Instructions for the Completion of the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Level of Care Eligibility Determination (LCED) Form for Home and Community Based Services (HCBS) Waiver, Comprehensive Care Coordination and other State Plan Services

Purpose:

The following information is intended to provide guidance on the completion of the ICF/IID Level of Care Eligibility Determination (LCED) and LCED form. The LCED form is used for the initial determination and annual redetermination (i.e., re-evaluation) for individuals seeking to access or maintain Home and Community Based Services (HCBS) Waiver, Comprehensive Care Coordination and other State Plan services. This information includes the criteria for determining eligibility as well as the step-by-step instructions for completing the LCED form. The criteria used are the same for the initial and annual redetermination reviews for HCBS Waiver, Comprehensive Care Coordination and other State Plan Services

This guidance replaces the "Instructions for the Completion of the ICF/MR Level of Care Eligibility Determination (LCED) Form for HCBS Waiver Participants" (HCBS Form 02.02.97 (5/2010, 4/2011)) revised 4/29/2011.

The LCED Form may be converted to an electronic record format as long as all the required fields and information are included, and the signatures are "valid" according to standards for electronic recordkeeping.

Background:

Pursuant to federal regulations, HCBS waiver services can only be provided to recipients who would otherwise require services consistent with the level of care provided in a Medicaid certified hospital, nursing facility or ICF/IID (42 CFR Section 441).

Once an individual is admitted to a waiver program, states must certify through an ***annual*** level of care redetermination (i.e., re-evaluation) process that he or she continues to present needs consistent with the level of care provided within those settings noted above (42 CFR Section 441).

Federal regulation 42 CFR Section 441requires that an HCBS waiver recipient's level of care be determined no less frequently than annually.

New York State regulations (14 NYCRR Section 635-10.3) also require that HCBS waiver participants meet the criteria for ICF/IID level of care. The regulations state that the HCBS waiver recipient's ICF/IID Level of Care Eligibility Determination shall be re-examined on an annual basis.

As of April 2018, New York State's Health Home State Plan eligibility criteria was expanded to serve individuals with intellectual and/or developmental disabilities (I/DD) chronic conditions, including:

1. Intellectual Disability
2. Cerebral Palsy
3. Epilepsy
4. Neurological Impairment
5. Familial Dysautonomia
6. Prader-Willi Syndrome
7. Autism

Individuals (adults and children) who have at least one of the I/DD Health Home chronic conditions listed above and that have received a determination made by the Office for People With Developmental Disabilities (OPWDD) that such I/DD condition, with onset prior to age 22 and likelihood of indefinite continuation, results in a substantial handicap to their ability to function normally in society (i.e., individuals who are eligible for OPWDD HCBS and meet level of care criteria) will be eligible for care management services and will be served in an Intellectual and Developmental Disability Health Home (I/DD HH) designated to serve individuals with I/DD. Individuals who meet these criteria are eligible for HCBS Waiver, Comprehensive Care Coordination and other State Plan Services .

Qualifications of Persons Performing LCED Initial Determinations and Redeterminations, Required Signatures, and LCED Timeframes:

Initial (i.e., first) LCED:

The initial LCED is completed by a professional with a minimum of one year's experience in the performance of assessments and the development of plans of care for individuals with I/DD. This professional will be a Qualified Intellectual Disabilities Professional (QIDP) (see 42 CFR Section 483.430(a)) assigned by the Developmental Disabilities Regional Office (DDRO) to complete the initial LCED.

The initial LCED must be reviewed, signed, and dated by a physician or nurse practitioner. The initial LCED information that is reviewed by the physician or nurse practitioner must include the relevant pre-admission evaluations: physical (medical), social, and psychological. The psychological evaluations must be conducted by qualified practitioners who may administer and interpret standardized measures of intelligence and adaptive behavior. A qualified practitioner is

a person with a directly relevant master's degree or doctoral degree in psychology, who has training and supervised experience in the use and interpretation of such measures consistent with the recommendations contained in the respective test manuals and with the requirements of the American Psychological Association (APA)/ American Educational Research Association (AERA)/ National Council on Measurement in Education (NCME) (2014) standards for test administration and use and interpretation of individual test results. A copy of the pre-enrollment evaluations must be sent to the DDRO or uploaded into the Information Technology (IT) system, CHOICES, along with the initial LCED form so they can be retained in the HCBS Enrollment permanent record. The I/DD HH should also retain these documents in the individual's care management record.

The DDRO Director (or designee) must also review, sign, and date the initial LCED and write in the effective date of the Eligibility Determination. Before signing, the DDRO Director (or designee) must review the LCED's supporting documentation and must assure that a DDRO Developmental Disability eligibility determination has been completed in accordance with the OPWDD eligibility guidelines, and that the findings substantiate I/DD eligibility. The effective date of the LCED can precede the signature date of the DDRO Director (or designee) but it can be no earlier than the date the physician or nurse practitioner reviewed/signed the LCED Form. Upon receiving the signature of a physician or nurse practitioner and DDRO Director (or designee), the initial LCED form must be uploaded into CHOICES.

For those individuals applying for the HCBS waiver, the initial LCED should be completed no later than thirty (30) days from the date that the DDRO receives the individual's signed application.

For HCBS Waiver, Comprehensive Care Coordination and other State Plan Services that require an ICF/IID LCED, enrollment and billing cannot precede the effective date of the LCED determination as indicated in the field "ICF/IID Level of Care Approved Effective (mm/dd/yy)" which is completed by the DDRO Director (or designee).

Annual LCED Redeterminations:

The purpose of the annual redetermination is to ascertain if the individual continues to meet ICF/IID level of care eligibility criteria. As it is unlikely that there will be significant changes to an individual's disability and level of functioning over a year's time, the person completing the annual LCED redetermination should be able to assess the development status of the individual based on the following: direct knowledge of the individual based on observations and discussions with them; a review of the most recent psychological evaluation, social history, physical/medical history, and other applicable information; and/or a review of the criteria outlined in the initial LCED Form (i.e., diagnosis, disability manifested before the age of 22; behavioral problems; health care needs; adaptive behavior deficits). If additional information is needed to make a determination, updates to the physical/medical examination, social evaluation, and/or psychological evaluation should be requested and reviewed. Updates may consist of notations and signatures on evaluations verifying that the status of the individual remains unchanged or may include newly

completed evaluations.

The LCED Form must be reviewed and approved (and signed and dated) by: a QIDP (as defined in federal regulation 42 CFR 483.430(a)) who is familiar with the participant's functional level; a physician; a physician's assistant (if so authorized by a physician); or a nurse practitioner.

Notes: A physician, physician's assistant or a nurse practitioner must review/sign the LCED annually for all residents of community residences subject to 14 NYCRR (see section 671.4(b)(1)(ii)).

The LCED redetermination must be completed and signed annually, not to exceed one year (i.e., 365 days) from the effective date of the initial LCED determination or from the signature date of the previous year's redetermination review date.

The LCED form includes a section titled "Annual ICF/IID Level of Care Eligibility Redetermination", in which the qualified person (i.e., a QIDP) completes the review as outlined in these instructions and, if there are no changes that impact ICF/IID level of care, signs and dates the redetermination section of the form. This date becomes the effective date of the redetermination. As long as there are no changes that impact the individual's eligibility for ICF/IID level of care, the same form can be used to certify the yearly LCED until the qualified reviewer chooses to complete a new form for the redetermination. If a new form is completed for redetermination, the reviewer is required to complete numbers 1-5 (Eligibility Determination Criteria) on the first page, fill out the identifying information on the second page, and sign and date on the first line under "Annual ICF/IID Level of Care Eligibility Redeterminations on the second page. This date would be the effective date of the LCED redetermination. Upon review and approval, the annual LCED redetermination must be uploaded into CHOICES.

If the annual LCED redetermination indicates that the individual may no longer meet the ICF/IID level of care criteria, the reviewer must refer the individual to the DDRO for further review and action which may include a Second Step Review or a Notice of Determination (NOD) notifying the individual that he/she is no longer eligible for HCBS Waiver, Comprehensive Care Coordination and/or other State Plan Services that require an ICF/IID LCED because he/she no longer meets the ICF/IID level of care eligibility criteria required for continued participation in these services and programs.

Determination of Eligibility:

An individual is determined eligible for ICF/IID Level of Care if:

There is documentation of one or more of the diagnoses listed under Question 1 (i.e., intellectual disability, epilepsy, autism, neurological impairment, cerebral palsy, familial dysautonomia, Prader-Willi syndrome, and/or other qualifying diagnosis)

AND

Question 2 (i.e., the disability manifested prior to age 22) is selected "Yes"

AND

A "Yes" is selected in either:

Question 3 (select "Yes" if the individual's record indicates that he/she exhibits severe behavior problems which endanger himself/herself or others)

OR

Question 4 (select "Yes" if any of the listed conditions are evident from the individual's record or from observations of the individual; specifically: A) medical condition which requires daily individualized attention from health care staff; and/or B) Self-injurious behavior which necessitates monitoring and treatment; and/or C) deficits in self-care skills are evident from review of the individual's record or from observations of the individual)

OR

Question 5 ("Yes" is selected to indicate adaptive behavior deficits in any of the listed areas).

COMPLETING THE FORM FOR ICF/IID LEVEL OF CARE ELIGIBILITY DETERMINATION:

Form Fields	Instructions
Name of Individual	Insert individual's first and last name and middle initial.
Address	Insert the address where the individual will be residing while receiving services and programs that require and ICF/IID.
D.O.B. (Date of Birth)	Insert the individual's date of birth. Include the month, day, and year.
Status (620 or 621)	Select whether the individual is considered "620" or "621" eligible. An individual may have one or both statuses or neither. For both Chapter 620 and Chapter 621, *inpatient* is defined as residential services without leaving the facility/facilities for any period of 90 days or longer. For **Chapter 620** eligibility, an individual must have five years of continuous *inpatient* service provided by a State facility. This five-year period must begin on or after 01/01/69. During the period 01/01/69 through 12/31/73, Family Care constitutes *inpatient*, but not thereafter. During the same period, 01/01/69 through 12/31/73, time spent in a Private Certified School for the Mentally Retarded is considered time in a State facility, provided the individual was in a State facility on 01/01/69. This is not true for any later period. For **Chapter 621** eligibility, an individual must have five years of continuous *inpatient* service provided by a State Facility. This five-year period must begin on or after 06/29/69. For **Chapter 621** eligibility, time in Family Care while on legal status is considered *inpatient*. For **Chapter 621** eligibility, time spent in a Private Certified School for the Mentally Retarded does not count towards the five-year continuous *inpatient* service requirement. Additional information can be found in the Benefits Resource Guide found on the OPWDD Website at: https://opwdd.ny.gov/sites/default/files/documents/Benefit_Development_Resource_Guide_2016_11_03.pdf
Responsible Medicaid District	Insert the name of the Medicaid district in which the individual's Medicaid case is currently active. If this information is not known, contact staff at the local Revenue Support Field Office (RSFO) for assistance.
Medicaid Number	Insert the individual's Medicaid Identification Number (i.e., Client Identification Number (CIN)).
TABS ID	Insert the individual's TABS ID (i.e., OPWDD Tracking and Billing System Identification number).

Medical, psychological and social evaluations are necessary for determining an individual's eligibility. However, the reviewer should also examine other portions of the record containing information which would assist him/her in determining an individual's eligibility as well as information that would allow him/her to gain a composite picture of the individual. The Developmental Disability Profile 2 (DDP2)/Coordinated Assessment System (CAS) should be used as an additional resource and should be reviewed to see if it is consistent with other level of care information available to the reviewer.

Dates of Pre-enrollment (i.e., pre-admission) evaluations **Note:** The dates for pre-admission evaluations need only be included on the form for the **initial LCED determination**. However, all assessments should be reviewed prior to the annual redetermination.	
Physical	Insert the date of the current (completed within the last 365 days) physical exam completed by a physician, registered physician's assistant, or nurse practitioner.
Social	Insert the date of the current evaluation (i.e., assessment) or update completed by the Care Manager or social worker. Ensure the social evaluation is a reflection of the individual's current social functioning.
Psychological	Insert the date of the current psychological evaluation. An annually updated evaluation is not needed if there is sufficient information in the individual's record to complete the diagnosis and adaptive behavior deficit/learning portions of the LCED form. A current evaluation (full assessment or update) must be carried out by a qualified practitioner if the person completing and/or approving the LCED form finds that there is not sufficient psychological information to complete the form. An Early Intervention Multidisciplinary Core Evaluation may be acceptable provided it includes standardized test scores relevant to cognitive, language and communicative, adaptive, social, and motor functioning and includes the participation of a school psychologist or licensed psychologist.

Eligibility Information	
1. Diagnosis	Select all that apply. There must be documentation that a physician has made or approved each diagnosis. In the case of an individual who also has a mental health/psychiatric diagnosis, the individual's primary diagnosis (that which is dominant in terms of affecting their level of functioning) must include one or more of those diagnoses listed under A-E at the time of the LCED. *According to NYS Mental Hygiene Law section 1.03 (22), a "developmental disability" means a disability of a person which: (a)(1) is attributable to intellectual disability, cerebral palsy, epilepsy, neurological impairment, familial dysautonomia, Prader-Willi syndrome or autism; (2) is attributable to any other condition of a person found to be closely related to intellectual disability because such condition results in similar impairment of general intellectual functioning or adaptive behavior to that of intellectually disabled persons or requires treatment and services similar to those required for such person; OR (3) is attributable to dyslexia resulting from a disability described in 1 or 2 above; (b) originates before such person attains age 22; (c) has continued or can be expected to continue indefinitely; AND (d) constitutes a substantial handicap to such person's ability to function normally in society.*
2. Disability manifested prior to age 22	Select "Yes" or "No" in accordance with the following: Select "YES" if the individual's impairment has been documented as having occurred prior to age 22 (e.g., through medical records showing a diagnosis of DD, within a school record, within the social history indicating significant delays in achieving developmental milestones, or through records documenting admission prior to age 22 to any program certified or operated by OPWDD). Select "NO" if there is no documentation indicating that the impairment originated prior to the individual reaching age 22. OR There is documentation that the impairment originated *after* the individual reached age 22.

3. Severe Behavior Problem	Select “Yes” or “No” in accordance with the following: Select "YES" if the individual's record indicates that he/she exhibits severe behavior problems which make the individual a danger to himself/herself or others. If "YES" is indicated, complete the frequency indicator. Examples include but are not limited to: A. Self-destructive behavior (e.g., attempted suicide) or other behaviors which actively threaten the life or safety of the individual. B. Aggressive or assaultive behaviors that threaten the safety of other individuals and which could potentially result in criminal prosecution. C. Severe property damage which could potentially result in criminal prosecution. NOTE: Before selecting “yes,” incidents which occurred more than one (1) year ago should be evaluated for severity, likelihood of reoccurrence and the individual's overall functioning level. Select "NO" if the above does not apply.
4. Health Care Need	Select "YES" if any of the conditions listed below (A, B, or C) are evident from the individual's record or from observation of the individual. A. Medical Condition The individual requires daily individualized care by health care staff (staff trained in observing and monitoring health care needs) to address a medical condition. B. Self-Injurious Behavior The individual demonstrates self-injurious behavior(s) which results in or could result in a condition that requires attention by health care staff. C. Health Related Skill Deficit The individual demonstrates a deficit in health care skills which are identified in a clinical evaluation. The results of the evaluation should indicate that the individual has deficits as described below:

	1. The individual has no self-care skills (staff must provide total care in performing self-care tasks); OR 2. The individual has some self-care skills but needs assistance and/or training in carrying out self-care skills. Select "NO" if there is no evidence of a health care need.
5. Adaptive Behavior Deficit	Select "Yes" if any adaptive behavior deficits are indicated in areas A-E below. If A-E are all selected "No," select "No" for this question. A. <u>Communication</u> Select "YES" if (1) or (2) is "YES." 1. Select "YES" if the individual has extremely limited or no expressive or receptive communication skills. 2. Select "YES" if the individual has some expressive or receptive communication skills but requires assistance and/or training to communicate self-care needs. B. <u>Learning</u> Select "YES" for this deficit area if (1), (2), (3), (4) or (5) is checked "YES." 1. Select "YES" if I.Q. cannot be determined and there is a statement certifying that the individual is untestable from a qualified psychologist; OR 2. Select "YES" if the individual evidences an I.Q. of less than 50 on an individually administered standardized instrument assessing cognitive functioning which has been administered by a qualified practitioner and demonstrates no pre-academic skills, or if there is a statement certifying that the individual is untestable from a qualified psychologist; OR 3. Select "YES" if, for individuals over 21 years of age, their reading and computational skills are at the first-grade level or below as documented by a standardized instrument; OR

4. Select "YES" if the individual evidences an I.Q. of 50-69 on an individually administered standardized test of intellectual functioning which has been administered by a qualified practitioner;

OR

5. Select "YES" if, for individuals over 21 years of age, their reading and computational skills are at the third-grade level or below as documented by a standardized instrument.

C. Mobility

This refers to basic ambulation, with or without adaptive equipment. Select "YES" for this deficit area if (1) or (2) is "YES."

D. Capacity for Independent Living

Select "YES" for this deficit area if (1) or (2) is "YES"

1. Select "YES" if the individual is completely dependent on others for all household activities.

2. Select "YES" if the individual needs assistance and/or training to perform tasks that would enable him or her to be a participating member of a household (e.g., using the telephone, using cooking appliances and utensils, or using laundry equipment).

E. Self-Direction

Select "YES" for this deficit area if (1), (2), (3) or (4) is "YES."

1. Select "YES" if the individual demonstrates a lack of internal control and direction in his or her interpersonal or individual behavior as evidenced by weekly or more frequent exhibition of the following inappropriate or challenging behaviors requiring individualized programming:

a) Actively resists supervision
b) Temper tantrums
c) Verbally abusive to others
d) Wandering, roaming or running away
e) Inappropriately handles/plays with bodily wastes
f) Eats non-food substances
g) Ritualistic or perseverative behaviors which interfere with social relationships
h) Other behavior inappropriate to social situations

	2. Select "YES" if the individual is completely dependent on others for management of his or her personal affairs within the general community. 3. Select "YES" if the individual demonstrates a lack of internal control and direction in his or her interpersonal or individual behavior as evidenced by monthly or more frequent exhibition of any of the inappropriate or challenging behaviors requiring individualized programming (see a-h listed in question (1) of this section). 4. Select "YES" if the individual needs assistance or training for management of his or her personal affairs within the general community.

Authorizations and Signatures for Initial ICF/IID Level of Care (page 2 of LCED form)

Form Fields	Instructions
Signature of the Qualified Person Completing the Form And Review Date	The QIDP or other authorized person who completes the initial ICF/IID Level of Care Eligibility Determination Form signs the form. The review date is the date of the reviewer's signature. If the form is being completed for redetermination purposes, the qualified person must be: the QIDP; physician; a physician's assistant (if so authorized by a physician); or a nurse practitioner.
This section to be completed by the DDRO for initial LCED determinations only	
Signature of Reviewing Physician or nurse practitioner and Review Date	Review by a physician or nurse practitioner is required for initial Level of Care eligibility determinations. The physician or nurse practitioner who reviews selects whether the criteria for ICF/IID level of care has been met, signs and dates the form (i.e., review date). The initial LCED information that is reviewed by the physician or nurse practitioner must include the relevant pre-admission evaluations: physical (medical), social, and psychological.
Has the OPWDD process for DD Eligibility been completed by the DDRO?	This line is used for the initial LCED determination only. Select "YES" if there is evidence that the DDRO has determined DD eligibility in accordance with the OPWDD eligibility guidelines, and that the findings substantiate DD eligibility.

	If “NO” is selected, the LCED cannot be approved and waiver eligibility must be declined until appropriate documentation is available.
ICF/IID Level of Care Approved Effective (mm/dd/yy): _____	**For initial determinations**, the DDRO Director (or designee) should write the date of approval for ICF/IID Level of Care on this line. This form is effective for one year from the date on this line; redeterminations must be completed within 365 days from the approved effective date. Only the DDRO Director (or designee) should fill in this line. The effective date of the LCED can be as early as the same day the physician or nurse practitioner signs the form, however, the effective date cannot precede the review date by the physician or nurse practitioner. If the initial level of care indicates that the individual may not meet the ICF/IID level of care, the DDRO must refer the individual for a Second Step Review. A Notice of Determination (NOD) must be issued to individuals notifying them that he or she does not meet the ICF/IID level of care eligibility criteria required for participation in the HCBS Waiver, Comprehensive Care Coordination and other State Plan Services **For redetermination purposes**, if a new form is completed, a QIDP or other qualified reviewer completes numbers 1-5 on the first page (Eligibility Determination Criteria), completes identifying information on the top of the second page, and signs and dates on the first line under “Annual Level of Care Redetermination” on the second page. This date is the effective date of the LCED. For children with I/DD in Foster Care or an I/DD Medically Fragile child, a qualified person at the DDRO must complete the Annual Level of are Eligibility Redetermination.
ICF/IID Level of Care not recommended	Select if the individual does not meet the criteria for ICF/IID Level of Care.

Annual Level of Care Eligibility Redetermination (i.e., Re-evaluation):

The "Annual Level of Care Eligibility Redetermination" section of the form can be used instead of completing an entirely new "ICF/IID Level of Care Eligibility Determination Form" for individuals who have not experienced any changes to their abilities which would result in a change in the required level of care for their continued participation in the HCBS Waiver, Comprehensive Care Coordination and other State Plan Services.

After reviewing the information on the first page of the ICF/IID Level of Care Eligibility Determination Form, the "Annual Level of Care Eligibility Redetermination" section on page two (2) of the form should be signed and dated by a qualified person (i.e., a QIDP who is familiar with the person; a physician, or a physician's assistant (if so authorized by a physician); or a nurse practitioner) within 365 days of the previous LCED effective date (generally, that is the previous signature date). The person signing the form should also include his or her title, i.e. a I/DD HH Care Manager. For children with I/DD in Foster Care or an I/DD Medically Fragile child, a qualified person at the DDRO must complete the Annual Level of are Eligibility Redetermination.

As long as there are no changes that impact the individual's eligibility for ICF/IID level of care, the same LCED Form can be used every 365 days to complete the annual LCED redetermination until the qualified reviewer chooses to complete a new LCED Form for the Redetermination. The reviewer can also attach additional pages to the LCED when signature lines run out as long as the certification language is present.

If a new form is completed for redetermination, the reviewer is required to complete numbers 1-5 (Eligibility Determination Criteria) on the first page, fill out the identifying information on the second page, and sign and date on the first line under Annual Level of Care Eligibility Redeterminations on the second page. This date would be the effective date of the LCED redetermination. The new form must then be uploaded into CHOICES.

Additional signature lines are available if a provider prefers to have an optional review by another person, such as a supervisor, advocate, or a physician.
There should be no break in the history of the documentation of Level of Care Eligibility; the redetermination should be completed within 365 days of the previous determination as triggered by the date of signature of the qualified person completing/signing the LCED form for redetermination.

Document Retention:

The initial LCED and a copy of the pre-enrollment evaluations must be permanently retained by the DDRO where they can be retrieved in the event of an audit.

The annual LCED form must be retained in the individual's Care Management Record for a period of six (6) years from the date the care management service was delivered, or when the service was billed, whichever is later (there will generally be the six (6) most recent LCED forms in a person's record).

For additional questions regarding LCED Document Retention, contact the People First Waiver at peoplefirstwaiver@opwdd.ny.gov.