**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Developmental disabilities “DD” level of care determination process**

(A) The purpose of this rule is to describe the level of care review and determination process for all individuals applying to or receiving services from intermediate care facilities or home and community based medicaid waivers administered by the Ohio department of developmental disabilities.

(B) Definitions

(1) “County board” means a county board of developmental disabilities

(2) “CDJFS” means a county department of job and family services.

(3) “Current diagnoses” means a written medical determination by the individuals attending physician, whose scope of practice includes diagnosis, listing those diagnosed conditions that currently impact the individual’s health and functional abilities.

(4) “Department” means the Ohio department of developmental disabilities. For the purpose of determining developmental disabilities level of care, the department is also the designee of the Ohio department of job and family services.

(5) “Evaluator” means person who coordinates or performs the evaluations and assessments of the 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.

1. Each evaluator shall complete department-approved training prior to making an initial level of care recommendation.
2. An evaluator may be
   1. 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;
   2. A person employed by an intermediate care facility in which a person is seeking placement or currently resides; or
   3. A person designated by the department.

(6) “Emergency admission” means admission to an intermediate care facility, as defined in section (B)(9) of this rule, 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

(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) “Home and community-based services” means any federally approved medicaid waiver service provided to an individual enrolled in a waiver as an alternative to institutional care under Section 1915(c) of the Social Security Act, 49 Stat. 620 (1935), 42 U.S.C.A. 1396n, as amended, under which federal reimbursement is provided for designated home and community-based services for eligible individuals.

(8) “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.

(9) “Intermediate care facility” means intermediate care facility for individuals with intellectual disabilities certified as in compliance with applicable standards for the medical assistance program by the director of health, in accordance with Title XIX of the Social Security Act.

(10) “Level of care determination” means an assessment by the Ohio department of job and family services or its designee of an individual’s physical, mental, social, and emotional status, using the processes described in rules \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of the Administrative Code, to compare the criteria for all possible levels of care as described in rules 5101: 3-3-06 through 5101:3-3-08 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 (12) months, unless the individual has experienced a significant change in condition as defined in section (B)(15) of this rule.

(11) “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.

(12) “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.

(13) “Psychologist” means a person licensed in Ohio as a psychologist or school psychologist, or licensed in another state as defined by applicable law.

(14) “Qualified Intellectual Disabilities Professional” has the same meaning as in 42 CFR §483.430(a), a person who:

(a) Has at least one year of experience working directly with persons with intellectual disability or other developmental disabilities; and

(b) Is one of the following:

(i) A doctor of medicine or osteopathy;

(ii) A registered nurse; or

(iii) An individual who holds at least a bachelor's degree in a human services field.

(15) "Significant change of condition" means that the individual has experienced a change in physical or mental condition or functional which may result in a change in the individual's level of care.

(C) A level of care assessment shall include:

(1) Current diagnoses, including an indication of whether the individual has been diagnosed with a severe, chronic disability as defined in 5101:3-3-07 (C)(1).

(2) Review of current functional capacity. This review shall be documented on a standardized functional assessment form that is approved by the Ohio department of job and family services.

(3) The assessment documentation shall be kept in the individual’s file and made available for state and federal quality assurance and audit purposes.

(D) For an initial developmental disabilities level of care determination, evaluators shall submit a recommendation and supporting documentation described in this section to the department for review and approval or denial of a developmental disabilities level of care determination as set forth in rule [5101:3-3-07](http://codes.ohio.gov/oac/5101%3A3-3-07) of the Administrative Code.

(1) A clinician’s verification of the presence of a substantial developmental delay or congenital condition for individuals ages birth through nine as defined in rule 5101: 3-3-07 (B) or the presence of a severe, chronic disability for individuals ages ten and above as defined in 5101:3-3-07 (C)(1). The verification shall be submitted in a format prescribed by the department and shall include:

(a) A medical evaluation performed by a physician as defined in section (B) ( ) of this rule which includes etiology of the condition leading to a developmental disability, diagnoses, and dates of onset; or

(b) A psychological evaluation completed by a psychologist as defined in section(B) ( ) of this rule or a psychiatric evaluation completed by a psychiatrist as defined in section (B)( ) of this rule which includes the most current diagnoses as specified in the most current diagnostic statistical manual of mental disorders, axes I, II and III.

(2)Developmental disabilities level of care determination form as approved by the Ohio department of job and family services.

(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 90 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, as defined in section (B)(9) of this rule, must be approved by the department prior to admission, unless the individual is determined to need emergency admission as defined in section (B)(6) of this rule. Level of care recommendations for individuals seeking emergency placement must be submitted to the department for review no later than thirty (30) days after the date of admission.

(E) Notification must be sent to the department in a format prescribed by the department within three (3) business days when an individual determined to have a developmental disabilities level of care:

(1) 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/prison; or

(e) other institutional setting

(2) Transfers from an intermediate care facility to any of the following:

(a) a hospital;

(b) a nursing facility;

(c) a jail/prison;

(d) other institutional setting; or

(e) a home and community-based services waiver.

(3) A review of the individual’s level of care must be completed upon return to the prior service setting. Evidence of this review shall be submitted to the department in a format prescribed by the department within three (3) business days of the individual’s return in order for payment authorization to resume for intermediate care facilities or home and community-based services providers.

(F) 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 upon a significant change of the individual’s condition, as defined in paragraph (B) ( 15 ) of this rule, which will establish one of the following:

(1) The individual has not had a significant change in condition. 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 (15) days in advance of the redetermination due date and may be submitted up to ninety (90) days in advance.

(2) The individual has experienced a significant change of condition from the time of the previous developmental disabilities level of care determination. The evaluator shall submit a clinician’s verification form described in paragraph (D)(1) of this rule and a developmental disabilities level of care form, as identified in section (D) (2) of this rule to the department. This redetermination should be completed immediately upon identification of a significant change.

(G) Following receipt by the department of the documentation specified in paragraph (D) (1)(c) of this rule, the department shall make a determination of whether the documentation is sufficiently complete for its personnel to make a determination based upon the criteria set forth in rule [5101:3-3-07](http://codes.ohio.gov/oac/5101%3A3-3-07) of the Administrative Code.

(1) 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 their behalf, has twenty days from the date the department mails the notice to submit additional documentation or the authorized form will be denied for being incomplete with no developmental disabilities level of care authorized. In the event an individual, or someone on their behalf, is not able to complete an authorized form in the time specified, the department shall, upon good cause, grant an extension when an extension is requested by the individual or someone on their behalf.

(2) Within thirty days of receipt of all required documentation, the department shall issue a level of care determination. A developmental disabilities level of care determination will be issued pursuant to the criteria as set forth in rule [5101:3-3-07](http://codes.ohio.gov/oac/5101%3A3-3-07) of the Administrative Code.

(3) A request for a developmental disabilities level of care will not be denied by the department for the reason that the individual does not meet the level of care criteria, as set forth in rule [5101:3-3-07](http://codes.ohio.gov/oac/5101%3A3-3-07) of the Administrative Code, until a qualified professional, whose qualifications include being ~~a registered nurse or~~ a qualified intellectual disabilities professional, as specified at 42 C.F.R 483.430, conducts a face-to-face assessment of the individual and reviews the medical records that accurately reflect the individual’s condition. Authorized personnel other than the person who conducted the face-to-face assessment will review the face-to-face assessment and make the final level of care determination.

(H) 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 rule [5101:6-2-02](http://codes.ohio.gov/oac/5101%3A6-2-02) to [5101:6-2-04](http://codes.ohio.gov/oac/5101%3A6-2-04) of the Administrative Code, and the time frames within which they must be exercised.

(1) If a hearing request is received in response to the notice specified in paragraph (F) of this rule and within the time frames specified in rule [5101:6-4-01](http://codes.ohio.gov/oac/5101%3A6-4-01) of the Administrative Code that require the continuation of benefits, authorization for payment will be continued pending the issuance of a state hearing decision.

(2) If the individual does not submit a hearing request within the time frame specified in paragraph (F) of this rule, vendor payment will automatically terminate on the date specified in the notice advising the recipient of ODJFS’ intent to terminate vendor payment.

(I) Individuals shall be notified of the option to receive services in a community-based setting, in lieu of an intermediate care facility, upon initial and each subsequent determination of their developmental disabilities level of care. Documentation that the individual has been informed of this option shall be maintained in the individual’s file and shall contain:

(1) Date of the notification;

(2) Name of the person informing the individual of the option to receive services in a community-based setting, in lieu of an intermediate care facility;

(3) The individual’s preferred setting option; and

(4) Steps taken to facilitate community-based service options for individuals who prefer to not receive services in an intermediate care facility.

This documentation shall be made available to the individual, the department, or the Ohio department of job and family services, upon request.

(J) Federal financial participation (FFP) shall not be claimed for services rendered in an intermediate care facility or home and community based waiver services delivered prior to the developmental disabilities level of care determination date. (vendor payment can be initiated to an ICF only when the individual is determined to have a dd loc.)