needs of the child as related to psychological strategies and enhancing the child's psychological and cognitive development.

11. “Sign Language and Cued Language Services” means instruction that includes sign language, cued language, auditory or oral language, providing oral transliteration services, and providing sign and cued language interpretation for an infant or toddler.

12. "Social and Emotional Services" means assessment and intervention services that address social and emotional development in the context of a family and parent• child interaction and includes:
    a. Home visits to evaluate an infant's or toddler's living conditions and patterns of parent-child interaction; and,
    b. The completion of social or emotional developmental assessment; and,
    c. The provision of individual or group counseling to an infant or toddler or a parent in order to understand the parental needs related to his or her child 's development and how to enhance the development of the child; and,
    d. The provision of social skill building activities with the child and parent; and,
    e. Intervention strategies to address issues in the living or caregiving situation that may affect the child 's development and/or utilization of other allowable early intervention services; and,
    f. The identification, mobilization and coordination of c01mnunity resources and services to enable an infant or toddler and his or her parent to receive maximum benefit from other early intervention services; and,
    g. Family training, education, and support provided to assist a parent or other caregivers in understanding the special needs of the child as related to strategies for enhancing the child's social or emotional development.

13. "Speech Language Pathology Services"
    a. Means assessment and intervention services to address the functional and communication needs of an infant or toddler, and includes:
        i. Language and speech development; and,
        ii. Oral motor functioning, including the identification of specific communication disorders; and,
        iii. Consultation to adapt an environment and activities to promote speech and language development and participation in everyday routines, activities and places; and;
        iv. Habilitation, rehabilitation or prevention of communication disorders, and delays in language and speed development; and,
        v. Referral for medical or other professional services necessary for the habilitation or rehabilitation of an infant or toddler with communication disorders or delays; and,
        vi. Family training, education and support provided to assist a parent or other caregivers in understanding the special needs of the child as related to speech language pathology strategies and enhancing the child's communication development.
    b. Does not include therapeutic services required due to, or as part of, a medical procedure, a medical intervention or an injury that is expected to heal without a long-term impact to child development and that are beyond the scope of the early intervention services identified in the child's Individualized Family Service Plan as being needed to meet the child's developmental outcomes.

14. "Transportation Services" means reimbursement for the cost of travel, including mileage, taxis, common carriers, and tolls or parking, that are necessary to enable an infant or

toddler and his or her parent to receive another Early Intervention Service identified in the Individualized Family Service Plan.

15. "Vision Services"
    a. Means evaluation and assessment of visual functioning, including the diagnosis and appraisal of specific visual disorders and delays that affect child development, and the intervention services to address the functional visual needs of an infant or toddler with significant vision impairment and includes:
        i. Communication skills training; and,
        ii. Orientation and mobility training for all environments; and,
        iii. Visual and other training necessary to activate visual motor abilities; and,
        iv. Refe1Tal for medical or other professional services necessary for the habilitation or rehabilitation of visual functioning disorders, or both; and,
        v. Consultation to adapt an environment and activities for a child with a visual impairment to promote development, access and participation in everyday routines, activities and places; and,
        vi. Family training, education and support provided to assist a parent or other caregivers in understanding the special needs of the child as related to vision strategies and enhancing the child's overall development.
    b. Does not mean therapeutic services required due to, or as part of, a medical procedure, a medical intervention or an injury and that are beyond the scope of the early intervention services identified in the child's Individualized Family Service Plan as being needed to meet the child's developmental outcomes.

PROCEDURES - Early Intervention Services

A. Planning for early intervention services shall include:
    a. With parental consent/or the use of family assessment, the identification of a family's lifestyle, routines, schedule, priorities and the environments that are natural and typical for that family;
    b. Identification of functional outcomes that are relevant to the natural environments and routines identified by the family;
    c. Development of strategies and activities that address the functional outcomes;
    d. Determination of which early intervention sen1ices are needed, as identified by the Individualized Family Service Plan team. The preference of any single team member is not a justification for services to be provided in an environment other than one that is natural and normal for the everyday routines and activities of that child and family;
    e. Selection of sen1ice settings that are not chosen based solely on factors, such as category of disability, severity of disability, configuration of the delivery system, age, availability of services, availability of space, availability of equipment or administrative convenience; and,
    f. Identification of qualified Early Intervention personnel to support specific strategies and activities in consultation with family members and other caregivers.

B. If a natural environment requirement creates a barrier to the implementation of a child's Individualized Family Service Plan due to unique community or family circumstances, the

Department will work with the Community Centered Board to develop creative strategies that are consistent with the natural environment policy and responsive to the needs of the child and family.

Appendix B

Counting Minutes for Timed Codes in 15 Minute Units

Units Number of Minutes

1 unit: ≥ 8 minutes through 22 minutes

2 units: ≥ 23 minutes through 37 minutes

3 units: ≥ 38 minutes through 52 minutes

4 units: ≥ 53 minutes through 67 minutes

5 units: ≥ 68 minutes through 82 minutes

6 units: ≥ 83 minutes through 97 minutes

7 units: ≥ 98 minutes through 112 minutes

8 units: ≥ 113 minutes through 127 minutes

The pattern remains the same for treatment times in excess of 2 hours.