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200.000 GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Early Intervention Day Treatment (EIDT) Providers

4-1-24

A provider must meet the following participation requirements to qualify as an Early Intervention Day Treatment (EIDT) provider under Arkansas Medicaid:

- A. Complete the provider participation and enrollment requirements contained within section 140.000 of this Medicaid manual;
- B. Except as provided in section 201.200 of this Medicaid manual, obtain a child-care facility license issued by the Arkansas Department of Education; and

- C. Obtain an Early Intervention Day Treatment license issued by the Arkansas Department of Human Services, Division of Provider Services and Quality Assurance (see Ark. Code Ann. §§ 20-48-1101 et seq. and DDS Policy 1089-B regarding requirements to obtain an Early Intervention Day Treatment license).

201.100 Academic Medical Center Specializing in Developmental Pediatrics 4-1-24

- A. An academic medical center specializing in developmental pediatrics is eligible for reimbursement as an EIDT provider if it:
1. Is located in Arkansas;
 2. Provides multi-disciplinary diagnostic and evaluation services to children throughout Arkansas;
 3. Specializes in developmental pediatrics;
 4. Serves as a large, multi-referral program and referral source for non-academic medical center EIDT providers within Arkansas;
 5. Provides training to pediatric residents and other professionals in the delivery of multi-disciplinary diagnostics and evaluation services to children with developmental disabilities and other special health care needs; and
 6. Does not provide treatment services to children.
- B. An EIDT provider operating as an academic medical center is not required to be a licensed child care facility.
- C. An EIDT provider that operates as an academic medical center may bill diagnostic and evaluation codes outside of those used by a non-academic medical center EIDT program, but may not bill EIDT treatment codes. [View or print the academic medical center billable EIDT procedure codes and descriptions.](#)

202.000 Documentation Requirements 1-1-21

202.100 Documentation Requirements for All Medicaid Providers 4-1-24

See section 140.000 of this Medicaid manual for the documentation that is required for all Arkansas Medicaid providers.

202.200 EIDT Documentation Requirements 4-1-24

- A. EIDT providers must maintain in each beneficiary's service record.
1. An initial evaluation referral signed and dated by the beneficiary's primary care provider (PCP) (see section 212.200);
 2. The annual treatment prescription for EIDT services signed and dated by the beneficiary's PCP (see section 212.300);
 3. The individualized treatment plan (ITP); and
 4. Discharge notes and summary, if applicable.
- B. The service record of a beneficiary who has not yet reached school age (see section 212.100(B)) must include the results of an annual comprehensive developmental evaluation pursuant to section 212.400 of this Medicaid manual.
- C. The service record of a school age beneficiary must include a documented qualifying diagnosis pursuant to section 212.500 of this Medicaid manual.

- D. EIDT providers must maintain in each beneficiary's service record the following documentation for all nursing services performed pursuant to section 222.150 of this Medicaid manual:
1. The date and beginning and ending time for each of the nursing services performed each day;
 2. A description of the specific services provided and activities performed each day; and
 3. Name(s) and credential(s) of the person(s) delivering each nursing service each day.
 4. Which client ITP goal(s) and objective(s) the day's services are intended to address; and
 5. Weekly or more frequent progress notes, signed or initialed by the person(s) providing the service(s) describing the client's status with respect to ITP goals and objectives for that service.
- E. EIDT providers must maintain in each beneficiary's service record the following documentation for all day habilitative services performed pursuant to section 222.120 of this Medicaid manual:
1. The date and beginning and ending time for the services performed each day;
 2. Name(s) and credential(s) of the person(s) delivering services each day;
 3. Which of the beneficiary's ITP goal(s) and objective(s) the week's services were intended to address; and
 4. Weekly or more frequent progress notes signed or initialed by the Early Childhood Development Specialist (ECDS) overseeing the beneficiary's ITP describing the beneficiary's status with respect to ITP goals and objectives.
- F. EIDT providers must maintain in the beneficiary's service record all the documentation specified in section 204.200 of Section II of the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services Medicaid manual for all occupational therapy, physical therapy, and speech-language pathology services performed pursuant to sections 222.130 and 222.140 of this Medicaid manual:
- G. EIDT providers must maintain the following documentation related to EIDT transportation services performed pursuant to section 222.210 of this Medicaid manual:
1. A separate transportation log must be maintained for each trip that a vehicle is used by an EIDT to transport one (1) or more beneficiaries that lists:
 - a. Each transported beneficiary's:
 - i. Name;
 - ii. Age;
 - iii. Date of birth;
 - iv. Medicaid ID number;
 - v. Exact address of pick up and drop off; and
 - vi. Exact time of pick up and drop off.
 - b. The driver of the vehicle;
 - c. Each attendant or any other persons transported; and
 - d. Odometer reading for vehicle at the trip's:
 - i. Initial pick up; and
 - ii. Final drop off.
 2. The driver of each vehicle must sign and date each transportation log verifying that each beneficiary that received transportation services from the EIDT was safely transported to and from:

- a. The **beneficiary's** home (or other scheduled pick-up or drop-off location); or
 - b. The EIDT facility.
- 3. An EIDT must maintain all transportation logs for five (5) years from the date of transportation.
- H. An EIDT provider must maintain documentation verifying the required qualifications of any individual performing occupational therapy, physical therapy, speech-language pathology, or nursing services on behalf of the EIDT. Refer to section 202.000 of this Medicaid manual.
- I. An EIDT provider must maintain a copy of the contractual agreement with any individual contracted to perform occupational therapy, physical therapy, speech-language pathology or nursing services on behalf of the EIDT.

202.300 Electronic Signatures

4-1-24

Arkansas Medicaid will accept electronic signatures in compliance with Ark. Code Ann. § 25-31-103, et seq.

210.000 PROGRAM ELIGIBILITY

211.000 Scope

4-1-24

Arkansas Medicaid will reimburse licensed EIDT providers for covered EIDT services **when such services are** provided pursuant to an individualized treatment plan in compliance with this Medicaid manual to beneficiaries enrolled in the Child Health Services (EPSDT) Program who meet the eligibility requirements of this Medicaid manual. Medicaid reimbursement is conditional upon compliance with this Medicaid manual, manual update transmittals, and official program correspondence.

212.000 Establishing Eligibility

1-1-21

212.100 Age Requirement

4-1-24

- A. A **beneficiary** must be under the age of twenty-one (21) to receive covered EIDT services.
- B. EIDT services may be provided year-round to **beneficiaries who have not yet reached school age**. For purposes of this Medicaid manual, a beneficiary has not yet reached school age if the beneficiary has:
 - 1. **Not** met the age requirement for kindergarten enrollment; or
 - 2. **Filed a signed kindergarten waiver and their first (1st) grade school year has not started.**
- C. EIDT services may be provided to school age **beneficiaries (i.e. beneficiaries who have met the age requirement for kindergarten)** during the summer when school is not in session to prevent a **beneficiary** from regressing.

212.200 Referral to Evaluate

4-1-24

- A. A beneficiary must receive an evaluation referral for EIDT services on a DMS-642 ER "Early Intervention Day Treatment (EIDT) Evaluation Referral" ([View or print the form DMS-642 ER](#)) signed and dated by the beneficiary's primary care provider (PCP). If a beneficiary is already enrolled in an EIDT program as of April 1, 2024, then an active treatment prescription for the EIDT services dated between April 1, 2023, and March 31, 2024, may be used as a substitute and a new DMS-642 ER is not required.

- B. An evaluation referral is only required for the *initial* qualifying evaluations related to EIDT core services.
1. No evaluation referral is required for an EIDT provider to perform the annual reevaluation required to demonstrate the continued eligibility of a beneficiary with an active treatment prescription for the particular EIDT core service that is about to expire.
 2. A school age beneficiary attending an EIDT during the summer when school is not in session does not require a new DMS-642 ER evaluation referral if they attended an EIDT the summer immediately prior to the beneficiary's current school year.
 3. If a beneficiary already has an active treatment prescription for occupational therapy, physical therapy, or speech-language pathology services through a private clinic or school at the time of their initial evaluation referral for EIDT services, then a new evaluation is not required. The PCP's active DMS-640 treatment prescription related to the private clinic or school occupational therapy, physical therapy, or speech-language pathology treatment services will be accepted in place of a DMS-642 ER evaluation referral for the service.

Example: Based on the results of a development screen, a PCP believes a three (3) year old beneficiary could qualify for year-round EIDT services. The beneficiary is currently receiving occupational therapy services through a private therapy clinic, and the PCP thinks the beneficiary may also qualify for physical therapy services. The PCP is required to complete (and an EIDT provider is required to maintain in the beneficiary's service record) the following:

- A. Comprehensive Developmental Evaluation: since the beneficiary has not yet reached school age and is not currently receiving EIDT services, the PCP would need to sign and date a DMS-642 ER with the "Developmental Evaluation" box checked.
1. If after evaluation the beneficiary qualifies for EIDT services, a new DMS-642 ER is not required to perform the annual reevaluations to demonstrate the beneficiary's continued eligibility for EIDT services if the beneficiary is still enrolled at the EIDT at the time. The EIDT provider can perform and submit a claim for the required comprehensive developmental reevaluation the next year when due without a new DMS-642 ER from the PCP.
 2. If after evaluation the beneficiary does not qualify for EIDT services, the PCP would have to issue a second DHS-642 ER with the "Developmental Evaluation" box checked for the EIDT provider to perform and submit a claim for another developmental evaluation later.
- B. Occupational Therapy: since the beneficiary already has an active treatment prescription for occupational therapy services through a private clinic, there is no need to perform an additional occupational therapy evaluation as part of the EIDT evaluation referral (unless the active occupational therapy treatment prescription is set to expire).
1. The DMS-640 active treatment prescription related to the occupational therapy treatment services by the private clinic at the time of EIDT service referral is all that must be maintained by the EIDT provider.
 2. However, if the PCP is already completing a DMS-642 ER related to initial developmental or other evaluations, the PCP may for clarity purposes also check the "Occupational Therapy" box on the same DMS-642 ER to clearly demonstrate on a single document the full array of potential EIDT services for which the PCP believes the beneficiary may qualify.
- C. Physical Therapy: since the beneficiary is not currently receiving physical therapy services, the PCP would need to check the "Physical Therapy" box on the same DMS-642 ER used for the developmental evaluation (see (C) 1).

1. If after evaluation the beneficiary qualifies for physical therapy services, a new DMS-642 ER is not required to perform the annual reevaluations to demonstrate the beneficiary's continued eligibility for physical therapy services if the beneficiary is still receiving physical therapy from the EIDT at that time. The EIDT provider can perform and submit a claim for the required physical therapy reevaluation the next year when due without a new DMS-642 ER from the PCP.
2. If after evaluation the beneficiary does not qualify for physical therapy treatment services, the PCP would have to issue a second DHS-642 ER with the "Physical Therapy" box checked for the EIDT provider to perform and submit a claim for another physical therapy evaluation later.

212.300

Treatment Prescription

4-1-24

- A. EIDT core services require an annual treatment prescription signed and dated by the beneficiary's primary care provider.
- B. A prescription for core EIDT services is valid for twelve (12) months, unless a shorter period is specified. The prescription must be renewed at least once a year for covered EIDT services to continue.
- C. The annual treatment prescription for year-round EIDT services must be on a form DMS-642 YTP "Early Intervention Day Treatment Services Year-Round Treatment Prescription." [View or print the form DMS-642 YTP](#). Beneficiaries who are already enrolled in an EIDT pursuant to a valid treatment prescription (on a DMS-640) as of April 1, 2024, are not required to obtain a new treatment prescription on a form DMS-642 YTP until their existing EIDT treatment prescription expires.
- D. The annual treatment prescription for EIDT services during the summer when school is not in session must be on a form DMS-642 STP "Early Intervention Day Treatment Services Summer Only Treatment Prescription." [View or print the form DMS-642 STP](#).

212.400

Comprehensive Developmental Evaluation for Beneficiaries yet to Reach School Age

4-1-24

- A. A beneficiary who has not yet reached school age (see section 212.100(B)) must have a documented developmental disability or delay based on the results of an annual comprehensive developmental evaluation.
- B. The annual comprehensive developmental evaluation must include the administration of a norm referenced (standardized) instrument and a criterion referenced instrument. [View or print the list of accepted norm referenced and criterion referenced evaluation instruments](#).
- C. The results of the annual comprehensive developmental evaluation must show:
 1. For ages from birth up to thirty-six (36) months, a score on both the norm and criterion referenced instruments that indicate a developmental delay of twenty-five percent (25%) or greater in at least two (2) of the following five (5) domains:
 - a. Motor (the delay can be shown in either gross motor, fine motor, or total motor);
 - b. Social;
 - c. Cognitive;
 - d. Self-help or adaptive; or
 - e. Communication;
 2. For ages three (3) through six (6):
 - a. A score on the norm referenced instrument of at least two (2) standard deviations below the mean in at least two (2) of the following five (5) domains:

- i. Motor (the delay can be in gross motor, fine motor, or total motor);
 - ii. Social;
 - iii. Cognitive;
 - iv. Self-help or adaptive; or
 - v. Communication; and
- b. A score of on the criterion referenced instrument indicating a twenty-five percent (25%) or greater developmental delay; and
- 3. The norm referenced and criterion referenced instruments must both indicate the same two (2) domains of delay regardless of the beneficiary's age.
- D. Each evaluator must document that they are qualified to administer each instrument and that the test protocols for each instrument were followed.

212.500 Qualifying Diagnosis for School Age Beneficiaries

4-1-24

School age beneficiaries up to the age of twenty-one (21) must have a documented qualifying intellectual or developmental disability diagnosis as defined in Ark. Code Ann. § 20-48-101(4).

212.600 Medically Necessary Speech-Language Pathology, Occupational Therapy, Physical Therapy, or Nursing Services

4-1-24

- A. In addition to meeting the applicable comprehensive developmental evaluation scoring thresholds in section 212.400 or having a qualifying diagnosis as defined in section 212.500 of this Medicaid manual, as applicable, one of the following services must also be medically necessary for a beneficiary to be eligible to receive covered EIDT services:
 - 1. Physical therapy;
 - 2. Occupational therapy;
 - 3. Speech-language pathology; or
 - 4. Nursing.
- B. Medical necessity for occupational therapy, physical therapy, and speech-language pathology services is established in accordance with sections 212.300 and 212.400 of this Medicaid manual, and section II of the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services Medicaid manual.
- C. Medical necessity for nursing services is established by a medical diagnosis and a comprehensive nursing evaluation approved by the beneficiary's primary care provider.

220.000 PROGRAM SERVICES

221.000 Non-covered Services

4-1-24

- A. Arkansas Medicaid will only reimburse for those covered EIDT services listed in sections 222.000 through 222.210 of this Medicaid manual, subject to all applicable limits.
- B. Covered EIDT services are clinic-based services and cannot be delivered through telemedicine or at any location other than the licensed EIDT facility.
- C. Core EIDT services are reimbursable if, and only to the extent, authorized in the beneficiary's individualized treatment plan. See section 224.000 of this Medicaid manual.

222.000 Covered EIDT Services

4-1-24

Covered EIDT services are either core services or optional services.

222.100 EIDT Core Services

4-1-24

EIDT core services are those covered EIDT services that a provider must offer to its enrolled beneficiaries to be licensed as an EIDT provider.

- A. All core EIDT services must be provided at the EIDT facility.
- B. All core EIDT services must be provided by individuals employed or contracted by the licensed EIDT provider.

222.110 EIDT Evaluation Services

4-1-24

- A. EIDT evaluation services involve the administration of a comprehensive developmental evaluation. See section 212.400 of this Medicaid manual. An EIDT provider may only be reimbursed for EIDT evaluation services when those services are medically necessary.
- B. For a beneficiary who has not yet reached school age (see section 212.100(B)) medical necessity for EIDT evaluation services is established as follows
 - 1. If the beneficiary is not already enrolled in an EIDT program, medical necessity is established by a DMS-642 ER evaluation referral signed and dated by the beneficiary's primary care provider (PCP) pursuant to section 212.200 of this Medicaid manual.
 - a. A DMS-642 ER evaluation referral is only required for a beneficiary's *initial* comprehensive evaluation.
 - b. An evaluation referral demonstrates medical necessity for a single comprehensive developmental evaluation.
Example: If a beneficiary does not qualify for EIDT services based on the results of an initial developmental evaluation, and the beneficiary's PCP wants the beneficiary reevaluated six (6) months later, then the PCP would have to issue another evaluation referral on a separate DMS-642 ER at that time for the EIDT provider to be reimbursed for administering the second developmental evaluation.
 - 2. If the beneficiary is currently enrolled in an EIDT program, medical necessity to administer the required annual comprehensive developmental reevaluation is demonstrated by an active treatment prescription (DMS-642 YTP) at the time of reevaluation (see section 212.300 of this Medicaid manual). No DMS-642 ER evaluation referral is required to perform the ongoing annual comprehensive developmental evaluation required each year to demonstrate the continued eligibility of a beneficiary already receiving EIDT services.
- C. For school age beneficiaries up to the age of twenty-one (21), medical necessity for EIDT evaluation services is established by a qualifying diagnosis pursuant to section 212.500 of this Medicaid manual.
- D. EIDT evaluation services are reimbursed on a per unit basis. The billable unit includes time spent administering and scoring the norm referenced (standardized) instrument and criterion referenced instrument, interpreting the results, and completing the comprehensive developmental evaluation. [View or print the billable EIDT evaluation services procedure codes and descriptions.](#)

222.120 Day Habilitative Services

4-1-24

- A. An EIDT provider may be reimbursed for medically necessary day habilitative services.
- B. Medical necessity for day habilitative services is established:

1. For a **beneficiary** who has **not reached school age** (see section 212.100(B)) by the results of a comprehensive developmental evaluation **pursuant to section 212.400 of this Medicaid manual**.
 2. For school age **beneficiaries** up to the age of twenty-one (21), by a qualifying diagnosis pursuant to **section 212.500 of this Medicaid manual**.
- C.** EIDT day habilitative services are instruction:
1. In the skill areas of:
 - a. Cognition;
 - b. Communication;
 - c. Social and emotional;
 - d. Motor; and
 - e. Adaptive; or
 2. To reinforce skills learned and practiced as part of occupational therapy, physical therapy, or speech-language pathology services.
- D.** EIDT day habilitative services must be designed to attain the habilitation goals and objectives specified in the **beneficiary's** individualized treatment plan.
- E.** EIDT day habilitative services must be overseen by an Early Childhood Development Specialist (ECDS) who:
1. Is a licensed:
 - a. **Speech-Language Pathologist**;
 - b. **Occupational Therapist**;
 - c. **Physical Therapist**; or
 - d. **Developmental Therapist**; or
 2. Has a bachelor's degree, plus at least one (1) of the following:
 - a. An early childhood or early childhood special education certificate;
 - b. A child development associate certificate;
 - c. A birth to pre-K credential; or
 - d. Documented experience working with children with special needs and twelve (12) hours of completed college courses in any of the following areas:
 - i. Early childhood;
 - ii. Child development;
 - iii. Special education
 - iv. Elementary education; or
 - v. Child and family studies.
- F.** There must be one (1) ECDS for every forty (40) **beneficiaries** enrolled at an EIDT.
- G.** EIDT day habilitative services are reimbursed on a per unit basis. No more than five (5) hours of EIDT day habilitative services may be billed per day. The unit of service calculation includes naptime but does not include time spent in transit to and from the EIDT facility. [View or print the billable EIDT day habilitative services procedure code and description.](#)

- A. An EIDT provider may be reimbursed for medically necessary occupational therapy, physical therapy, and speech-language pathology evaluation services.
1. Medical necessity for occupational therapy, physical therapy, and speech-language pathology evaluation services is demonstrated by an initial evaluation referral signed and dated by the beneficiary's primary care provider (PCP).
 2. Evaluation referrals must be on a form DMS-642 ER "Early Intervention Day Treatment Services Evaluation Referral." See section 212.200 of this Medicaid manual. [View or print the form DMS-642 ER.](#)
 3. An evaluation referral is only required for *initial* occupational therapy, physical therapy, and speech-language pathology evaluations.
 4. No evaluation referral is required to perform the required annual re-evaluation of a beneficiary who is already receiving occupational therapy, physical therapy, or speech-language pathology treatment services. Medical necessity is demonstrated by the fact the beneficiary is currently receiving the service.
- B. Occupational therapy, physical therapy, and speech-language pathology evaluation services must be performed and billed in compliance with Section II of the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services Medicaid manual. [View or print the billable Occupational Therapy, Physical Therapy, and Speech-Language Pathology evaluation services procedure codes and descriptions.](#)

222.140 Occupational Therapy, Physical Therapy, and Speech-Language Pathology Treatment Services

4-1-24

- A. An EIDT provider may be reimbursed for medically necessary occupational therapy, physical therapy, and speech-language pathology treatment services. Medical necessity for occupational therapy, physical therapy, and speech-language pathology treatment services is demonstrated by:
1. The results of a comprehensive evaluation conducted in accordance with Section II of the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services Medicaid manual; and
 2. A written treatment prescription signed and dated by the beneficiary's primary care provider.
 - a. Treatment prescriptions relating to year-round EIDT occupational therapy, physical therapy, and speech-language pathology treatment services must be on a form DMS-642 YTP "Early Intervention Day Treatment Services Year-Round Treatment Prescription." See section 212.300 of this Medicaid manual. [View or print the form DMS-642 YTP.](#)
 - b. Treatment prescriptions relating to summer only EIDT occupational therapy, physical therapy, and speech-language pathology treatment services must be on a form DMS-642 YTP "Early Intervention Day Treatment Services Summer Only Treatment Prescription." See section 212.300 of this Medicaid manual. [View or print the form DMS-642 STP.](#)
 - c. Beneficiaries who are already receiving occupational therapy, physical therapy, and speech-language pathology treatment services pursuant to a valid treatment prescription (on a DMS-640) when those services are transitioning over to an EIDT are not required to obtain a new treatment prescription on a form DMS-642 YTP or DMS-642 STP until their existing treatment prescription expires.
- B. EIDT providers are all-inclusive habilitative therapy treatment providers, meaning a beneficiary attending an EIDT must have all their medically necessary habilitative occupational therapy, physical therapy, and speech-language pathology treatment services performed by the EIDT program at the EIDT clinic.

1. A beneficiary should not receive habilitative occupational therapy, physical therapy, or speech-language pathology services in any other setting or through any other Medicaid program when enrolled in an EIDT.
2. This restriction does not apply to:
 - a. Rehabilitative therapies prescribed to regain lost skills or functioning due to illness or injury; or
 - b. Specialized habilitative therapeutic activities that are unable to be performed at an EIDT clinic (such as aquatic therapy, or animal-assisted therapy activities).
- C. Occupational therapy, physical therapy, and speech-language pathology treatment services must be performed and billed in compliance with Section II of the Occupational Therapy, Physical Therapy, and Speech-Language Pathology Services Medicaid manual. [View or print the billable Occupational Therapy, Physical Therapy, and Speech-Language Pathology treatment services procedure codes and descriptions.](#)

222.150**Nursing Services****4-1-24**

- A. An EIDT provider may be reimbursed for medically necessary nursing services.
 1. Medical necessity for nursing services is established by a medical diagnosis and a comprehensive nursing evaluation approved by the beneficiary's primary care provider (PCP).
 2. The nursing evaluation must specify the required nursing services.
 3. The beneficiary's PCP must prescribe the specific number of medically necessary nursing service units per day.
- B. EIDT nursing services must be:
 1. Performed by a licensed registered nurse or licensed practical nurse; and
 2. Within the performing nurse's scope of practice as set forth by the Arkansas State Board of Nursing.
- C. EIDT nursing services are defined as the following, or similar, activities:
 1. Assisting ventilator dependent beneficiaries;
 2. Tracheostomy suctioning and care;
 3. Feeding tube administration, care, and maintenance;
 4. Catheterizations;
 5. Breathing treatments;
 6. Monitoring of vital statistics, including diabetes sugar checks, insulin, blood draws, and pulse ox;
 7. Cecostomy tube administration, care, and maintenance;
 8. Ileostomy tube administration, care, and maintenance; and
 9. Administration of medication when the administration of medication is not the beneficiary's only medically necessary nursing service.
- D.
 1. The EIDT provider must identify the licensed registered nurse or licensed practical nurse as the performing provider on the claim when billing for the service.
 2. Each licensed registered nurse or licensed practical nurse listed as a performing provider must be an enrolled Arkansas Medicaid provider.

- E. EIDT nursing services are reimbursed on a per unit basis with up to twelve (12) units per day billable without an extension of benefits. The unit of service calculation does not include time spent taking a beneficiary's temperature and performing other acts of standard first aid. [View or print the billable EIDT nursing services procedure codes and descriptions.](#)

222.200 EIDT Optional Services

4-1-24

EIDT optional services are those covered EIDT services that a licensed EIDT provider may, but is not required to, offer to its beneficiaries.

222.210 EIDT Transportation Services

4-1-24

- A. An EIDT provider may be reimbursed for providing its beneficiaries with transportation services to and from its EIDT clinic, meaning transporting the beneficiary from:
1. Their home (or other scheduled original pick-up location) directly to the EIDT clinic; and
 2. The EIDT clinic directly back to the beneficiary's scheduled drop-off location after the completion of the day's EIDT core services
- B. EIDT transportation services are reimburseable if each of the following is met:
1. The transportation is provided by a licensed EIDT provider;
 2. The beneficiary transported is receiving EIDT services from the EIDT that is providing the EIDT transportation service; and
 3. The transportation is provided only to or from the EIDT provider's facility.
- C. EIDT transportation services are reimbursed on a per person, per mile basis.
1. Billable mileage for a beneficiary is the number of miles from the beneficiary's pick-up address to the drop-off address using the shortest direct driving route.
 2. Mileage is computed to the tenth of a mile.
 - a. If the shortest direct driving route between the beneficiary's pick-up address and the drop-off address is less than one-tenth of a mile, then billable mileage is one-tenth of a mile.
 - b. Billable mileage should otherwise be rounded down to nearest tenth of a mile.
 3. The number of miles a beneficiary rides on a vehicle during a trip is irrelevant to the computation of billable mileage (unless the beneficiary is the only passenger, and the shortest direct driving route is used). Odometer readings are not used for the computation of billable mileage.
 4. When transporting more than one beneficiary, an EIDT provider must make all reasonable efforts to minimize the total number of miles and amount of time each beneficiary is riding on a vehicle each trip. For example, when transporting multiple beneficiaries to an EIDT facility the beneficiary with a pick-up location farthest away from the EIDT facility should be picked up first, and the beneficiary with the pick-up location closest to the EIDT facility should be picked up last.
- D. [View or print the billable EIDT transportation services procedure codes and descriptions.](#)

224.000 Individualized Treatment Plan (ITP)

4-1-24

- A. Each beneficiary receiving EIDT services must have an individualized treatment plan (ITP).

1. An ITP is a written, individualized plan developed and updated by the Early Childhood Developmental Specialist (ECDS) in collaboration with:
 - a. Each therapist overseeing the delivery of any occupational therapy, physical therapy, or speech-language pathology services received by the beneficiary at the EIDT;
 - b. The parent/guardian of the beneficiary; and
 - c. Any other individuals requested by the parent/guardian.
 2. The ITP must be reviewed and, if necessary, updated at least annually by the ECDS.
 3. The ECDS's signature and the date reviewed or updated must be recorded on the ITP.
 4. Each supervising therapist's signature and the date signed must be recorded on the ITP.
- B. Each ITP must at a minimum contain:
1. The beneficiary's identification information, which includes without limitation the beneficiary's:
 - a. Full name;
 - b. Address;
 - c. Date of birth;
 - d. Medicaid number; and
 - e. Effective date of EIDT eligibility; and
 2. The name of the ECDS responsible for ITP development and service delivery oversight;
 3. The goals and objectives for each covered EIDT service. Each beneficiary goal and objective must be:
 - a. Written in the form of a:
 - i. Typical function, task, or activity the beneficiary is working toward successfully performing; or
 - ii. Behavior the beneficiary is working toward eliminating;
 - b. Measurable; and
 - c. Specific to each individual beneficiary;
 4. A written description of the specific medical and remedial services, therapies, and activities that will be performed and how and to which goals and objectives each of those services, therapies, and activities are linked;
 5. A schedule of service delivery that includes the frequency and duration of each type of EIDT service;
 6. The job title(s) or credential(s) of the personnel that will furnish each EIDT service; and
 7. The criteria or other data that will be collected and used to measure the beneficiary's progress towards their goals and objectives; and
 8. The schedule for completing re-evaluations of the beneficiary's condition and updating the ITP.
- C. The total number and types of goals and objectives included on a beneficiary's ITP must correlate with and support the frequency, intensity, and duration of the prescribed core EIDT services, and be clinically appropriate for the beneficiary.

230.000 EXTENSION OF BENEFITS

- A. An extension of benefits is required for an EIDT provider to be reimbursed for:
1. Over five (5) hours of day habilitative services in a single day;
 2. Over ninety (90) minutes per week of any of the following EIDT services:
 - a. Occupational therapy treatment services,
 - b. Physical therapy treatment services, or
 - c. Speech-language pathology treatment services; and
 3. Over one (1) hour of nursing services in a single day;
 4. Over eight (8) total combined hours of core EIDT services in a single day;
- B. [View or print instructions for submitting a request for extension of benefits for core EIDT services](#)

250.000 REIMBURSEMENT**251.000 Method of Reimbursement**

4-1-24

- A. Except as otherwise provided in this Medicaid manual, covered EIDT services use fee schedule reimbursement methodology. Under fee schedule methodology, reimbursement is made at the lower of the billed charge for the service or the maximum allowable reimbursement for the service under Arkansas Medicaid. The maximum allowable reimbursement for a service is the same for all EIDT providers.
- B. The following standard reimbursement rules apply to all EIDT services:
1. A full unit of service must be rendered to bill a unit of service.
 2. Partial units of service may not be rounded up and are not reimbursable.
 3. Non-consecutive periods of service delivery over the course of a single day may be aggregated when computing a unit of service.
 4. Time spent cleaning or prepping a treatment area before or after services is not billable.
 5. If a single beneficiary is receiving a single unit of services involving multiple clinicians or other billable professionals, only a single unit can be billed for that time. Concurrent billing of the same time by multiple billable professionals is not allowed.
 6. Time spent on documentation alone is not billable as a service.

251.100 Fee Schedules

4-1-24

- A. Arkansas Medicaid provides fee schedules on the Division of Medical Services website. [View or print the EIDT fee schedule.](#)
- B. Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.
- C. Fee schedules and procedure codes do not guarantee payment, coverage, or the reimbursement amount. Fee schedule and procedure code information may be changed or updated at any time.