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5123:2-8-01 Developmental disabilities level of care.

(A) Purpose

This rule sets forth the criteria and process used to determine whether an individual has the level of care necessary to receive medicaid-funded services from an intermediate care facility or through enrollment in a home and community-based services waiver administered by the Ohio department of developmental disabilities.

(B) Definitions

- (1) "County board" means a county board of developmental disabilities.
- (2) "Current diagnoses" means a written determination by a qualified professional, whose scope of practice includes diagnosis, which lists the diagnosed conditions that currently impact the individual's health and functional abilities.
- (3) "Department" means the Ohio department of developmental disabilities.
- (4) "Developmental disabilities level of care" means the level of care required for admission to an intermediate care facility or enrollment in a home and community-based services waiver administered by the department.
- (5) "Developmental disabilities level of care assessment" means a standardized process approved by the Ohio department of medicaid for the purpose of determining an individual's functional capacity.
- (6) "Emergency admission" means admission to an intermediate care facility for an individual who is facing a situation that creates for the individual a risk of substantial self-harm or substantial harm to others if action is not taken within thirty days. Emergency admission may be necessitated by one or more of the following:
 - (a) Loss of present residence for any reason, including legal action;
 - (b) Loss of present caretaker for any reason, including serious illness of the caretaker, change in caretaker's status, or inability of the caretaker to perform effectively for the individual;
 - (c) Abuse, neglect, or exploitation of the individual;
 - (d) Health and safety conditions that pose a serious risk to the individual or others of immediate harm or death; or

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- (e) Change in emotional or physical condition of the individual that necessitates substantial accommodation that cannot be reasonably provided by the individual's existing caretaker.
- (7) "Evaluator" means a person who coordinates or performs the evaluations and assessments of an individual to make a recommendation to the department as to whether or not the individual meets the criteria for the developmental disabilities level of care.
 - (a) Each evaluator shall complete department-approved training prior to completing evaluations or assessments and recommending level of care.
 - (b) An evaluator shall be:
 - (i) A person employed by or under contract with a county board of developmental disabilities for the purpose of recommending level of care for home and community-based services waivers;
 - (ii) A person employed by an intermediate care facility in which an individual is seeking placement or currently resides; or
 - (iii) A person designated by the department.
- (8) "Home and community-based services" has the same meaning as in section 5123.01 of the Revised Code.
- (9) "Individual" means a person with a developmental disability or for the purposes of giving, refusing to give, or withdrawing consent for services, his or her guardian in accordance with section 5126.043 of the Revised Code or other person authorized to give consent.
- (10) "Intermediate care facility" means an intermediate care facility for individuals with intellectual disabilities as defined in rule 5123:2-7-01 of the Administrative Code.
- (11) "Level of care determination" means an assessment by the department of an individual's physical, mental, social, and emotional status using the processes described in this rule, to compare the criteria for all possible levels of care as described in rules 5160-3-06 to 5160-3-09 of the Administrative Code and make a decision about whether an individual meets the criteria for level of care. A level of care determination shall be valid for up to twelve months, unless the individual has experienced a significant change of condition.
- (12) "Physician" means a person licensed under Chapter 4731. of the Revised Code or licensed in another state as defined by applicable law, to practice medicine and surgery or osteopathic medicine and surgery.
- (13) "Psychiatrist" means a physician licensed under Chapter 4731. of the Revised Code or licensed in another state as defined by applicable law, to practice psychiatry.

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- (14) "Psychologist" means a person licensed under Chapter 3319. or Chapter 4732. of the Revised Code or licensed in another state as defined by applicable law, to practice psychology.
- (15) "Qualified intellectual disability professional" has the same meaning as in 42 C.F.R. 483.430 as in effect on the effective date of this rule.
- (16) "Significant change of condition" means that the individual has experienced a change in physical or mental condition or functional abilities which may result in a change in the individual's level of care.

(C) Criteria for developmental disabilities level of care

- (1) For individuals birth through age nine, the criteria for a developmental disabilities level of care is met when:
 - (a) The individual has a substantial developmental delay or specific congenital or acquired condition other than an impairment caused solely by mental illness; and
 - (b) In the absence of individually planned supports, the individual has a high probability of having substantial functional limitations in at least three areas of major life activities set forth in paragraphs (C)(2)(b)(i) to (C)(2)(b)(vii) of this rule later in life.
- (2) For individuals age ten and older, the criteria for a developmental disabilities level of care is met when:
 - (a) The individual has been diagnosed with a severe, chronic disability that:
 - (i) Is attributable to a mental or physical impairment or combination of mental and physical impairments, other than an impairment caused solely by mental illness;
 - (ii) Is manifested before the individual is age twenty-two; and
 - (iii) Is likely to continue indefinitely.
 - (b) The condition described in paragraph (C)(2)(a) of this rule results in substantial functional limitations in at least three of the following areas of major life activities, as determined through use of the developmental disabilities level of care assessment:
 - (i) Self-care;
 - (ii) Receptive and expressive communication;

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- (iii) Learning;
- (iv) Mobility;
- (v) Self-direction;
- (vi) Capacity for independent living; and
- (vii) Economic self-sufficiency.

(c) The condition described in paragraph (C)(2)(a) of this rule reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance of lifelong or extended duration that are individually planned and coordinated.

(D) Level of care determination process

(1) A level of care assessment shall include:

- (a) Current diagnoses, including an indication of whether the individual has been diagnosed with a severe, chronic disability as described in paragraph (C)(2)(a) of this rule.
- (b) Review of current functional capacity. This review shall be documented using the developmental disabilities level of care assessment.
- (c) The assessment documentation shall be maintained in the individual's record and made available for state and federal quality assurance and audit purposes.

(2) For an initial developmental disabilities level of care determination, evaluators shall submit a recommendation and supporting documentation to the department for review and approval or denial. Supporting documentation shall include:

- (a) A clinician's verification of the presence of a substantial developmental delay or congenital condition for individuals birth through age nine as described in paragraph (C)(1)(a) of this rule or the presence of a severe, chronic disability for individuals age ten and older as described in paragraph (C)(2)(a) of this rule. The verification shall be submitted in a format prescribed by the department and include:
 - (i) The results of a medical evaluation performed by a physician which includes etiology of the condition leading to a developmental disability, diagnoses, and dates of onset; or

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- (ii) For children birth through age five, the results of an evaluation performed by a qualified professional using appropriate diagnostic instruments and/or procedures; or
 - (iii) The results of a psychological evaluation completed by a psychologist or a psychiatric evaluation completed by a psychiatrist which includes the current diagnoses as specified in the "Diagnostic and Statistical Manual of Mental Disorders" (fifth edition), axes I, II, and III.
- (b) A completed developmental disabilities level of care assessment.
- (3) Initial level of care recommendations for individuals seeking enrollment in a medicaid home and community-based services waiver must be approved by the department prior to enrollment in the waiver. Level of care recommendations may be submitted to the department up to ninety days in advance of the proposed enrollment date.
- (4) Initial level of care recommendations for individuals seeking medicaid funding for placement in an intermediate care facility must be approved by the department prior to admission, unless the individual is determined to need emergency admission. Level of care recommendations for individuals seeking emergency placement must be submitted to the department for review no later than seven days after the date of admission.
- (5) The county board shall send notification to the department in a format prescribed by the department within three business days when an individual determined to have a developmental disabilities level of care transfers from a home and community-based services waiver to any of the following:
 - (a) An intermediate care facility;
 - (b) A hospital;
 - (c) A nursing facility;
 - (d) A jail or prison; or
 - (e) Another institutional setting.
- (6) An intermediate care facility shall send notification to the department in a format prescribed by the department within three business days when an individual determined to have a developmental disabilities level of care transfers from the intermediate care facility to any of the following:
 - (a) A hospital;
 - (b) A nursing facility;

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- (c) A jail or prison;
 - (d) Another institutional setting; or
 - (e) A home and community-based services waiver.
- (7) Subsequent to a transfer described in paragraph (D)(5) or (D)(6) of this rule, a review of the individual's level of care must be completed upon the individual's return to the prior home and community-based services waiver or intermediate care facility. Evidence of this review shall be submitted to the department in a format prescribed by the department within three business days of the individual's return in order for payment authorization to resume for the intermediate care facility or providers of home and community-based services.
- (8) The evaluator shall submit a developmental disabilities level of care redetermination to the department within twelve months of the previous level of care determination and whenever circumstances suggest the individual may have experienced a significant change of condition which will establish one of the following:
- (a) The individual has not experienced a significant change of condition since the previous developmental disabilities level of care determination. The evaluator shall submit to the department in a format prescribed by the department documentation verifying that the individual's condition has not changed significantly since the previous level of care determination and shall recommend continuation of the developmental disabilities level of care. All recommendations to continue the developmental disabilities level of care shall be submitted to the department at least fifteen days in advance of the redetermination due date and may be submitted up to ninety days in advance.
 - (b) The individual has experienced a significant change of condition since the previous developmental disabilities level of care determination. The evaluator shall submit a clinician's verification described in paragraph (D)(2)(a) of this rule and a developmental disabilities level of care assessment described in paragraph (D)(2)(b) of this rule to the department. This redetermination shall be completed immediately upon identification of a significant change of condition.
- (9) Following receipt by the department of the documentation specified in paragraph (D)(2) or (D)(8) of this rule, the department shall make a determination of whether the documentation is sufficiently complete to make a determination based upon the criteria set forth in paragraph (C) of this rule.
- (a) If the documentation is not complete, the department shall notify the individual and the evaluator regarding the need for additional documentation. This notice shall specify the additional documentation that is required and shall indicate that the individual, or someone on the individual's behalf, has fifteen days from the date the department mails the notice to submit additional documentation or the

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developmental disabilities level of care determination will be denied. In the event the individual, or someone on the individual's behalf, is not able to provide the necessary documentation in the time specified, the department shall, upon good cause, grant an extension when the individual, or someone on the individual's behalf, requests an extension.

- (b) Within thirty days of receipt of all required documentation, the department shall issue a level of care determination. A request for a developmental disabilities level of care shall not be denied by the department for the reason that the individual does not meet the criteria, as set forth in paragraph (C) of this rule, until a qualified intellectual disability professional conducts a face-to-face assessment of the individual and reviews medical records that accurately reflect the individual's condition.
- (10) Once a final level of care determination is made, the department shall notify the individual. The notice shall establish the individual's hearing rights, as set forth in rules 5101:6-2-02 to 5101:6-2-04 of the Administrative Code, and the time frames within which they must be exercised.
- (a) If the individual submits a hearing request within the time frame specified in rule 5101:6-4-01 of the Administrative Code that requires the continuation of benefits, authorization for payment shall be continued pending the issuance of a state hearing decision.
 - (b) If the individual does not submit a hearing request within the time frame specified in rule 5101:6-4-01 of the Administrative Code, vendor payment will automatically terminate on the date specified in the notice advising the recipient of the intent of the Ohio department of medicaid to terminate vendor payment.
- (11) Federal financial participation shall not be claimed for services rendered in an intermediate care facility or for home and community-based waiver services delivered prior to the developmental disabilities level of care effective date.

Replaces: 5123:2-7-06, 5160-3-07, 5160-3-15.3,
5160-3-15.5
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