

**NEW MEXICO**

**Early Childhood Education and Care Department-  
Family Support and Early Intervention Division**

**FISCAL YEAR 2024  
STATE GENERAL FUND**

**Services for**

**FAMILY INFANT TODDLER PROGRAM**

**Services for infants and toddlers (birth to three) with, or at risk  
of, developmental delays and their families**

**SERVICE DEFINITIONS AND STANDARDS**

**EFFECTIVE JULY 1, 2023**

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## **INTRODUCTION**

These standards apply to the services provided under State General Funded provider agreements with the Family Support and Early Intervention Division of the Early Childhood Education and Care Department (ECECD) for State Fiscal Year 2024 (July 1, 2023-June 30, 2024). Services included in these standards are those provided to families of infants and toddlers (birth to 3) with, or at risk for, developmental delays and those provided to individuals with developmental disabilities.

These standards clarify, interpret, and further enforce the Human Services Department regulations governing the provisions of 8.320.4 NMAC “Medicaid Early Periodic Screening Diagnosis and Treatment Services” under “Special Rehabilitation Services” and the 8.9.8 NMAC “Requirements of the Family Infant Toddler Early Intervention Services.” The standards address each service provided under State General Funded Provider Agreements with the Family Support and Early Intervention Division. These standards also include personnel requirements for people employed by or contracting with agencies providing Family Infant Toddler Program State General Funded services, known herein as *the provider*. Children and families should expect to receive services that meet these standards.

## **GENERAL REQUIREMENTS**

Pertinent laws and regulations governing the provision of services under the State General Funded Provider Agreement with the Family Support and Early Intervention Division include, but is not limited to, the following:

- Fair Labor Standards Act and Child Labor Laws
- The Federal Individuals with Disabilities Education Act (IDEA), Part C
- Requirements for Family Infant Toddler Early Intervention Services (8.9.8 NMAC)
- 8.8.3 NMAC, “Governing Background Checks and Employment History Verification or ECECD’s Background Check Unit, per Section 9-29-8(H), NMSA 1978; as applicable.
- The ECECD Provider Agreements for Fiscal Year 2022
- And any rules, regulations, policies, director’s releases or interpretive memorandum published by FSEI/ECECD that specify applicability to the State General Funded services described herein

## **CHILD FIND AND PUBLIC AWARENESS NMAC 8.9.8 effective July 20, 2021**

Child Find and public awareness activities promote identification and referral of eligible children with, or at risk for, developmental delays for early intervention services and assist the child in becoming Medicaid eligible, as appropriate. These activities include interagency planning, presentations and coordination to improve child identification and/or service delivery. The scope of service requires all provider agencies to implement Child Find and Public Awareness are outlined below.

### **A. SCOPE OF SERVICE**

1. Develop materials to inform the general public about the benefits and availability of early intervention services that are of no cost to families. Provider agencies will use standardized Family Infant Toddler (FIT) Program print materials in their child find and public awareness and ensure that reference to the Family Infant Toddler Program is included in agency print materials.
2. Distribute public awareness materials at sites that are frequented by parents of children of young children (Materials include those produced by the provider and those generated by the New Mexico Family Infant Toddler Program).
3. Engage in outreach to potential primary referral sources (including physicians; nurses; hospital staff; child care providers; social workers; Head Start / Early Head Start grantees; home visiting providers; tribal communities, Women Infant & Children (WIC); homeless and domestic violence shelters, CYFD etc.) regarding early intervention services and inform them of their responsibility helping the family with making a referral if the family is concerned about their child's development or if the child is identified as having or being at risk for developmental delays.
4. Provide opportunities for developmental screening, using the Ages and Stages Questionnaire 3 (ASQ-3), and other child find activities within the geographical area that they serve, including Native American tribes, within those boundaries.
5. Coordinate efforts with other agencies and organizations (including public schools, Head Start programs, health centers etc.) regarding child find activities and events, such as public health fairs or community outreach clinics.
6. Conduct presentations/ seminars within the geographical area served on issues regarding early intervention to heighten awareness regarding early intervention and the availability of services, in an effort to ensure that all community partners are aware of the availability and referral process for Early Intervention services.

### **B. SERVICE REQUIREMENTS**

1. Screening and other child find activities are available to any child who is birth to three years old if the family has a concern about their child's development. (Note: A child does not have to receive a screening to receive a developmental evaluation).
2. Public Awareness materials should meet the cultural and linguistic needs of the population served.

3. All public awareness materials must indicate that the provider agency is “funded in part by the Early Childhood Education and Care Department - Family Infant Toddler (FIT) Program.”
4. Child Find and Public Awareness activities must be provided to all communities, Native American reservations/Pueblos, and/or military bases within the geographical area served, as listed in the Provider Agreement. Providers should identify and target any underserved groups by comparing numbers served compared to Census data.
5. Interagency collaboration with other providers (including Children’s Medical Services, Medically Fragile, NMSD; NMBVI, etc.) must occur to ensure a streamlined referral and intake process and to avoid duplication.
6. In counties where there is more than one FIT provider agency, providers shall coordinate child find and public awareness activities and events to prevent duplication of effort and to efficiently use time and resources, (e.g. deciding who will do outreach to which referral sources; who will distribute FIT public awareness materials to which sites; and coordination of child find events, etc.). The provider will promote the FIT program by using the FIT public awareness materials that list all providers in that area. If there is a request for information regarding a specific agency, information regarding that agency should be distributed at that time. This coordination should be reflected in the annual Child Find / Public Awareness Plan that is submitted to the FIT Program.

## C. AGENCY REQUIREMENTS

### 1. Administrative Requirements

- a. Establish and maintain financial reporting and accounting for expenditures under this service.
- b. Maintain a record of time spent by staff towards the scope of service listed above.
- c. Maintain a log of where, when and how (e.g. by mail, presentations, visit by staff etc.) materials have been distributed.
- d. Send one copy of all public awareness materials produced to the FIT Program Regional Coordinator.
- e. Ensure that demographic and referral information on all children and families is entered into the Family Infant Toddler Program database. **Information must be entered on all children and families that are referred to early intervention, even if they are found to not be eligible for IDEA part C services.**
- f. Ensure compliance with the regulations for the Family Infant Toddler Early Intervention Program NMAC 8.9.8.
- g. Submit an Annual Performance Report (APR) within the required time frame using the FIT supplied template. A timeline for due dates will be supplied by the FIT Program.
- h. Submit a Quarterly Performance Report based on the federal annual performance indicators within the required timeframe and in the format provided by the Family Infant Toddler Program.
- i. Submit an Annual Child Find / Public Awareness plan according to the instructions on the template provided by the FIT Program.
- j. Submit a Quarterly Child Find/Public Awareness report using the template provided by the FIT Program within 30 days of the end of each quarter.

### 2. Staffing Requirements

- a. Any staff within the provider agency can conduct Child Find and Public Awareness activities.
- b. Screening activities should only be conducted by, or under the direct supervision of, a Developmental Specialist II or higher level of certification/licensure.

## D. REIMBURSEMENT

1. Requests for reimbursements for child find/public awareness shall be submitted monthly in accordance with directions provided by the Family Support and Early Intervention - Administrative Services Bureau at the Early Childhood Care and Education Department.
2. Reimbursements shall be made based on the invoice indicating the services provided that month.
3. Reimbursement for Child Find/Public Awareness activities will not occur until the FIT Program has received and approved the annual Child Find / Public Awareness plan

Reporting Category

4 Unit Rate: 70002  
\$1.00



**COMPREHENSIVE MULTIDISCIPLINARY EVALUATION NMAC 8.9.8 effective July 20, 2021**

The Comprehensive Multidisciplinary Evaluation (CME) is required by IDEA Part C and is designed to inform the eligibility determination process through a timely, non-discriminatory, comprehensive and multidisciplinary approach. The evaluation determines the developmental status of the child and determines eligibility for early intervention services. This service includes activities provided by early intervention personnel for completion of an initial comprehensive multidisciplinary developmental evaluation to determine eligibility for FIT services (in accordance with NMAC 8.9.8(F)) The evaluation shall include parent/caregiver report, information from a routines-based interview process, the child's health and medical status and must cover the developmental areas listed below. The CME must be conducted in the family's native language as defined in NMAC 8/9/8.

1. Cognitive development
2. Physical (including vision and hearing) development
3. Communication development
4. Social or emotional development
5. Adaptive development (i.e. self-help)

**A. SCOPE OF SERVICE**

1. If the team decides to first conduct a developmental screening for a referred child, the Ages and Stages Questionnaire 3 (ASQ-3) shall be utilized.
2. To ensure accurate evaluation results, observations and evaluations should be conducted in environments where the child typically spends his/her day (e.g. home, child care, preschool, grandparents' house) and with the people (e.g. parent, grandparents, teacher, nanny) who interact with and support the child and family.
3. The evaluation team shall use all phases of the Infant-Toddler Developmental Assessment (IDA) as the approved statewide tool as part of the Comprehensive Multidisciplinary Evaluation. Information from the routines-based interview process shall be included in the CME report noting child strengths and parent concerns. (For more information on assessment and evaluation: please visit: [Evaluation and Assessment – ECLN Portal \(unm.edu\)](http://www.unm.edu)).
5. Other developmental domain specific tools may be used in addition to the IDA as part of the Comprehensive Multidisciplinary Evaluation (CME). If the IDA does not indicate a 25% delay, a developmental domain specific tool can be used to inform eligibility under developmental delay based on either a -1.5 Standard Deviation or greater, or Informed Clinical Opinion with the exception of newborns and infants where a specific process and set of tools apply
6. A review and summary of the child's records related to current health status and prior medical history shall be conducted and relevant information included in the CME report.
7. Hearing screenings are a required part of the CME process as follows:
  - a. Any personnel conducting hearing screenings must be trained by New Mexico School for the Deaf (NMSD) in the use of the equipment and completion of the NMSD Hearing Screening form within 6 months of hire.
  - b. The Family Service Coordinator (FSC) must:

- i. Ensure all infants/toddlers 6 months of age or older obtain initial hearing screening during the CME. If an infant is under 6 months at CME, ensure screening at 6 months.
  - ii. Confirm newborn hearing screening results from medical records for infants younger than 6 months, or for any child who presents with hearing concerns.
  - iii. Ensure all children receive an annual hearing screening.
  - iv. Ensure documentation of the child's hearing status on the CME report, initial IFSP and annual IFSPs.
  - v. Schedule and ensure timely re-screening when a child does not pass the initial or annual hearing screening.
  - vi. Document all hearing screening attempts on the FIT "New Mexico Hearing Screening Tool" and in log notes.
  - vii. Coordinate follow-up/referrals recommended on the FIT "New Mexico Hearing Screening Tool."
- c. Children failing/referring on more than two consecutive hearing screenings will be referred to their Primary Care Provider for medical/audiological follow-up.
  - d. FIT providers will contact the designated Regional Supervisor of the New Mexico School for the Deaf (NMSD) for consultation and guidance regarding all children who have been identified as having a hearing concern.
  - e. Once a permanent hearing loss is identified *or suspected*, a formal referral for services will be made to the NMSD Regional Supervisor, with family/caregiver consent.
  - f. The Family Service Coordinator is responsible for following up on any hearing concerns and documentation of results, attempts to complete the hearing screening, and referrals made.
8. Vision screenings are a required part of the CME process.
- a. Any personnel conducting the vision screening must be trained by New Mexico School for the Blind and Visually Impaired (NMSBVI) in the use of the NMSBVI Vision screening tool within 6 months of hire.
  - b. The CME must address the child's functional vision through use of the NMSBVI screening tool.
  - c. The Vision Screening tool must be completed in conjunction with the IDA, which includes a developmental portion based on the IDA.
  - d. If the screening indicates concerns about the child's functional vision, the child will be referred to NMSBVI with family permission.
  - e. A statement summarizing the results must be provided in the written evaluation report.
9. The completed and typed Comprehensive Multidisciplinary Evaluation (CME) report, written using family friendly language, shall include:
- a. the reason for referral
  - b. relevant medical history including current vision and hearing status
  - c. parent/caregiver concerns

- d. child strengths and interests
- e. the child's functioning in each developmental domain providing a picture of the child's overall functioning and ability to participate in family and community life
- f. a statement regarding the child's eligibility for the FIT Program, and
- g. approaches and strategies to be considered by the IFSP team when developing outcomes.

10. The FIT Program "Evaluation Summary form" which summarizes the evaluation result shall be used when a full evaluation report cannot be completed prior to the initial IFSP. However, the full evaluation report must still be completed and given to the team, including the family, within 30 days of the evaluation.

11. The Family Service Coordinator, the family and the evaluation team shall collaborate to determine eligibility for the FIT Program.

**Informed Clinical Opinion (ICO)** refers to the knowledgeable perceptions of caregivers and professionals who use qualitative and quantitative information regarding difficult-to-measure aspects of a child's development to make an eligibility determination for the FIT Program. The requirements below describe the process that must be utilized when ICO is used to make an eligibility determination. See Technical Assistance Document: Evaluation and Assessment, April 2013, for additional details and requirements.

When ICO is used to determine eligibility (significant atypical development), documentation must be provided to justify the decision. Documentation may include information from a parent and other caregiver reports of ways in which daily activities are being impacted. Documentation of impact on daily functioning may include professional observations during the evaluation session and in other settings/situations, when applicable, and/or a description of the child's abilities and/or behaviors and how they differ from those of a typical same-age peers.

This documentation must provide a description of the child's abilities and areas of concern including why these abilities differ from typical children of the same age and the way they impact the child's daily activities.

The evaluation report must be reviewed by a "second level reviewer" (someone who is not part of the evaluation team who has equal or higher-level certification or licensure) and shall include a statement of approval and second level reviewer signature.

ICO can only be used as the primary means of determining eligibility for one year, without prior review and approval from the FIT Program (as pertains to Annual Redetermination of Eligibility).

To request an additional year of ICO: The "Informed Clinical Opinion Statement Additional Approval Request Form" shall be reviewed and signed by a designated agency representative (administrator, manager, supervisor etc.) before being submitted to the FIT Program Regional Coordinator.

The FIT Program will respond with a decision within ten (10) working days after the receipt of the "Informed Clinical Opinion Statement Additional Approval Request Form". Once the approval from the FIT Program is received, the FSC will conduct the IFSP meeting.

12. Early intervention provider agencies must maintain documentation of eligibility status on file.
  - a. If it is determined that the child does not meet the eligibility criteria, the Family Service Coordinator will provide the family with a copy of the CME report as well as information about other early learning services in the community (Home Visiting, Early Head Start, child care, etc.) and inform the family that they can return for a developmental screening if they are concerned about their child's development prior to age 3 years
13. **Newborn Evaluations** (under one month of adjusted age)
  - a. The IDA will **not** be used. Instead, one of the approved tools below shall be used together with the informed clinical opinion (ICO). All 5 developmental domains shall be assessed and addressed in the CME report, including parent/caregiver information and information from the routines-based interview process.
  - b. Approved tools for infants under 1 month of age include:
    - Test of Infant Motor Performance (TIMP)
    - Alberta Infant Motor Scale (AIMS)
    - Motor Skills Acquisition Checklist (existing protocols may be used but this is no longer available for purchase)
    - Newborn Individualized Developmental Care and Assessment Program (NIDCAP) - for use with newborns in the newborn intensive care setting only
    - Newborn Behavior Assessment Scale (NBAS)
    - Newborn Behavioral Observations System (NBO)
    - Hammersmith Infant Neurological Examination (HINE)
    - General Movements Assessment (GMA)
    - Other tools as approved by the FIT Program via a memo
  - c. Due to the varying nature and purpose of the scores of each of the above approved tools, the scores themselves will not lead to eligibility, but rather they will provide additional information for the team to consider in reaching a determination of the child's developmental status and eligibility determination.
  - d. The process shall include a review of the pertinent records related to the child's current health status and medical history and should include observation and parent input on feeding, sleeping, motor, behavior, state regulation, communication, visual tracking and auditory responses.
  - e. If the team feels there is atypical development, then Informed Clinical Opinion must be used to determine eligibility.
  - f. For newborns the intake, evaluation and IFSP will be conducted after the child and family return home with the exception of hospital-based providers.
14. **Infant Evaluations** (over one month of age and under four months of age adjusted)
  - a. The IDA shall be used in conjunction with one of the FIT approved tools.
  - b. Approved tools for infants over one month of age (adjusted) and under four months include:
    - i. Test of Infant Motor Performance (TIMP)
    - ii. Alberta Infant Motor Scale (AIMS)
    - iii. Infant Toddler Sensory Profile I & 2
    - iv. Peabody Developmental Motor Scale (PDMS-2)
    - v. Motor Skills Acquisition Checklist (existing protocols may be used but this is no longer available for purchase)
    - vi. Receptive Expressive Emergent Language-3 (REEL-3)
    - vii. The Rossetti Infant Toddler Language Scale

- viii. The Newborn Behavioral Observations system (NBO) (up to 3 months)
- ix. The Hammersmith Infant Neurodevelopmental Examination (HINE)
- x. The General Movements Assessment (GMA)
- xi. Other tools as approved by the FIT Program via memo
- c. All 5 developmental domains shall be assessed and addressed in the CME report, including parent/caregiver information and information from the routines-based interview process.
- d. Due to the varying nature and purpose of the scores of each of the above approved tools, the scores themselves will not lead to eligibility, but rather they will provide additional information for the team to consider in reaching a determination of the child's developmental status and eligibility determination.
- e. The process shall include a review of the pertinent records related to the child's current health status and medical history and should include observation and parent input on feeding, sleeping, motor, behavior, state regulation, communication, visual tracking and auditory responses.
- f. If the team feels there is atypical development, then Informed Clinical Opinion must be used to determine eligibility.

**15. M-CHAT R/F Autism Spectrum Disorder (ASD) Screening:**

- a. For children referred between 18 months and 30 months of age the M-CHAT R/F Autism screening shall be conducted as part of their initial Comprehensive Multidisciplinary Evaluation (CME).
- b. For children referred between 16-18 months, the M-CHAT R/F may be administered as part of the initial CME.
- c. The CME report shall indicate that the M-CHAT R/F was completed, provide the results of the M-CHAT R/F, and discuss any outcomes such as follow up and referral as determined by the results of the M-CHAT R/F.
- d. For children referred who are younger than 18 months, and who have not yet been screened with the M-CHAT R/F. Autism screening shall be conducted once the child turns 18 months old and again at 24 months of age per the recommendations of the author and the American Academy of Pediatrics. (Personnel may bill for the time spent conducting the screening based on the location where the screening takes place).
- e. A medium risk score resulting from the first twenty questions requires the completion of the follow up questions to determine the final risk score.
- f. Referral for a diagnostic evaluation shall be made, with the consent of the parent(s)/caregiver, if the result of the M-CHAT R/F, including completion of the supplemental/follow up questions is "High Risk".
- g. A consultation with the Early Childhood Evaluation Program (ECEP) can occur when there is a low risk M-CHAT R/F score with a moderate to high levels of provider concerns and with parent consent.
- h. Consultation with a supervisor or Provider Agency Evaluation Lead is recommended as well as consultation with NMSBVI and NMSD for children with vision and hearing loss regarding any questions about whether to pursue a referral to Early Childhood Evaluation Program (ECEP)
- i. The M-CHAT R/F authors do not recommend adjusting for prematurity. (<http://mchatscreen.com/>)

## 16. Evaluation of Infants/Toddlers with Vision loss

- a. If a vision diagnosis is known prior to the CME, NMSBVI should be consulted to collaborate with the CME team.
- b. The CME team will consult with NMSBVI to determine which tool and process will be most appropriate to measure the child's developmental skills, given his/her diagnosis:
  - i. The IDA may be used with supplemental items from the Oregon Project Skills Inventory and with consultation from NMSBVI **OR**
  - ii. The Oregon Project Skills Inventory will be used in lieu of the IDA
- c. For a child who is blind, the CME team, in collaboration with NMSBVI, will administer The Oregon Project Skills Inventory, in lieu of the IDA, as it is designed as an assessment tool for blind and visually impaired children.
- d. For a child who has visual impairments or low vision, but who is not blind, the IDA may be used.
- e. NMSBVI can contribute vision information that will be included in the vision section of the CME report, but NMSBVI is **NOT** considered to be a second or third discipline on the CME team.
- f. The CME must address the child's vision using the NMSBVI I vision screening tool. If a formal vision testing has been completed this information shall be reviewed by the CME team. *(Note: Formal vision testing by an optometrist or ophthalmologist does not assess a child's ability to use their vision for learning (functional vision). The NMSBVI screening tool assesses possible risk for vision difficulties as well as ability to use vision for learning. Therefore, formal vision testing is not a substitute for the NMSBVI vision screening tool).*
- g. A statement summarizing the results must be provided in the written evaluation report. If vision screening results indicate a concern, a referral shall be made to NMSBVI with consent of the parent/caregiver.
- h. NMSBVI I will provide follow up to the family by collaborating with the child's Primary Care Provider and/or a pediatric ophthalmologist and the FIT provider agency.
- i. The Family Service Coordinator is responsible for following up on any vision concerns.
- j. The Oregon Project Inventory Tool and training for the CME team will be provided by NMSBVI.

## 17. Evaluation of Infants/Toddlers Who Are Deaf or Hard of Hearing:

- a. If a hearing loss or diagnosis is known prior to the CME, NMSD must be consulted to collaborate with the CME team.
- b. For a child who is deaf or hard of hearing, the following evaluation tools are approved:
  - The Visual Communication and Sign Language Checklist
  - The MacArthur-Bates Communicative Development Inventories
  - The Language Development Scale

- c. NMSD will consult with the CME team and/or administer one or more of the approved tools and this information will be used to supplement developmental information gained from the IDA.
- d. If appropriate, NMSD staff may function as an additional or third discipline for the CME as a Developmental Specialist.
- e. Consultation with NMSD shall occur:
  - i. During the CME for a child who is hard of hearing or deaf
  - ii. During the CME for a child who can hear but whose parents are deaf, NMSD shall be consulted to assess the child's ASL skills. (NMSD would not be an ongoing member of the child's IFSP team as the child does not have a hearing loss)
  - iii. Post CME: Conduct E & A as needed to assess a child's ASL skills when the child's parents are deaf post CME

## **B. SERVICE REQUIREMENTS**

The provider is responsible for determining eligibility for early intervention services and maintaining documentation of eligibility status on file.

Children are eligible for early intervention services who meet the following criteria

- Are from birth to three years old (If a child is referred to the FIT Program fewer than 45 days prior to the child's third birthday an evaluation will not be conducted.);
- Reside in the state of New Mexico;
- Have been referred for evaluation or early intervention services; and
- Parent/caregiver has given their prior informed consent
- Meet one or more of the eligibility criteria for FIT Early Intervention services as described in NMAC 8.9.8

## **C. AGENCY REQUIREMENTS**

### **1. Administrative Requirements**

- a. Establish and maintain financial reporting and accounting for each child.
- b. Establish and maintain a confidential record for each child. Each signed document within the confidential record must include valid signatures. Valid signatures include wet signatures using pen and ink, signatures using electronic platforms such as Adobe, and signatures drawn with an electronic mouse or electronic pen/pencil.
- c. Complete a typed report that addresses all developmental domains, vision, hearing, and medical information, which shall serve as documentation for Comprehensive Multidisciplinary Evaluation.
- d. Maintain and update on a regular basis a Policy and Procedure Manual to reflect current policies consistent with FIT Program requirements related to at least, the following activities:
  - Intake and referral
  - Comprehensive Multidisciplinary Evaluations
- e. Develop a Quality Assurance (QA) plan that includes but is not limited to developing an ongoing monitoring process, which regularly reviews compliance, and provides for the evaluation of quality and the family's satisfaction with the Comprehensive Multidisciplinary Evaluation.
- f. Ensure that demographic, eligibility data and evaluation data is entered into the FIT Program database FIT-KIDS (Key Information Data System) within 30 days following the respective activity.
- g. Provide Comprehensive Multidisciplinary Evaluations to all families referred in the geographical area served under the ECECD Provider Agreement.
- h. Submit a Quarterly Performance Report based on the federal annual performance indicators (APR) within the required timeframe and in the format provided by the Family Infant Toddler Program



- i. Submit an Annual Performance Report (APR) within the required time frame and in the format provided by the Family Infant Toddler Program
- j. Conduct Correction of Noncompliance activities, as necessary, in accordance with requirements and format provided by the FIT Program. Correction of identified noncompliance must occur within one year of the date of the written notification of the noncompliance (finding/deficiency) and must be twofold. (1) The provider agency must demonstrate that it is correctly implementing the regulatory requirement (based on updated data) for which it was previously noncompliant, and (2) for any noncompliance concerning a child specific requirement, the provider agency must demonstrate that it has corrected each individual case of noncompliance (although late), unless the child is no longer within the jurisdiction of the early intervention program
- k. The provider shall not charge any fee to families for the Comprehensive Multidisciplinary Evaluation.

## 2. Staffing Requirements and Evaluator Qualifications

- a. The agency must provide adequate supervision and training to all staff providing Comprehensive Multidisciplinary Evaluations.
- b. Personnel must have a BS/BA or higher degree and Developmental Specialists must be certified at level II or III.
- c. Personnel conducting a Comprehensive Multidisciplinary Evaluation must have an early childhood development background. This can include work experience, course work, online training, workshops and specialized training.
- d. Evaluation personnel must be trained (online training, coursework, workshops, mentoring, work experience) in FIT evaluation and eligibility procedures and the tool(s) that they are administering, including the following:
  - Infant Toddler Developmental Assessment (IDA) (online, mentoring)
  - NMSBVI Vision Screening Tool (in person, mentoring)
  - NMSD Hearing Screening (in person, mentoring)
  - Environmental Risk Assessment (ERA) Tool (online, mentoring)
  - M-CHAT R/F ( [Archived Training – Autism Portal \(unm.edu\)](#))
  - Tools (specified in these Standards) used for infants under 4 months old
  - Any domain-specific tools that may be necessary to determine eligibility
  - Evaluation and assessment tools shall be used in accordance with the respective manuals and established protocols, including those designated by the FIT Program.
- e. The Multidisciplinary evaluation team shall include two or more personnel who possess a valid license or certification from the following list:
  1. Audiologist – licensure from the NM Audiology Board
  2. Developmental Specialist certification II or III –in accordance with Family Infant Toddler Program regulations (NMAC 8.9.8) and ECECD Policy.
  3. Family Therapy and Counseling – licensure from the NM Counseling and Therapy Practice Board
  4. Nurse – licensure from the NM Board of Nursing as a registered nurse
  5. Nutritionist – licensure from the NM Nutrition and Dietetics Practice Board
  6. Occupational Therapist– licensure from the NM Board of Occupational Therapy Practice
  7. Physical Therapist – licensure from the NM Physical Therapy Licensing Board
  8. Psychologist – licensure from the NM Board of Psychologist Examiners
  9. Social worker – licensure from the NM Board of Social Work Examiners
  10. Speech/Language Pathologist – licensure from the NM Board Speech, Language Pathology, Audiology and Hearing Aid Dispensers Board

## D. REIMBURSEMENT

1. Request for reimbursement for Comprehensive Multidisciplinary Evaluations shall be submitted monthly through the FIT-KIDS (Key Information Data System).
2. Staff entering data related to billing shall complete the online FIT-KIDS training when

available.

3. Request for reimbursement for Comprehensive Multidisciplinary Evaluation shall be submitted in accordance with directions provided by the ECECD Family Support and Early Intervention Division.
4. This rate covers the work of multidisciplinary evaluation team members in conducting direct assessment activities, administering evaluation instruments and tools with child and family, reviewing medical and other records or reports, and writing the comprehensive developmental evaluation report.
5. If a developmental screening is conducted for a child and it is determined that the child is not suspected of having a developmental delay and therefore does not receive a full CME, the agency may bill for the early intervention time taken to conduct the screening and bill according to the location where the screening occurred.
6. If the CME cannot be completed before the child transfers to another FIT provider, time spent by agency staff conducting the evaluation can be billed by discipline as an Evaluation & Assessment (E&A).
  - a. The “Evaluation Summary Form” must be used to document the partial CME and may be used to develop the IFSP.
  - b. The CME unit cannot be billed until the full CME report has been written.
7. CME unit shall be submitted once the written evaluation report has been completed.
8. If a child is evaluated and determined **not eligible** for early intervention services, and is re-referred less than 6 months from the first CME:
  - a. The team will review the new referral concerns, the child’s updated medical records and conduct a screening to determine the need for additional assessment. If the review and screening process indicates the need for further assessment, a second CME may be conducted with approval.
  - b. Prior authorization is needed from the FIT Program.
  - c. If the review and screening process does not indicate the need for further evaluation, the FSC will provide the family with other potential resources to support the family and the child’s development, including information on home visiting programs available and how to access. A referral to the local home visiting program will be made if requested by the caregiver. The FSC will also provide information on how to re-refer should new concerns arise in the future.
9. If a child is evaluated and determined **not eligible** for early intervention services, and is re-referred more than 6 months from the first CME:
  - a. A second CME will be conducted
  - b. No prior authorization is needed from the FIT Program
  - c. If the CME process does not indicate the need for further evaluation, the FSC will provide the family with other potential resources to support the family and the child’s development, including information on home visiting programs available and how to

access them. A referral to the local home visiting program will be made if requested by the caregiver. The FSC will also provide information on how to re-refer should new concerns arise in the future.

10. If a child is evaluated and determined **eligible** for early intervention:
  - a. The child's eligible status for EI services is valid for one year from the date of the evaluation determination.
  - b. If the child subsequently exits early intervention services for one of a variety of reasons and is re-referred within the one year of the eligibility determination, the team will conduct an assessment using an approved ongoing assessment tool, to update the child's development and complete a new IFSP within 30 days. No prior authorization is needed to conduct the assessment.
  - c. If the child is re-referred to early intervention services after the one-year period of eligibility, then a second CME can be conducted to determine eligibility for early intervention services and no prior authorization is needed from the FIT Program.
11. Billing for a second CME can be submitted in the FIT-KIDS database in the same manner as the first CME is billed.
12. If a developmental screening is conducted, in accordance with NMAC 30.30.8.10(E) prior to the full CME, the screening is included in the reimbursement for the CME.

### **Comprehensive Multidisciplinary Evaluation**

Reporting Category 700023

Rate: \$970.00 Unit: one completed evaluation

Medicaid H2000 TL

Rate: \$970.00 Unit: one completed evaluation

## **FAMILY SERVICE COORDINATION**

Family service coordination services are activities carried out by a designated individual to assist and enable the families of children from birth to three to access, and if determined eligible, receive early intervention services. The family service coordinator helps to develop the Individual Family Service Plan (IFSP); assists the family in receiving all services identified; coordinates those services; ensures that they are delivered in a timely manner; and seeks additional services and or supports that may help the child or family. The Family Service Coordinator works with the family to determine their service needs and if the family chooses to be involved in service coordination responsibilities they should be supported in that role.

### **A. SCOPE OF SERVICE**

Family service coordination includes, but is not limited to, the following:

1. Coordinating intake, evaluations and assessments and the process of determining eligibility.
2. Facilitating and participating in the development of the initial and annual Individual Family Service Plan (IFSP) as well as the 6-month review of the IFSP.

3. Facilitating the completion of the initial and exit ratings for the Early Childhood Outcomes.
4. Assisting families in identifying and accessing all available services and resources, not just those related to the child's condition (e.g. housing, mental health services etc.).
5. Coordinating and monitoring the delivery of IFSP services (including subcontractors and providers from other agencies).
6. Informing families of advocacy services and empowering the family to enhance their own Family Service Coordination skills.
7. Coordinating with medical and health providers.
8. Facilitating the development of a transition planning process for each child and family.
9. Gathering and researching resource information for the family and making referrals where appropriate.

## **B. SERVICE REQUIREMENTS**

1. A family will have only one Family Service Coordinator designated on the IFSP, regardless of whether the child may be receiving services from more than one FIT program.
2. Families must be informed when there is a change in their Family Service Coordinator and if the Family Service Coordinator is on extended leave, another Family Service Coordinator must be assigned.
3. A family may direct the level of support and assistance that they need from their Family Service Coordinator and may choose to perform some of the Family Service Coordinator functions themselves. A family may not be paid to provide Family Service Coordination for their child and family.

4. The Family Service Coordinator shall contact the family once a month, at a minimum, to meet the requirement for “coordinating and monitoring the delivery of services”. If a face-to-face visit with the family does not occur that month due to a family reason, then that will be documented in the case notes in the child’s record.
5. The Family Service Coordinator will discuss with each family their need for family supports including: parent-to-parent support; parent training; respite; and other resources and referrals.
6. A Release of Information (ROI) signed by the parents is required for the transfer in FIT-KIDS and for the release of physical documents (child records). (For more information see the Transfer Section below).
7. The Family Service Coordinator will coordinate with the Medically Fragile Case Management Program if the child is also eligible for medically fragile services to align and avoid duplication of services. This may include joint meetings and sharing of records with the consent of the parent(s).

## 8. Intake/Referral

- a. Family service coordination shall be provided upon referral of the child and family to the FIT Program.
- b. For newborns, the intake, evaluation and IFSP will be conducted after the child and family return home except for hospital-based providers.
- c. If a child is referred to Part C **fewer than 45 days prior to the child’s third birthday** an intake and evaluation **will not** be conducted.
  - i. The Family Service Coordinator will let the family know of preschool options available in the community, e.g. preschool special education; Head Start; private preschools, etc., and will assist with a referral to those entities, with the permission of the parent(s).
- d. The Family Service Coordinator will inform the parent(s) about early intervention services and the IFSP process.
- e. During the intake process, the Family Service Coordinator will:
  - i. review the FIT Family Handbook with the family.
  - ii. have the family complete a “Freedom of Choice Form” to select a FIT Provider in counties where there is more than one provider agency.
  - iii. complete the Public and Private Insurance form with each family at intake and at least annually to determine if the child is or may be eligible for Medicaid or if they are covered under a private insurance plan.
  - iv. obtain consent from the parent(s) to bill their private insurance via signature on the Public and Private Insurance forms.
  - v. explain the Comprehensive Multidisciplinary Evaluation (CME) process
  - vi. explain the Individualized Family Service Plan (IFSP) process
  - vii. gather information about family routines and activities, including what is working and what is challenging for the child and family in each major routine using a routines-based interview approach

## 9. Individualized Family Service Plan (IFSP)

- a. This initial IFSP shall be developed within forty-five (45) calendar days from the date of referral for children who are deemed eligible and whose families want to proceed with the IFSP.
- b. Families shall receive prior written notice of the IFSP meeting.
- c. The IFSP will be conducted in the family's native language in accordance with NMAC 8.9.8.11.
- d. Participants at the initial IFSP and annual IFSP meeting shall include:
  - i. the parent(s);
  - ii. other family members, as requested by the parent(s) (if feasible);
  - iii. an advocate or person outside of the family, as requested by the parent(s);
  - iv. a person or persons directly involved in conducting evaluations and assessments of the child;
  - v. If a person or persons directly involved in conducting evaluations and assessments of the child is unable to attend a meeting, the family service coordinator shall make arrangements for the person's participation through other means, including: *participating by telephone/telehealth; having a knowledgeable authorized representative attend; or submitting a report;*
  - vi. a person or persons who are or will be providing early intervention services to the child and family, as appropriate;
  - vii. the family service coordinator; and
  - viii. other individual(s) as applicable, such as personnel from: child care; Early Head Start; home visiting; Medically Fragile; Children's Medical Services; Child Protective Services; physician and other medical staff, with permission of the parent(s).
- e. All services must be delivered in accordance with the frequency and intensity indicated on the IFSP.
- f. IFSP frequency and intensity must be written as smallest denominator reasonable, e.g. 60 minutes per week, rather than 240 minutes per month.
- g. Service provision in any given week / month may at times exceed the amount on the IFSP. Examples include (e.g. if an IFSP meeting is held that month OR early intervention services are provided twice in a week to make up for services missed OR if the early intervention session goes beyond the amount planned for on the IFSP). If a permanent change is needed to the IFSP, then a meeting will be held to update the services page.
- h. Changes to the frequency, intensity, location or method of services on the IFSP shall be made by utilizing the "Amendments" section on the Supports and Services page by adding the revised service on a new line. The same process would be used to end a service before the next IFSP. The family shall sign a Prior Written Notice form giving their consent to any service changes.
- i. Services must be provided in natural environments, defined as places and activities that are natural or normal for children of the same age who have no apparent developmental delay.
- j. Justification on the Individualized Family Service Plan (IFSP) is required if the team determines that outcomes cannot be met in a natural environment. Justification must include:
- k. A statement of where services will be provided

1. Steps that will be taken to enable early intervention services to be delivered in the natural environment.

## **10. Prior Authorization for Services**

- a. Prior authorization is required when ongoing early intervention services proposed by the IFSP team will exceed 16 hours per month. Ongoing services do not include: Family Service Coordination; consultation between personnel; respite; and other services not funded through the FIT Program. The team may provide up to 16 hours without prior approval from the FIT Program.
- b. If the IFSP team recommends that more than 16 hours is needed to meet the outcomes on the IFSP, the family shall be informed of the need for approval for the additional hours. The team will complete an “IFSP Supports & Services Prior Authorization Form”. The team should utilize a Transdisciplinary Team Approach meeting to complete the form.
- c. The “IFSP Supports & Services Prior Authorization Form” shall be reviewed and signed by a designated agency representative (administrator, manager, supervisor, etc.) before being submitted to the FIT Program Regional Coordinator.
- d. The FIT Program will respond with a decision within ten (10) working days after the receipt of the “IFSP Supports & Services Prior Authorization Form” for over 16 hours.
- e. Once the approval from the FIT Program is received, the FSC will meet with the family to update the services page on the IFSP.
- f. Circumstances which may justify the need for services over 16 hours per month include a diagnosis of autism spectrum disorder for which the intensity of intervention is a recommended practice; complex family circumstances that may require time-limited intensive intervention.
- g. Exceptions to the Prior Authorization process are for children enrolled in the following classroom-based toddler programs: NMSD, NMSBVI, PEI.

## **11. Early Childhood Outcomes (ECO)**

- a. All providers of early intervention services, including Family Services Coordinators, must take the ECO training provided by UNM Early Childhood Network (ECN) within six months of hire and then again every three years.
- b. The Family Service Coordinator will coordinate the collection of information and data for the Federally mandated ECO score in accordance with the ECO Manual and the ECO Decision Tree for Summary Rating Discussions and shall include:
  - i. All developmental levels documented using age ranges obtained from evaluation and assessment results
  - ii. Child strengths and needs, including how the child is doing in the family’s everyday routines and activities.
  - iii. Information which is relevant to the family routines and child’s functional skills and written using family-friendly language
- c. The team shall determine federally required ECO scores in accordance with the FIT Program ECO Manual including the use of the Decision Tree.
- d. The initial ECO score is to be determined by the IFSP team prior to services being provided and no later than 30 days following the initial IFSP.



- e. The exit ECO must be completed within 30 days prior to when the child exits the program.
- f. If the child exits unexpectedly before his/her 3<sup>rd</sup> birthday, and an exit ECO was not completed before he/she exited, the IFSP team shall convene to complete an exit ECO within 45 days of the exit date.
- g. The rating must be entered into FIT-KIDS within 30 days of the rating determination.

## 12. Ongoing Assessment

- a. Ongoing assessment is the process of using professional observation, parent input and assessment tools to identify the unique strengths, needs, developmental functioning and progress of a child that inform intervention practices.
- b. Ongoing assessment information is gathered by all team members and at every visit, with or without the use of the assessment tool.
- c. All team members shall note specific skills that the child has/needs as part of their observations during a visit. These observations shall be recorded in the tool's protocol periodically to ensure monitoring of the child's progress and coordination of intervention strategies implemented by the team.
- d. Ongoing assessment information should be used, at a minimum, to inform the following:
  - i. Intervention strategies implemented by the IFSP team and family
  - ii. IFSP goals and strategies
  - iii. Exit ECO ratings
  - iv. Annual re-determination of eligibility
  - v. Changes in services and supports.
- e. Documentation: The protocols that record the results of the ongoing assessment tools shall be updated in the child's file, *at a minimum*, two times per year: once before the 6-month review and again at the time of the annual re-determination of eligibility. Ongoing assessment protocols may be updated more often based on the guidelines of the tool and/or needs of the team or child/family.
  - g. Approved Tools:
    - i. Assessment, Evaluation, and Programming System for Infants and Children (AEPS)
    - ii. Hawaii Early Learning Profile (HELP)
    - iii. For children with vision impairments: Oregon Project Skills Inventory
    - iv. The Visual Communication and Sign Language Checklist: for children who are deaf and/or hard of hearing
    - v. The MacArthur-Bates Communicative Development Inventories: for children who are deaf or hard of hearing
    - vi. The Language Development Scale: for children who are deaf or hard of hearing
    - vii. Other tools as approved by the FIT Program

## 13. Periodic review of the IFSP

- a. A review of the IFSP shall occur at a minimum every six months and shall include a determination of progress towards outcomes and the need for modification of outcomes or services.
- b. A review can occur at any time at the request of the parent(s), IFSP team, or early intervention provider agency.

- c. Participants at a periodic review meeting shall include:
  - i. the parent(s);
  - ii. other family members, as requested by the parent(s) (if feasible);
  - iii. an advocate or person outside of the family, as requested by the parents
  - iv. the family service coordinator; and
  - v. persons providing early intervention services, as appropriate.

#### **14. Annual Redetermination of Eligibility:**

- a. Eligibility for the NM FIT Program must be redetermined on an annual basis. In order to determine the child's continued eligibility for the NM FIT Program, the IFSP team must follow the same guidelines for determination of the eligibility category or categories as described for the initial evaluation process.
- b. The team that redetermines eligibility must be comprised of at least two professionals from different disciplines.
- c. If there is only one ongoing service on the IFSP, a one-time E&A (Evaluation and Assessment) would be added to the existing IFSP with sufficient time to allow a second discipline to participate in the IDA process and complete the redetermination of eligibility prior to the Annual IFSP Meeting.
- d. If the ongoing IFSP team is comprised of two or more disciplines, the team must use current ongoing assessment information (see list of approved Ongoing Assessment Tools) to inform and/or score the IDA Provence Profile and complete the full IDA process to determine the child's continued eligibility for the NM FIT Program.
- e. If the ongoing IFSP team consists of only one discipline, and a second discipline is added for the purpose of conducting the annual redetermination of eligibility, then the team needs to conduct an evaluation session utilizing the IDA.
- f. In situations where service providers have not been able to regularly see the family and may not have sufficient ongoing assessment information, but the child still has an active IFSP that will soon expire, the following applies: the team needs to conduct a reassessment utilizing the IDA or other approved evaluation tools. If the child remains eligible for FIT services, the annual IFSP must be completed as soon as possible. In situations that are unclear, the FIT Provider Agency may seek guidance from the assigned Regional Coordinator.
- g. Based on the needs of the child and at the team's discretion, additional domain-specific tools may be used to support the redetermination of eligibility. If the IDA does not indicate a 25% delay, a developmental domain specific tool can be used to inform eligibility under developmental delay based on either a -1.5 Standard Deviation or greater, or Informed Clinical Opinion.
- h. In order to determine the child's continued eligibility for the NM FIT Program, during a transdisciplinary team consultation meeting, the team will discuss and synthesize the information that has been gathered through each professional's ongoing assessments, including:
  - i. Developmental information obtained through ongoing assessment tools;
  - ii. Review and updating of the child's health and medical status; and
  - iii. Information regarding the child's performance in daily living activities, as reported by the parents and other caregivers (including RBI process).
- i. In addition to redetermining eligibility, the assessment process should provide

- information regarding the child’s current strengths and needs to inform the Annual IFSP Process.
- j. ICO can only be used as the primary means of determining eligibility for one year, without prior review and approval from the FIT Program (as pertains to Annual Redetermination of Eligibility).
  - k. To request an additional year of ICO: The “Informed Clinical Opinion Statement Request for Additional Year form shall be reviewed and signed by the agency EI Coordinator before being submitted to the FIT Program Regional Coordinator.
    1. ii. The FIT Program will respond with a decision within ten (10) working days after the receipt of the “Informed Clinical Opinion Statement Request for Additional Year” form to request an additional year of eligibility using ICO.
    - ii. Once the approval from the FIT Program is received, the FSC will conduct the IFSP meeting.
  - l. Documentation of Annual Redetermination of Eligibility: The team of at least two disciplines must document their eligibility decision in at least one of the following ways, and filed in the child’s record:
    - i. Agency-specific formal report
    - ii. IDA Record Summary Paragraph (pg.14)
    - iii. TTCM Contact Log
    - iv. FIT Eligibility Determination Form
  - m. FIT “Informed Clinical Opinion Request for Additional Year” form (as applicable)

## **15. Annual IFSP**

- a. At least annually, the family service coordinator shall convene the IFSP team, including the family, to review progress regarding outcomes on the IFSP and revise outcomes, strategies or services, as appropriate.
- b. The team shall develop a new IFSP for the coming year; however, information may be carried forward from the previous IFSP if the information is current and accurate.
- c. Results of current evaluations and assessments and other input from professionals and parents shall be used in determining what outcomes will be addressed for the child and family and the services to be provided to meet these outcomes.
- d. The annual IFSP review shall include a determination of the child’s continuing eligibility utilizing the tool(s) approved by the FIT Program.
- e. At any time when monitoring of the IFSP by the family service coordinator or any member of the IFSP team, including the family, indicates that services are not leading to intended outcomes, the team shall be reconvened to consider revision of the IFSP. The IFSP team can also be reconvened if there are significant changes to the child’s or family’s situation, e.g., moving to a new community, starting child care or Early Head Start, health or medical changes, etc.

## **16. Transition**

- a. The Family Service Coordinator will manage the transition process which begins with completion of Part I of the Transition Plan at the initial IFSP.
- b. Transition Plan, Part II of the transition plan shall be initiated by the child’s 2<sup>nd</sup>

- birthday (24 months of age), to include, at a minimum, planned activities and projected completion dates.
- c. The Family Service Coordinator will plan and schedule the Transition Conference to be held at least 3 months, but no more than 9 months, prior to the child's third birthday.
  - d. If a child is referred within 90 days of turning three years old, the process outlined in the NM Transition Guidance Manual as quoted below:

“For children referred to the FIT program fewer than 45 days before the child's third birthday, the early intervention provider agency will not conduct intake or an evaluation to determine FIT eligibility. The FIT program will let the family know of preschool options available in the community, e.g., preschool special education, Head Start, private preschools, etc., and will assist with a referral to the LEA with the consent of the parent(s).

If the child is referred to the FIT Program between 45 and 90 days of the child's third birthday and, therefore, the transition conference cannot be held at least 90 days before the child's third birthday, the family service coordinator will discuss the process for transition with the family during the intake process and the transition plan will be incorporated into the initial IFSP. If the child is

determined eligible under “Established Condition” or “Developmental Delay,” a referral must be sent to the LEA, with parental consent, as soon as possible. If the FIT provider determines that the child is potentially eligible for Part B services, the referral may be made prior to FIT eligibility determination and the development of an IFSP and transition plan, again with the parent's consent. The family service coordinator should check the box “90 day timeline for this meeting cannot be met due to child not being enrolled in the FIT Program at that time” on the Transition Referral Form. LEA staff is required to document the date of a late referral in the STARS database and the corresponding noncompliance reason code.”

- e. All families shall be informed of their rights to, and the benefits of having a transition conference. In the event that the family wishes to decline the conference or refuses to proceed with discussions on transition, the FSC must fully document all attempts made to inform the family of their rights and options related to transition. Documentation must include providing a PWN in person or sending via email or mail. Services for the child will continue, as outlined in the IFSP, until the child's third birthday.
- f. If a child is potentially eligible for Part B services, the Family Service Coordinator will convene a Part B Transition Conference which shall include participation of the LEA and shall meet the IFSP attendance requirements as specified in NMAC 8.9.8.
- g. The timely completion of the Part B Transition Conference shall not be delayed due to the availability of the LEA on the scheduled date of the conference.

- h. The IFSP team shall complete the conference according to the guidelines specified in the New Mexico Guidance: Children Transitioning from Part C to Part B, section 9
- i. It is the FIT provider agency's responsibility to ensure that the Part B Transition Conference is conducted in the family's native language in accordance with NMAC 8.9.8.13
- j. If the child is potentially eligible for Part B services, and with parent consent, the Family Service Coordinator shall send the:
  - i. LEA referral form to the LEA at least 60 days prior to the Part B Transition Conference;
  - ii. LEA transition assessment summary form at least 30 days prior to the Part B Transition Conference; and
  - iii. LEA invitation to all parties who will be attending the transition conference at least 30 days prior to the Part B Transition Conference.
- k. LEA personnel are required to participate in the transition conference; however, if the LEA does not respond to timely attempts to schedule the conference or does not attend the conference, the FIT Provider agency must still hold a transition conference.
- l. The FSC must provide parents at the conference with the information about Part B preschool services, including a description of the Part B eligibility definitions, state timelines and the process for consenting to an evaluation and conducting eligibility determinations under Part B.
- m. After holding the transition conference, a subsequent transition conference may be scheduled with the LEA so that the family can be fully informed (New Mexico Guidance: Children Transitioning from IDEA Part C to Part B, 2019, page 14-15).
- n. In the event that a family declines the 90 Day Transition Conference, the FIT Provider Agency must do the following:
  - i. Document that the parent was given comprehensive information about the purpose and benefits of the Transition Conference, and made an informed decision to decline the conference, using a PWN.
  - ii. If the family still wants to proceed with the steps outlined in the Transition Plan Part II, proceed with all documented steps that are not associated with the Transition Conference that was declined.
  - iii. If the family chooses to make any changes to the Transition Plan Part II, update the plan with the family and proceed accordingly.
- o. If a child is **not eligible** for Part B services (At Risk eligibility only), the Family Service Coordinator, with parent consent, shall:
  - i. Convene an Exit Transition Conference which shall meet the IFSP attendance requirements;
  - ii. The conference shall be documented in Part 3 of the Transition Plan; and
  - iii. The date of the conference entered in FIT KIDS.
  - iv. The Exit Transition Conference shall be conducted in the family's native language in accordance with NMAC 8.9.8.1
  - v. The Family Service Coordinator will facilitate the transition conference and follow-up on implementation of the action steps to ensure a smooth and effective transition for the child and family.
- p. The Family Service Coordinator, with parent/caregiver permission, will invite other people providing services and supports to the child and family, including: child care staff; Early Head Start staff; other early learning providers; Home Visiting providers; WIC personnel; medical providers; medically fragile providers; respite providers; infant

mental health providers; autism providers, etc. to the meeting.

**17. Transfers:**

- a. If a child is transferring from another state where the child/family received early intervention services, an interim IFSP will be developed, based on services provided in the previous state, to continue services while the initial evaluation process is being completed. An initial IFSP must be developed within 45 days.
- b. If a child is transferred from another FIT provider agency where the child/family received early intervention services, family service coordination will be provided to the family immediately, and the family's IFSP from their previous agency will function as the plan for services until a new IFSP is developed within 30 days.
- c. If the child is being transferred from another FIT Provider agency, the "FIT Program Child/Family Transfer" form must be completed by the transferring agency according to the specified requirements on the form. The form and documents must be sent to the receiving agency within four (4) working days of the receiving agency being notified of the transfer by phone.
- d. A Release of Information (ROI) signed by the parents is required for the transfer in FIT-KIDS and for the release physical documents (child records).
- e. The Freedom of Choice form will also be used when a family is transferring to another FIT agency in a county in which there is more than one FIT Provider Agency.
- f. In the event that a family presents themselves to a second FIT Provider agency without a referral from the previous agency, the receiving agency will obtain a signed Release of Information from the family and a signed Freedom of Choice form and submit those to the previous agency when requesting a transfer. The previous agency will complete the "FIT Program Child/Family Transfer" form according to the specified requirements on the form. The form and documents must be sent to the receiving agency and a transfer must occur within FIT KIDS within four (4) working days of the requested transfer.

**18. Discharge:**

- b. Prior to discharge, the Family Service Coordinator will provide information to the family about other early learning services in the community (Home Visiting, Early Head Start, child care, etc.) and inform the family that they can return for a developmental screening if they are concerned about their child's development prior to age 3 years. If the child is already 3 years of age, they can contact their local school district Child Find program.
- c. In order to exit a child and their family from services when there has been a series of unexcused no-shows (i.e. the parent(s) did not notify the agency), the Family Service Coordinator (FSC) must follow up via a home visit or phone call with the child's parent(s) to discuss the reason for the no shows and explain the importance of regular early intervention, while at the same time remaining sensitive to any special family circumstances influencing participation patterns.
- d. If the FSC is not able to contact the parent(s), the agency shall send a Prior Written Notice informing them that early intervention services will end if they do not contact the agency by a given date.
- e. Prior Written Notice shall also be sent if the parent(s) informs the FSC that they no longer want to receive early intervention services.

- e. The FSC shall record the steps taken in the child’s record.
- f. The parent(s) may request to be re-referred at any time prior to the child’s 3rd birthday..

## **C. AGENCY REQUIREMENTS**

The provider must adhere to the following:

### **1. Administrative Requirements**

- a. Establish and maintain financial reporting and accounting for each child served.
- b. Establish and maintain a confidential record for each child served, which include the following: signed consent and release forms; current evaluation and assessment results; documentation of eligibility determination; Medical and other appropriate records; IFSP documents; progress notes; and contact notes.
- c. Contact notes/ case notes must include date, time in/time out, a brief description of the service provided and the first initial and last name of the Family Service Coordinator. Documentation must include all time spent with the family and work done on behalf of the family.
- d. Each program’s Policy and Procedure Manual must be updated regularly to reflect current policies consistent with FIT Program requirements related to, at least, the following activities:
  - i. Initial IFSP development
  - ii. Annual IFSP development
  - iii. IFSP review and revisions
  - iv. Ongoing Assessment
  - v. ECO Early Childhood Outcomes
  - vi. Transdisciplinary Team Approach
  - vii. C o l l a b o r a t i v e Consultation
  - viii. Transition Plans and Conferences
  - ix. Exit procedures
- e. A quality assurance plan will be developed that includes, but is not limited to, developing an ongoing monitoring process which regularly reviews compliance and provides for the evaluation of quality, effectiveness of the services provided, and the family’s satisfaction with the above listed activities.
- f. Utilize the state FIT Program IFSP Forms for all eligible children and families.
- g. Ensure that all data is entered into the FIT Program database FIT-KIDS (Key Information Data System) within 30 days following the respective activity. This includes demographic data, IFSP data (including initial IFSP delay reasons), transition plan and conference dates (including conference delay reasons), Early Childhood Outcomes (ECO), delivered services data, and exit data.
- h. Ensure compliance with the regulations for the Family Infant Toddler Early Intervention Program NMAC 8.9.8.
- i. Family Service Coordination must be provided from the time of referral to all eligible children and families in the geographical area served under the ECECD Provider Agreement.
- j. Submit a Quarterly Performance Report based on the federal annual performance indicators (APR) within the required timeframe and in the format provided by the

Family Infant Toddler Program.

- k. Submit an Annual Performance Report (APR) within the required time frame using the FIT supplied template (Indicators 1,7,8a & 8c). A timeline for due dates will be supplied by the FIT Program.
- l. Conduct “Correction of Noncompliance” activities, as necessary, in accordance with the requirements and format provided by the FIT Program. Correction of identified noncompliance must occur within one year of the date of the written notification of the noncompliance (finding/deficiency) and must be twofold: (1) The provider agency must demonstrate that it is correctly implementing the regulatory requirement (based on updated data) for which it was previously noncompliant; and (2) for any noncompliance concerning a child specific requirement, the provider agency must demonstrate that it has corrected each individual case of noncompliance (even if it is late), unless the child is no longer within the jurisdiction of the early intervention program.
- m. The provider shall not charge any fee to families for Family Service Coordination.
- n. Ensure that caseloads enable each Family Service Coordinator to perform all of the roles and responsibilities of Family Service Coordination adequately to all families on their caseload.

## **2. Staffing Requirements**

Family Service Coordinators must possess one of the following qualifications:

- a. A bachelor’s degree in social work; counseling; psychology, nursing; special education; early childhood education or closely related field.
- b. Individuals with a bachelor’s degree in another field can substitute two (2) years of direct experience in serving individuals with disabilities and/or families.
- c. If there are no suitable candidates with the previously described qualifications, individuals with an Associates degree or a registered nurse (who does not have a baccalaureate degree in nursing) and who have a minimum of three (3) years of experience in community health or social service settings can be employed as a service coordinator.
- d. An exemption to the above requirements can be approved by the FIT Program in order to hire service coordinators who meet the cultural or linguistic needs of the population served or if the applicant is a parent of a child with special needs (NOTE a parent cannot be paid to provide Family Service Coordination to their own family). The agency should submit a letter to the FIT Program requesting an FSC waiver in this instance.
- e. In addition to the above listed qualifications, Family Service Coordinators must abide by the following:
  - i. Family Service Coordinators must attend the required Family Service Coordination trainings (online and classroom) within 6 months of hire.
  - ii. Provider will ensure that Family Service Coordinators receive in-house training and coaching including reflective feedback, and observation of intake, IFSP, transition meetings, etc.) before working independently with families.
  - iii. Family Service Coordinators must receive monthly planned and ongoing



reflective supervision. Sub-contractors must find their own supervision if the agency does not provide this for them. Reflective Supervision is defined as an approach designed to encourage learning through thoughtful observation of oneself and others. Reflective supervision is a supervisor – supervisee relationship that pays attention to the influence of relationships on other relationships, the parallel process, and empowers the supervisee to discover solutions/concepts through consciously using strategies that include active listening and waiting. The goal of reflective supervision is to support staff who then support families- and create a more effective working relationship. Ultimately, the relationship between children and their families is improved.

## D. REIMBURSEMENT

Request for reimbursement for Family Service Coordination shall be submitted monthly through the FIT- KIDS (Key Information Data System) in accordance with directions from the ECECD. Staff entering data related to billing shall complete the online FIT-KIDS training through the FIT Program.

1. Request for reimbursement for Family Service Coordination under State General Funds shall be submitted in accordance with directions provided by the Family Support and Early Intervention Division-Administrative Services Division (ASD) at ECECD. Reimbursement for Family Service Coordination is a monthly flat rate.
2. Reimbursement for Family Service Coordination is provided for both face-to-face contacts with the family and work done on behalf of the family (coordinating services, advocating, submitting applications, etc.).
3. A minimum of one (1) accumulated and documented hour of Family Service Coordination must occur to be reimbursed for that month. Documentation must include all time spent with the family and work done on behalf of the family related to Service Coordination. Actual time spent is to be recorded in the service coordination notes. Travel time may not be included.
4. The Family Service Coordinator should keep clear and accurate records of their time spent with, and on behalf of, families for audit purposes.
  - a. Family Service Coordination may be billed for the month(s) prior to the Initial IFSP being in place as part of the intake process.
  - b. Family Service Coordination may be reimbursed for up to 90 days (three months) after the child has successfully transitioned to preschool or another appropriate setting. This option is available to ensure that the transition process is smooth and effective and must be agreed upon by the family and documented in the IFSP transition plan and service coordination notes.
  - c. If the Family Service Coordinator has a dual role, (i.e., they provide another service to the child and family, such as developmental instruction, speech therapy, etc.) the time spent providing the other services are not to be counted towards Family Service Coordination. All activities under each role should be documented separately and distinctly.
  - d. If the child is transferred during the month, and the transfer occurs after the 15<sup>th</sup> of the month, the “original” Family Service Coordinator is authorized to bill for that month. If the transfer occurs on or before the 15<sup>th</sup> of the month, then the new Family Service Coordinator bills for the entire month. Providers shall not postpone the transfer of a child until after the 15<sup>th</sup> of the month in order to bill services for that month.

The FY24 Family Service Coordination rate structure is outlined below:

Reporting Category	700021
Unit Rate:\$224.50	1 (one) unit per month maximum
Medicaid	T2023 TL
Unit Rate:\$224.50	1 (one) unit per month maximum

## **EARLY INTERVENTION**

Early Intervention services are designed to enhance the capacity of families to meet the special needs of their infants and toddlers with disabilities. Early Intervention services support the parents in achieving child and family outcomes and are incorporated in the everyday routines, activities and places of the child and family. Early Intervention services must be conducted in the family's native language.

Specific services, supports, and strategies, such as coaching and TTCM (transdisciplinary teaming approach), are designed to promote development in one or more of the following areas:

1. Cognitive
2. Physical/motor
3. Communication
4. Social or emotional
5. Adaptive (self-help)

### **A. SCOPE OF SERVICE**

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

- Assistive Technology devices, adaptive equipment, and services
- Audiological services
- Developmental Instruction
- Family Therapy, Counseling and Training
- Health Services (to enable the child to benefit from other early intervention services)
- Medical services (for diagnostic or evaluation purposes)
- Nursing services
- Nutrition services
- Occupational Therapy

- Physical Therapy
- Psychological Services
- Sign Language and Cued Language Services
- Social Work Services
- Speech/Language Pathology Services
- Transportation (to enable the child / family to receive early intervention services)
- Vision Services

## B. SERVICE REQUIREMENTS

The following conditions and requirements apply to all Early Intervention Services:

1. Children who are eligible for this service are between the ages of birth to three years old, and meet the eligibility requirements set forth in NMAC 8.9.8, Requirements for Family Infant Toddler Early Intervention Service.
2. Supports and services will be incorporated into the family’s everyday routines, activities and places.
3. Services will also be provided in the early childhood setting (Early Head Start, child care, etc.), if that is where the child spends their day, utilizing inclusive practices, supporting the center staff, and not pulling the child out of the classroom.
4. The provider must provide flexible time/day options for services as needed to parents who work or who are in school.
5. Services must be provided in natural environments, defined as places and activities that are natural or normal for children of the same age who have no apparent developmental delay.
6. New Mexico’s FIT Program has adopted the following two best practice modalities which are named and defined below. All services shall occur using the below outlined practice standards:
  - a. **Caregiver Coaching using Family Guided Routines Based Intervention (FGRBI):** “Family Guided Routines Based Intervention, or FGRBI, is an approach to early intervention services and supports that integrates family-centered practice, adult learning, coaching, and feedback with evidence-based intervention on functional and meaningful outcomes in everyday routines and activities. The term family guided is used to highlight the important role of the family as the decision-maker and guide for their children’s development and learning within early intervention. FGRBI facilitates collaboration by involving caregivers in the assessment and intervention process as partners with their IFSP team members as they identify their priorities and plans for their child, their preferred routines and activities, and when, where, and how often to embed intervention strategies as they occur throughout the day. FGRBI has been applied and evaluated within home-based and center-based programs.” (Source: What is FGRBI? – Family Guided Routines Based Intervention)

- b. Transdisciplinary Team Approach to Early Intervention Service Delivery: “The Transdisciplinary Team Approach is a family-centered process for supporting families of young children with disabilities or delays. In this approach, one member of an identified transdisciplinary team is selected as the lead interventionist and receives coaching from other team members as needed. The lead, in turn, uses coaching as the key intervention strategy to build the capacity of parents and other care providers in using everyday learning opportunities to encourage the development of their children’s skills.” (Source: Transdisciplinary Team Approach – ECLN Portal (unm.edu)) In New Mexico this consists of the following three components: lead interventionist, co-visits between IFSP team members, and Transdisciplinary Team Consult Meetings.**
7. Justification on the IFSP is required if the team determines that outcomes cannot be met in a natural environment. Justification must include:
- a. A statement of where services will be provided; and
  - b. Steps that will be taken to enable early intervention services to be delivered in the natural environment.
8. If the provider operates early intervention services with a group of children in a center (where the parents are not present) the center must be licensed by ECECD in accordance with 8.16.2 NMAC, or accredited by a national organization if not under the jurisdiction of ECECD.
9. Families of children eligible under Biological / Medical Risk or Environmental Risk are limited to receive up to 24 hours of ongoing early intervention services per IFSP year. The following **are not included in the 24 hours**:
- a. Family Service Coordination
  - b. Evaluation & Assessments (E&A) services
  - c. Collaborative Consultation Meetings
  - d. TTCM Meetings
10. All services must be delivered in accordance with the frequency and intensity indicated on the IFSP and under the following conditions:
- a. IFSP frequency and intensity must be written at smallest denominator reasonable, e.g. 60 minutes per week, rather than 240 minutes per month.
  - b. Service provision in any given week / month may at times exceed the amount on the IFSP. Examples include if an IFSP meeting is held that month OR early intervention services are provided twice in a week to make up for services missed OR if the early intervention session goes beyond the amount planned for on the IFSP.
  - c. If a permanent change is needed to the IFSP, then a periodic review meeting will be held to update the services page.
  - d. Changes to the frequency, intensity, location or method of services on the IFSP shall be made by utilizing the amendment section on the Supports and Services page by adding the revised service on a new line. The same process would be used to end a service before the next IFSP.
  - e. The family shall sign a Prior Written Notice form giving their consent to any service changes.

## **11. Prior Authorization for Services**

- a. Prior authorization is required when ongoing early intervention services proposed by the IFSP team will exceed 16 hours per month of ongoing services. Ongoing services do not include: Family Service Coordination; Collaborative Consultation, Evaluation & Assessment (E&A), TTCM; respite; and other services not funded through the FIT Program.
  - b. If the IFSP team recommends that more than 16 hours of ongoing services is needed to meet the outcomes on the IFSP, the family shall be informed of the need for approval of the additional hours.
  - c. The team will complete an “IFSP Supports & Services Prior Authorization Form.” The team should utilize a Transdisciplinary Team Approach meeting to complete the form.
  - d. The “IFSP Supports & Services Prior Authorization Form” shall be reviewed and signed by a designated agency representative (administrator, manager, supervisor, etc.) before being submitted to the FIT Program Regional Coordinator.
  - e. The FIT Program will respond with a decision within ten (10) working days after the receipt of the “IFSP Supports & Services Prior Authorization Form” requesting over 16 hours of direct services.
  - f. Once the approval from the FIT Program is received, the FSC will meet with the family to update the services page on the IFSP.
  - g. Circumstances which may justify the need for services over 16 hours per month include a diagnosis such as autism spectrum disorder, for which the intensity of intervention is a recommended practice, and complex family circumstances that may require time-limited intensive intervention.
  - h. Exceptions to the Prior Authorization process are for children enrolled in the following classroom-based toddler programs: NMSD, NMSBVI, and PEI.
12. The provider is responsible for providing, purchasing or arranging through other community resources any services listed above or listed on the IFSP.
  13. Each ongoing Early Intervention service must be delivered within 30 days of the start date for the service on the IFSP and consented to by the parent(s). Ongoing services do not include: Collaborative Consultation, TTCM, Evaluation & Assessment, Family Service Coordination, respite and other services not funded through FIT.
  14. If the family is also enrolled in a Federal, state or privately (including foundation) funded Home Visiting program, the IFSP process shall be used to determine the mix of services the child and family will receive to meet the outcomes on the IFSP. This will enable services and strategies for the child and family to be aligned, avoids duplication, prevents parents from being overwhelmed and helps eliminate confusion.
  15. The team shall determine federally required Early Childhood Outcomes (ECO) scores in accordance with the FIT Program ECO Manual and the ECO Decision Tree for Summary Rating Discussions.
  16. The initial ECO score is to be determined by the IFSP team prior to services being provided and no later than 30 days following the initial IFSP.
  17. The rating must be entered into FIT-KIDS within 30 days of the rating determination.
  18. The “Exit ECO” must be completed within 30 days prior to the child exiting the program. If the child exits unexpectedly before their 3<sup>rd</sup> birthday, and an Exit ECO was not completed before they exited, the team shall convene to complete an Exit ECO within 45 days of the

exit date.

## 19. Ongoing Assessment

- a. Ongoing assessment is the process of using professional observation, parent input and assessment tools to identify the unique strengths, needs, developmental functioning and progress of a child, that then inform intervention practices.
- b. Ongoing assessment information is gathered by all team members and at every visit, with or without the use of the assessment tool.
- c. All team members shall note specific skills that the child has/needs as part of their observations during a visit. These observations shall be recorded in the tool's protocol periodically to ensure monitoring of the child's progress and coordination of intervention strategies implemented by the team.
- d. Ongoing assessment information should be used, at a minimum, to inform the following:
  - i. Intervention strategies implemented by the IFSP team and family;
  - ii. IFSP goals and strategies;
  - iii. Exit ECO ratings;
  - iv. Annual re-determination of eligibility; and
  - v. Changes in services and supports.
- e. Documentation: The protocols that record the results of the ongoing assessment tools shall be updated in the child's file, *at a minimum*, two times per year: once before the 6-month review and again at the time of the annual re-determination of eligibility. Ongoing assessment protocols may be updated more often based on the guidelines of the tool and/or needs of the team or child/family.
- f. Approved Tools:
  - i. Assessment, Evaluation, and Programming System for Infants and Children (AEPS)
  - ii. Hawaii Early Learning Profile (HELP)
  - iii. For children with vision impairments: Oregon Project Skills Inventory
  - iv. The Visual Communication and Sign Language Checklist: for children who are deaf and/or hard of hearing
  - v. The MacArthur-Bates Communicative Development Inventories: for children who are deaf and/or hard of hearing
  - vi. The Language Development Scale: for children who are deaf and/ or hard of hearing
  - vii. Other tools as approved by the FIT Program

## 20. Periodic review of the IFSP

- a. A review of the IFSP shall occur at a minimum every six months and shall include a determination of progress towards outcomes and the need for modification of outcomes or services.
- b. A review can occur at any time at the request of the parent(s) or early intervention provider agency.
- c. Participants at a periodic review meeting shall include:
  - i. the parent(s);
  - ii. other family members, as requested by the parent(s) (if feasible);
  - iii. an advocate or person outside of the family, as requested by the parent(s);

- iv. the family service coordinator; and
- v. persons providing early intervention services, as appropriate.

**21. Annual Redetermination of Eligibility:**

- a. Eligibility for the NM FIT Program must be redetermined on an annual basis. In order to determine the child’s continued eligibility for the NM FIT Program, the multidisciplinary IFSP team must follow the same guidelines for determination of the eligibility category or categories as described for the initial evaluation process.
- b. The team that redetermines eligibility must be comprised of at least two professionals from different disciplines.
- c. If there is only one ongoing service on the IFSP, a one-time E&A (Evaluation and Assessment) must be added to the existing IFSP with sufficient time to allow a second discipline to participate in the review of ongoing assessment information and the IDA process and complete the redetermination of eligibility prior to the Annual IFSP Meeting.
- d. If the ongoing IFSP team is comprised of two or more disciplines, the team must use current ongoing assessment information (see list of approved Ongoing Assessment Tools) to inform and/or score the IDA Provence Profile and complete the full IDA process to determine the child’s continued eligibility for the NM FIT Program. *See the Evaluation & Assessment Technical Assistance document for more information on this process.*
- e. If the ongoing IFSP team is comprised of only one discipline, and a second discipline is added for the purpose of conducting the annual redetermination of eligibility, then the team needs to conduct an evaluation session utilizing the IDA.
- f. Based on the needs of the child and at the team’s discretion, additional domain-specific tools may be used to support the redetermination of eligibility. If the IDA does not indicate a 25% delay, a developmental domain specific tool can be used to inform eligibility under developmental delay based on either a -1.5 Standard Deviation or greater, or Informed Clinical Opinion.
- g. In order to determine the child’s continued eligibility for the NM FIT Program, the team will discuss and synthesize the information during a transdisciplinary team consultation meeting that has been gathered through each professional’s ongoing assessments, including:
  - i. Developmental information obtained through ongoing assessment tools;
  - ii. Review and updating of the child’s health and medical status; and
  - iii. Information regarding the child’s performance in daily living activities, as reported by the parents and other caregivers (including RBI process).
- g. In the event that a child has not been receiving ongoing services, however, still has an active IFSP, the following process should be used: If the child has not received an early intervention session for six months or less, ongoing assessment information and an evaluation session with two different disciplines should be scheduled in order to score the IDA. If the child has not received an early intervention session for six months and one day or more, a CME should be scheduled in order to establish eligibility.
- h. In addition to redetermining eligibility, the assessment process should provide information regarding the child’s current strengths and needs to inform the Annual IFSP Process.
- i. The team of at least two disciplines must document their eligibility decision in at least one of the following ways, and file it in the child’s record:
  - i. Agency-specific formal report
  - ii. IDA Record Summary Paragraph (pg.14)
  - iii. TTCM Contact Log



- iv. FIT Eligibility Determination Form
- v. FIT Informed Clinical Opinion Additional Year request form (as applicable)

- 22. Informed Clinical Opinion (ICO)** refers to the knowledgeable perceptions of caregivers and professionals who use qualitative and quantitative information regarding difficult-to-measure aspects of a child's development to decide about the child's eligibility for the FIT Program.
- a. When ICO is used to determine eligibility (significant atypical development), documentation must be provided to justify the decision, which may include parent and other caregiver reports of ways in which daily activities are being impacted, professional observations during the evaluation session and in other settings/situations, a description of the child's abilities and/or behaviors and how they differ from those of a typical same-age peers.
  - b. This documentation must provide a description of the child's abilities and areas of concern including:
    - i. why these abilities differ from typical children of the same age; and
    - ii. the way they impact the child's daily activities.
  - c. The evaluation report must be reviewed by a "second level reviewer" (someone who is not part of the evaluation team who has equal or higher-level certification or licensure) and shall include a statement of approval and second level reviewer signature.
  - d. ICO can only be used as the primary means of determining eligibility for one year without prior review and approval from the FIT Program (as pertains to Annual Redetermination of Eligibility) and under the following conditions:
    - i. To request an additional year of ICO: The "Informed Clinical Opinion Additional Year Request" form shall be reviewed and signed by a designated agency representative (administrator, manager, supervisor, etc.) before being submitted to the FIT Program Regional Coordinator.
    - ii. The FIT Program will respond with a decision within ten (10) working days after it has received the "Informed Clinical Opinion Additional Year Request" form to request an additional year of eligibility using ICO.
    - iii. Once the approval from the FIT Program is received, the FSC shall conduct the IFSP meeting.

**23. Annual IFSP (NMAC 8.9.8)**

- a. At least annually, the family service coordinator shall convene the IFSP team to review progress regarding outcomes on the IFSP and revise outcomes, strategies or services, as appropriate.
- b. The team shall develop a new IFSP for the coming year; however, information may be carried forward from the previous IFSP if the information is current and accurate.
- c. Results of current evaluations and assessments and other input from professionals and parents shall be used in determining what outcomes will be addressed for the child and family and the services to be provided to meet these outcomes.
- d. The annual IFSP review shall include a determination of the child's continuing eligibility utilizing the tool(s) approved by the FIT Program.
- e. At any time when monitoring of the IFSP by the family service coordinator or any member of the IFSP team, including the family, indicates that services are not leading to intended outcomes, the team shall be reconvened to consider revising the IFSP. The IFSP team can also be reconvened if there are significant changes to the child's or family's situation, e.g., moving to a new community, starting child care or Early Head Start, or health changes, etc.

## C. AGENCY REQUIREMENTS

The provider must adhere to the following:

### 1. Administrative Requirements

- a. Establish and maintain financial reporting and accounting for each child.
- b. Establish and maintain a confidential record for each child served that includes the following: signed consent and release forms; documentation of Written Prior Notice as required by FIT Procedural Safeguards (8.9.8 (E) NMAC); current evaluation and assessment reports; IFSP documents; progress notes; and contact logs.
- c. The provider shall maintain 'contact logs' / 'encounter sheets' that must include: date; time in/ time out; a brief description of service provided; the first initial and last name of the person providing the service; and their discipline / qualification. A separate 'contact log' / 'encounter sheet' must be completed for each discipline providing a service, including co-visits. For group services, time in/ time out shall be recorded for all attendees including staff.
- d. The provider will develop a quality assurance plan that includes, but is not limited to, developing an ongoing monitoring process that evaluates the quality and effectiveness of services provided and the families' satisfaction with those services.
- e. Submit an Annual Performance Report (APR) within the required time frame using the FIT supplied template (Indicators 1,7,8a & 8c). A timeline for due dates will be supplied by the FIT Program.
- f. Submit a Quarterly Performance Report based on the federal annual performance indicators (APR) within the required timeframe and in the format provided by the Family Infant Toddler Program within the required time frame.
- g. Conduct "Correction of Noncompliance" activities, as necessary, and in accordance with the requirements and format provided by the FIT Program. Correction of identified noncompliance must occur within one year of the date of the written notification of the noncompliance (finding/deficiency) and must be twofold: (1) The provider agency must demonstrate that it is correctly implementing the regulatory requirement (based on updated data) for which it was previously noncompliant; and (2) for any noncompliance concerning a child specific requirement, the provider agency must demonstrate that it has corrected each individual case of noncompliance (even if late), unless the child is no longer within the jurisdiction of the early intervention program.
- h. Ensure that all data is entered into the FIT Program database FIT-KIDS (Key Information Data System) within 30 days following the respective activity. This includes demographic data, IFSP data (including initial IFSP delay reasons), transition plan and conference dates (including conference delay reasons), Early Childhood Outcomes (ECO), delivered services data, and exit data.
- i. Early intervention services must be provided in accordance with the IFSP to all eligible children and families in the geographical area served under the ECECD provider agreement.
- j. The provider shall not charge any fee to families for early intervention services.

- k. The Provider Agency must keep a current copy of licenses of staff and sub-contractors and Developmental Specialist Certifications.

## 2. Staffing Requirements

All Early Intervention Personnel (employees and subcontractors) must receive monthly planned and ongoing reflective supervision. Sub-contractors must find their own supervision if the agency does not provide this for them. Additional supervision of therapists and other early intervention personnel is provided according to their licensing board's requirements. *Reflective Supervision is an approach designed to encourage learning through thoughtful observation of oneself and others. Reflective supervision is a supervisor – supervisee relationship that pays attention to the influence of relationships on other relationships, the parallel process, and empowers the supervisee to discover solutions/concepts through consciously using strategies that include active listening and waiting. The goal of reflective supervision is to support staff who then support families- and create a more effective working relationship. Ultimately, the relationship between children and their families is improved.*

**All Developmental Specialists (including supervisors) are required to be certified and work within the scope of work allowed under the designated level of certification in accordance with Family Infant Toddler Developmental Specialist Certification manual. All newly hired personnel must apply for Developmental Specialist Certification within one month of the date of hire and the agency shall ensure that all Developmental Specialists are certified by the FIT Program before they can bill and that they renew their certification at the required time.**

- a. The provider may not subcontract for Developmental Specialists certified as a DS I Basic or DS I Advanced.
- b. All Developmental Specialists, including subcontractors, must have a current written Individual Personnel Development Plan (IPDP), which includes the Self-Assessment Tool, as required for re-certification in accordance with the policy titled “Certification and Re-certification Requirements for Developmental Specialists.”
- c. All IPDPs must be updated at least annually. However, the Self-Assessment Tool may be completed once at the beginning of every three-year-cycle.

**Early Intervention personnel must meet one of the following qualifications:**

- a. Audiologist – licensure from the NM Audiology Board
- b. Developmental Specialist – Certification in accordance with FIT Program regulations and FIT Policy
- c. Education of the Deaf and Hard and Hearing - Certification
- d. Education of the Blind and Visually Impaired – Certification from NMSBVI and / or Teaching license
- e. Family therapist – licensure from the Counseling and Therapy Practice Board as a Family Therapist, Professional Clinical Mental Health Counselor, Professional Mental Health Counselor, or Registered Mental Health Counselor
- f. Nurse – licensure from the NM Board of Nursing as a registered nurse or licensed practical

nurse

- g. Nutritionist – licensure from the NM Nutrition and Dietetics Practice Board
- h. Occupational Therapist (or Certified OT Assistant COTA) – licensure from the NM Board of Occupational Therapy Practice. AOTA practice and supervision standards as well as the NM Regulation and Licensing Department guidelines for practice, supervision and training must be followed.
- i. Orientation and Mobility Specialist – Certification from NMSBVI and/or ACVREP (Academy for Certification of Vision Rehabilitation and Education Professionals).
- j. Physical Therapist (or PT Assistant) – licensure from the NM Physical Therapy Licensing Board. APTA practice and supervision standards, as well as the NM Regulation and Licensing Department guidelines for supervision, practice and training, must be followed.
- k. Psychologist (or Psychologist Associate) – licensure from the NM Board of Psychologist Examiners
- l. Social worker – licensure from the NM Board of Social Work Examiners
- m. Speech/Language Pathologist or ASL (Apprentice in Speech Language)– licensure from the NM Board Speech, Language Pathology, Audiology and Hearing Aid Dispensers Board, the American Speech Language Hearing Association (ASHA) Speech Language Pathology Assistant Scope of Practice (doi: 10.1044/policy.SP2013-00337) and New Mexico Regulation and licensing Department guidelines for supervision, practice and training must be followed.

#### **D. REIMBURSEMENT**

1. Requests for reimbursement for early intervention shall be submitted monthly through the FIT- KIDS (Key Information Data System) and in accordance with directions from ECECD. Staff entering data related to billing shall complete the online FIT-KIDS training.
2. **Reimbursement is for the direct intervention time (face-to-face) with the child and family (with the exception of consultation).** Reimbursement for this service is based on where the early intervention activity occurred and whether the method of providing the service was to an individual child and family or to a group.
3. **The following activities are built into in the unit rate and may not be billed separately:**
  - Travel to and from the home or community location (except transporting the child to receive early intervention services);
  - Attendance at training and other personnel development activities;
  - Impromptu meetings with other personnel or administrative staff meetings;
  - Preparation of billing statements, progress notes, or reports, data entry; and
  - Supervision time.
4. **Services locations and methods:**

**Home Individual:** Defined as a place where the child lives with parents/guardian. It is a location away from the provider site. “Home Individual” is a service that is provided to an individual child and their family.

**Community Individual:** Defined as a natural environment for the child and family. It is a location away from the provider site, including but not limited to: a relative’s home; child care

setting; park or play area; or other natural environment for the child and family which involves travel for the early intervention personnel and is a location in which children without disabilities typically spend time. “Community Individual” is a service that is provided to an “individual” child and their family.

**Home Group:** defined as a place where more than one child lives with parents/guardian and the family has chosen to have the children receive services together as group. It is a location away from the provider site which involves travel for the early intervention personnel.

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

**Developmental Delay Program (DDP) Individual:** defined as (agency operated center < 50% typically developing children) a service location that is operated by the provider where the early intervention personnel providing services do not have to travel and where the child / family receive services individually. If the FIT provider agency operates a licensed child care program, DDP/Individual may be used to provide early intervention to an eligible child served in that setting if the intervention is directed to one eligible child in that classroom and not a group of eligible children.

**Inclusive Provider Location (IPL) Individual:** defined as a service location (center > 50% typically developing children) that is operated by the provider where the early intervention personnel providing services do not have to travel and where the child / family receive services individually. If the FIT provider agency operates a licensed child care program, IPL individual may be used to provide early intervention to an eligible child served in that setting if the intervention is directed to one eligible child in that classroom and not a group of eligible children.

**DDP Group:** defined as a service location that is operated by the provider where the early intervention personnel providing services do not have to travel and where two or more eligible children / families receive services at the same time and where there is less 50% typically developing children. **The child must be present for this service.**

**IPL Group:** defined as a service location (center < 50% typically developing children) that is operated by the provider where the early intervention personnel providing services do not have to travel and where two or more eligible children / families receive services at the same time. **The child must be present for this service.**

## CONSULTATION:

Below are the requirements for both TTCM and Collaborative Consultation. Table 1 on page 49 of this document provides distinguishing features of each type of consultation.

- a. **Transdisciplinary Team Consult Meeting (TTCM):** Consultation occurs between transdisciplinary team members including Family Service Coordinators. Family Service

Coordinators will document this as a Family Service Coordination activity. The primary purpose is to integrate and plan effective early intervention strategies. TTCMs are meant for intentional sharing of strategies with the transdisciplinary team members. TTCMs are not staffing, general family updates, or informal communications. TTCMs may also be used for the IFSP team to review the assessment information, develop the Early Childhood Outcomes score, prepare for the IFSP, etc. TTCMs must be performed under the following conditions:

- i. Up to 12 hours a year of TTCMs can be billed per discipline. TTCMs consultations must be planned.
- ii. TTCMs consultations must be listed on the IFSP in the Transdisciplinary Team Consultation section indicating the frequency and duration.
- iii. Each of the IFSP team members participating in the TTCM can bill for their time.
- iv. Team members may participate via teleconference or web / videoconference.
- v. TTCM should involve the entire team. However, there may be times when the entire team is not available to meet.
- vi. Note: billing can occur for the IFSP team members who attend, even if one or two team members are absent.
- vii. TTCM participants are those that are listed under Early Intervention Personnel in these Standards and are listed on the IFSP.
- viii. Transdisciplinary Team Consultation is entered on the IFSP separately from services in the designated section.
- ix. Documentation (log) of meetings must include signatures and credentials as well as time in/time out for each participant. A log must be completed for each meeting with each participant signing with credentials and indicating their time in/time out, or individual logs may be completed.
- x. Two individuals of the same discipline can bill for the same TTCM session as long as both individuals are written on the IFSP and each has a specific specialty (e.g., a DS who is a Music Therapist and another DS who specializes in working with children with autism).

**b. Collaborative Consultation** is utilized by IFSP team members for the purposes of integrating and planning effective early intervention strategies and can be done by an individual or the full IFSP team. Collaborative Consultation is not direct services and includes but is not limited to:

- i. Meeting with Early Head Start, child care or home visiting personnel (e.g. to share strategies for promoting the child's development or plan for upcoming intervention sessions).
- ii. Meeting with the child's doctor or other medical specialist (e.g. to align early intervention strategies with the medical management of the child).
- iii. Attending ECEP evaluations (note: only the time spent sharing information about the child and family, up to 1 hour per discipline).
- iv. Meetings with Community Infant Teams to align strategies to support foster parents and birth parents.
- v. Testifying in court on behalf of the child and family when requested or subpoenaed.
- vi. IFSP meetings (Initial, Periodic Review, Annual).
- vii. Transition Conference / IEP meeting (e.g. to share information and align strategies to

facilitate a smooth transition to preschool services).

- c. Follow-up Collaborative Consultation** Follow-up collaborative consultation is solely for the purpose of supporting the transition from Part C. This consultation can occur with family members and/or professionals **after the child has turned three years** old. For example, a member of the IFSP team may provide information regarding effective strategies to preschool personnel and/or family members during follow-up consultation. Follow-up consultation is reimbursable for IFSP early intervention providers for up to a total of 12 twelve hours across disciplines within 90 days **after the child turns three**. The IFSP team members providing follow-up consultation will be determined by the IFSP team as part of the Transition Conference.
- i. Follow-up Family Service Coordination may occur but is not included in the 12 hours. See the Family Service Coordination section of these Standards for more information on Follow-up Family Service Coordination.

**d. Collaboration Consultation Requirements**

- i. Collaborative consultation is reimbursed for consultation conducted face to face, via video conference, and/or via telephone.
- ii. Collaborative consultation is reimbursed at the community individual rate.
- iii. Collaborative Consultation does not need to be entered on the IFSP.
- iv. The documentation (log) of meetings must include signatures and credentials as well as time in/time out for each participant. A log must be completed for each meeting with each participant signing with credentials and indicating their time in/time out or individual logs may be completed
- v. Collaborative Consultation is billed for attendance at IFSP meetings.



## Transdisciplinary Team Consult Meeting Vs. Collaborative Consult Meeting

TTCM: Distinguishing Features	Collaborative Consultation Meeting: Distinguishing Features
<p><b>Purpose</b></p> <p>For the IFSP team to support the lead provider, review ongoing assessment information, and plan for upcoming services in order for the family to receive a coordinated system of supports and services</p>	<p><b>Purpose</b></p> <p>Meeting with community partners outside the FIT provider agency to help strengthen the support network for the child and family with the following exception:</p> <ul style="list-style-type: none"> <li>· <i>Attendance at IFSP meetings</i></li> </ul>
<p>Limit of 12 hours per year per discipline per child</p>	<p>There is no specific limit on how much or how often collaborative consultation can be billed with the following two exceptions:</p> <ul style="list-style-type: none"> <li>· <i>Attendance at ECEP evaluations</i></li> <li>· <i>Follow-up collaborative consult related to transition out of Part C</i></li> </ul>
<p>Must be listed on the IFSP indicating the frequency</p>	<p>Does not need to be entered on the IFSP</p>
<p>All billing participants must be licensed in an approved discipline, certified as a Developmental Specialist, or providing Family Service Coordination and MUST be written on the IFSP</p>	<p>All billing participants must be licensed in an approved discipline (e.g., OT, PT, SLP, SW) and MUST be written on the IFSP</p>
<p>Ideally should include all IFSP Team members but at minimum, must include at least two members of the IFSP Team (this can include the FSC)</p>	<p>Can occur between one or more IFSP team member and a collaborative partner outside of the FIT Provider Agency</p>

**e. Co-Visits are visits that occur jointly between 2 or more practitioners under the following circumstances:**

- i. Conducted to support transdisciplinary approach and to support the lead practitioner and align IFSP strategies.
- ii. In order to enhance the integration of services by supporting a transdisciplinary teaming approach
- iii. Are reimbursed based on the location where the activity occurred.
- iv. Must be documented in the IFSP as one of the strategies to be used to meet the child/ family outcome(s), but does not need to be listed on the IFSP Supports and Services page.
- v. Cannot be used to provide supervision to staff or to travel together to reduce travel costs.
- vi. **Reimbursement for a co-visit** is per provider at the location where the service occurred.
- vii. **FIT-KIDS coding: Co-visits are billed using the service type “-ongoing” or “E&A” and the method of “individual” or “group” and the location as “home” or “community”, “Developmental Delay Program (DDP)” or “Inclusive Provider Location (IPL)”..**
- viii. **Documentation:** Each personnel providing co-visit must complete a ‘contact log’ / ‘encounter sheet.’

**f. Telehealth (video-conferencing):** may be provided in accordance with Medicaid Policy 8.310.0, which includes:

- i. A telehealth communication system must include both interactive audio and video and be delivered on a real-time basis at the originating (home community location of the child and family) and at the distant-sites (location of the early intervention personnel providing the telehealth service) using Medicaid approved HIPA A compliant means of communication. Agency staff should discuss the family’s access to equipment and internet to see if they meet the communication criteria.
- ii. The local provider agency will discuss telehealth options with families, including pros and cons and methods to be used. This includes parent preference for whether they want a service provider to be in the home or not during the telehealth visit. A parent may request this at any time. This request should be documented in the child’s record.
- iii. Prior to adding telehealth services as a strategy for providing early intervention services, the local early intervention provider agency representatives will first establish rapport with the family.
- iv. Telehealth must be documented on the IFSP as one of the strategies to be used to meet the child/ family outcome(s), but does not need to be listed on the Supports and Services page.
- v. Parents may decline telehealth services at any time, and this shall be documented in the child’s file, and service changes shall be documented using a prior written notice.
- vi. The Family Service Coordinator will obtain parental feedback on telehealth services as part of the monthly check-in. Documentation of this discussion shall be kept in the child’s file (FSC notes).
- vii. Use of the telehealth communications system fulfills the requirement for a face-to-face encounter.
- viii. Family preference shall be considered regarding the use of telehealth services and, if requested, a team member can be at the home to help facilitate the session.
- ix. **Reimbursement** is at the Home/Community individual’ rate.
- x. **FIT-KIDS coding:** Service Type ‘Ongoing’; Method: Individual · Location ‘Telehealth’

- xi. Documentation:** Each personnel providing telehealth services must complete a 'contact log' / 'encounter sheet' Preparation time for early intervention activities

**FY24 FIT RATE STRUCTURE**

<b><u>METHOD</u></b>	<b><u>LOCATION</u></b>			
	<b>Home</b>	<b>Community</b>	<b>DDP</b>	<b>IPL</b>
<b>Individual</b>	Unit: 15 minutes Medicaid T1027 TL <b>Unit Rate: \$ 33.00</b> Type: Ongoing or E&A	Unit: 15 minutes Medicaid T1027 TL <b>Unit Rate: \$33.00</b> Type: Ongoing or E&A	Unit: 15 minutes Medicaid T1027 TL TT <b>Unit Rate: \$27.50</b> Type: Ongoing or E&A	Unit: 15 minutes Medicaid T1027 TL TT <b>Unit Rate: \$27.50</b> Type: Ongoing or E&A
<b>Group</b>	Unit: 15 minutes Medicaid T1027 TL TJ <b>Unit Rate: \$13.00</b> Type: Ongoing or E&A	Unit: 15 minutes Medicaid T1027 TL TJ <b>Unit Rate: \$13.00</b> Type: Ongoing or E&A	Unit: 15 minutes Medicaid T1027 TL HQ <b>Unit Rate: \$11.00</b> Type: Ongoing or E&A	Unit: 15 minutes Medicaid T1027 TL HQ <b>Unit Rate: \$11.00</b> Type: Ongoing or E&A
<b>Transdisciplinary Team Consult Meetings (TTCM)</b>	NA	NA	Unit: 15 minutes Medicaid: T1027 TL TT <b>Unit Rate: \$30.00</b> Type: Ongoing	Unit: 15 minutes Medicaid: T1027 TL TT <b>Unit Rate: \$30.00</b> Type: Ongoing
<b>Collaborative Consultation (CC)</b>	Unit: 15 minutes Medicaid: T1027 TL HT <b>Unit Rate: \$30.00</b> Type: Ongoing	Unit: 15 minutes Medicaid: T1027 TL HT <b>Unit Rate: \$30.00</b> Type: Ongoing	NA	NA

**Please direct questions regarding FIT Program Standards to your FIT Regional Coordinator.**

