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Putting People First

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ICF/MR- Level of Care Eligibility Determination (LCED) Form
Effective 4/29/2011
Questions and Answers
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Purpose:

The ICF/MR level of care eligibility determination (LCED) and annual redetermination form is a Medicaid required form for HCBS Waiver services. On April 29, 2011, OPWDD issued a revised format for the LCED which incorporates the clarifications and streamlining associated with Administrative Memorandum # 2009-05 "ICF/MR Level of Care Eligibility Determination Form (LCED) Qualified Mental Retardation Professional (QMRP) authorized to sign annual LCED forms" issued on December 14, 2009.

In the subsequent months, OPWDD received numerous questions regarding the new form. The attached document is a compilation of these questions with clarifying answers.

If there are any additional questions regarding the service or this document, agencies can contact OPWDD at the following numbers:

- For programmatic questions, call the Waiver Unit at 518-474-5647
- For evaluation requirement questions, call Behavioral and Clinical Solutions at 518-474-3558

LCED Questions and Answers

#	Topic	Question	Answer
1.	Redeterminations	When using the new form, what needs to be completed to make the form valid?	The first time the new form is used for a redetermination, the MSC agency should complete the first page (it is not necessary to include the date of the pre-evaluations, since this is a redetermination), complete the person's name and CIN at the top of the second page, and then have the QMRP (or physician if the person resides in a CR) sign the first line of the multi-line box at the bottom of the second page.
2.	Redeterminations	For a redetermination, can an agency sign the back of the new form and attach the signature page to an old LCED evaluation?	No, the front and back of a new form must be completed. As per page 12 of the LCED instructions, the front of the form should be completed (pre-enrollment dates are not required), the individual's identifying information should be entered on the top of the second page, and the QMRP should sign in the box under "Annual ICF/MR Level of Care Eligibility (LCED) Redetermination".
3.	Signatures	For an initial LCED, what signatures are required?	For an initial LCED, signatures are required by the person completing the form (generally the MSC), the physician reviewing the evaluations, and the DDSO Director/designee. Note, the signature requirement is different for the initial LCED than for the redetermination. See additional information below.
4.	Signatures	For a redetermination, who needs to sign the form, and where do they sign?	OPWDD issued an ADM in December, 2009, which allowed a QMRP who is familiar with the person's functional level to sign the LCED in place of the physician/physician's assistant/nurse practitioner on the LCED for annual re-determinations for all individuals enrolled in the HCBS waiver except residents of community residences. Community residences are subject to section 671.4 which requires in regulation the signature of a physician or physician's assistant/nurse practitioner. The new form is designed to more readily accommodate this option. See question #2 above for signature locations.
5.	Signatures	Which signature on the LCED do we go by when determining the renewal date?	For the initial determination, the DDSO Director/designee writes in the effective date of the Waiver Enrollment (i.e. eligibility date) which cannot be before the physician's review date. Moving forward, the redetermination date will either be the effective date of the Waiver Enrollment, or the DDSO Director's signature date, whichever is earlier. For redeterminations, the QMRP or review physician's signature must be within 365 days of the effective date – the effective date will be either the date of waiver enrollment, or the last review date (e.g., the QMRP's signature date).

LCED Questions and Answers

6.	Signatures	For redeterminations where does the QMRP sign?	Once the front of the form is completed, the person's identifying information is completed on the second page, and the QMRP signs the document in the box labeled "Signature and Title of Qualified Person Completing the Form" and dates the signature. This date becomes the effective date of the LCED. Subsequent annual reviews can be signed below this signature.
7.	Signatures	Is a physician's signature (or PA or NP) required for individuals residing in IRAs or Family Care settings?	For redeterminations the QMRP may sign for people living in IRAs, Family Care, or non-certified settings. The 633 regulations require that an individual residing in a certified setting (which includes CRs, IRAs, and Family Care homes) be evaluated annually *by the habilitation provider* to determine if medical services are needed. The MSC should be in contact with the habilitation provider to determine whether this evaluation has taken place, since the MSC will be integral in coordinating services for the individual. Also, this information should be considered when reviewing the information on the LCED to attest that the person's Level of Care has not changed.
8.	Signatures	If the QMRP is allowed to sign the LCED for an individual who resides in an IRA, why do the instructions say that a physician (or PA or NP) must sign the LCED for an individual residing in a Community Residence (CR)?	The 671 regulations cover a class of residences specifically called Community Residences (CRs). This is a specific classification and does not include IRAs and Family Care. For those residing in residences that are classified as CRs, a physician's signature is still required on the redetermination – OPWDD is working on changing this regulation, but the change is not yet complete.
9.	Signatures	The QMRP is required to sign the redetermination form within 365 days of the previous form. Does that mean in the same month where the 365th day falls? For redeterminations, the old form has an effective period – can we use the starting date of the effective period?	The LCED is a federally required document for Medicaid services which must be signed annually. Consequently, the redetermination must be signed within 365 days of the previous review date. For the redetermination changing over to the new form, the previous signature date of the QMRP or physician should be used to determine when the new form must be completed, not the effective period dates.
10.	Signatures	Does the MSC Need to sign the form?	No, an MSC's signature is not required by OPWDD on the redetermination. However, some agencies have the MSC complete the form before a QMRP signs the form. In that instance, the MSC can sign the box near the top of the second page (Signature of Qualified Person Completing the Form), or for future redetermination, the MSC can sign in the box under the "Annual ICF/MR Level of Care Eligibility (LCED) Redetermination" section at the bottom of the second page. Additional agency staff can also sign in this box if required by the agency.

11.	Billing Documentation	How should the billing checklist be completed if the QMRP's is the only required signature on the LCED?	If an MSC is completing the form, the LCED box should be checked, signed, and dated by the MSC on the MSC Service Note. In the Monthly Summary section of the note, the MSC should document any activities which support the findings that the LCED is still appropriate (e.g. called IRA staff to confirm that health evaluation was made and the person's health is consistent).
12.	Change of Vendor	In the event of a vendor change, does the new agency need to complete a new LCED immediately, or is the LCED currently in place acceptable for the life of the "effective dates" indicated? If the agency needs a new one "immediately" – what is that time frame?	When a person switches agencies, there is no need for the new agency to complete a new LCED redetermination. An annual LCED redetermination is required for HCBS waiver participants and in OPWDD's system, this documentation is maintained in the Service Coordination record. Going forward, agencies will have copies of LCEDs when they receive updated Service Plans. Eventually, as part of the CHOICES project, ISPs and LCEDs will be available electronically through the web-based system. If a person switches MSC vendors, the prior MSC vendor must continue to provide the LCED forms upon request if habilitation providers are audited. The new LCED must be completed within 365 days of the signature date of the previous LCED (see #8 above for additional clarification).
13.	Change of Vendor	Also in the event of a vendor change, does the agency need 6 years worth of LCEDs? I don't think any agency can be required to have ANY type of documentation for a period for which they didn't bill.	It is OPWDD's understanding that the OMIG will be reviewing an individual's eligibility for receiving waiver services that were billed by that particular provider and that the ICF/MR LCED is not the only acceptable documentation of a person's eligibility for waiver services. As a reminder, vendors providing Medicaid services can be audited by a number of oversight agencies, including the OMIG. They may not accept additional documentation to verify eligibility of an individual. Therefore, each MSC agency should make every effort to ensure that the documentation for the period in which billing is submitted is complete.
14.	Eligibility and age	How long does provisional eligibility determination last, and at what age must a child have a diagnosis?	As can be found in the "OMRDD Advisory Guidelines and Memoranda (2001 and 2002)", a determination of "Provisionally Eligible" can extend through age 7 and ends when the child achieves the age of 8 years. By the age of 8, the child must meet the "regular" eligibility criteria which require a named condition, the likelihood of expected continuation of the DD condition and associated deficits, and substantial adaptive deficits as delineated in our eligibility policy, etc. Provisional eligibility is predicated on the likelihood of a developmental disability, but allows for those situations where a named condition has not yet been diagnosed but the clinical presentation and adaptive limitations are all indicative of a developmental disorder or condition. The threshold for demonstrating substantial adaptive

			deficits is also a bit different, in that we allow for one area of functional skills to be substantially impaired, or two or more areas to be mildly to moderately impaired, to meet the definition of "substantial handicap" for young children (consistent with the language for early intervention services).
15.	Evaluation Dates	What dates do we use for the pre-admissions or pre-enrollment dates on the LCED?	The dates for the pre-enrollment evaluations need only be indicated on the form for the initial determination. A person must have a current medical, social/developmental evaluation, and psychological evaluation for the initial Level of Care Eligibility Determination (LCED) as part of the HCBS Waiver application. A current medical evaluation or social/developmental evaluation is an evaluation that has been completed within twelve months prior to the submission of the initial LCED to the DDSO. For psychological evaluations, an updated evaluation is not needed if there has not been a significant change in functioning, and if there is sufficient information in the individual's record to complete the diagnosis and adaptive behavior deficit/learning portions of the LCED form.
16.	Evaluation Dates	Should the most recent evaluation dates be included on the first page of the LCED for a redetermination?	Evaluation dates are only required for the initial determination. If an agency chooses to include the most recent evaluation dates, it is acceptable; however "pre-enrollment" should be crossed out with a single line and initialed with the date. The new evaluation dates should also be entered, initialed, and dated.
17.	Evaluation Dates	How frequently are evaluations needed once the initial LCED is completed?	Once the initial LCED has been completed and eligibility for the HCBS Waiver has been established, there is no ongoing schedule for subsequent evaluations. The need for new or updated evaluations depends on the needs and circumstances of the person, and is not based on a predetermined schedule. Providers should not interrupt services or require an update to an evaluation when there is no clinical indication that such an update is needed. The need for additional evaluations is determined on an individual basis. More frequent evaluations may be indicated if there is a significant change in any area of the person's functioning. For children who are provisionally eligible for HCBS Waiver, updated evaluations may be warranted based on clinical need. It is important to distinguish between assessments that are specifically required to assist in the determination of Level of Care from other reasons why additional evaluations and assessments may be necessary. For example, continued Medicaid and SSI eligibility may require updated evaluations on a more frequent basis than those required by OPWDD. There is nothing in OPWDD guidance prohibiting additional evaluations if

			they are required to maintain or recertify eligibility for other state or federal agency services, or if they are needed due to medical necessity. The 'qualified person' completing the annual LCED redetermination is expected to review the most recent evaluations when completing the redetermination, but there are no requirements as to how often these evaluations must be updated in order to maintain waiver eligibility and complete the annual level of care. If at any time it appears to the qualified person completing the annual LCED redetermination that the needs and circumstances of the person being reviewed have changed considerably, a referral for an updated evaluation(s) should be made.
18.	MSC Record	We have always kept the original and current LCED in the MSC record. Is it necessary to go back and put six years in the record, or can we begin keeping them from now on?	The Service Coordination record (or a similar accessible location) should contain the six prior years of LCED forms to help ensure the Service Coordinator has easy access at all times.
19.	MSC Record	Is the DDSO required to return the Initial LCED to the MSC Vendor along with the NOD?	Yes. The Initial LCED should be returned to the MSC Vendor (or sent to the chosen vendor if the family approached the DDSO directly for waiver eligibility) so that subsequent redeterminations can be completed on the same form.
20.	QMRP Quals	What is a QMRP?	Information regarding the qualifications for a QMRP can be found in the clarification memo to ADM#2009-05. These guidance documents can be found on the OPWDD website at: http://www.opwdd.ny.gov/wt/memoranda/index.jsp
21.	QMRP Quals	What about those MSC's who do not have the 4 year degree but were grandfathered in when CMCM went to MSC. DO they qualify as QMRP's?	An MSC Service Coordinator is not automatically qualified to be a QMRP. A person must have at least a 4 year degree in one of the listed areas to be a QMRP. Someone "grandfathered in" to MSC without a 4 year degree, despite the many years as a service coordinator, does not qualify as a QMRP.
22.	Renewal Dates	When is the annual renewal due?	The annual redetermination must be completed one year (i.e. 365 Days) from the anniversary date of the previous LCED. The anniversary date for the redetermination if there has been a previous redetermination is the signature date of the qualified person completing the LCED or for an initial determination, the signature date of the DDSO Director (or designee) or the waiver effective date (whichever is earlier).

LCED Questions and Answers

23.	Social Security #	Is it possible to only put the last 4 digits of the social security number on the LCEDs when distributing them as protection against identity fraud?	The social security number is no longer a required element in the form.
24.	Party Responsible For LCED completion	Must the LCED be completed by the MSC agency? Can a QMRP who is familiar with the person at the provider agency complete the LCED? What if the MSC fails to give the provider a redetermination, can the provider just go ahead and do it themselves?	The MSC is responsible for completing the LCED on an annual basis. However, there is nothing prohibiting a provider agency from completing the LCED so long as all qualifications are met. However, we do require the LCED to be retained in the service coordination file and the MSC is ultimately responsible for the timely completion of it.
25.	ICF	Are Day Hab providers required to have annual LCEDs on file for people residing in ICFs?	At this point in time, the OMIG has not released a day hab protocol. For ICF residents in a day service there would not be a paid claim for day service which could be part of a day hab audit. The ICF is responsible for the cost of day services for individuals residing in the ICF; in that instance, the day service is not billed as a Medicaid paid waiver the way it is for waiver-enrolled individuals.
26.	Distribution to DDSO	Should an MSC Vendor still send annual LCED redeterminations to the DDSO?	If the DDSO has historically required that the LCED redetermination be submitted to its office, continue submitting them. As CHOICES becomes available, this will no longer be required, as the DDSO will have the ability to access the LCED redetermination electronically.
27.	Distribution	Should an MSC agency continue to distribute the new LCED forms to hab providers?	The annual LCED redetermination must be included in the ISP package when it is distributed to the service providers.
28.	Distribution of past LCEDs	Are we required to accommodate requests for all LCEDs for all individuals served for the last six years, or will we be providing past LCEDs only what is requested in the event of an audit?	We are suggesting past LCEDs be provided only when requested in the event of an audit. However, if all the prior LCED forms are available within an easily accessible location with the MSC, a suggestion would be for the MSC to copy the six years of prior LCED's and attach to updated ISPs that are distributed to all of the ISP recipients. Then, gradually, all the service providers would have the past LCED documentation for all individuals served that covers the billing periods.

29.	OMIG Protocol	What if the LCED Form is Missing?	According to the OMIG, the level of care eligibility form will not be the single test for compliance with the requirement of the annual ICF/MR level of care determination necessary for the HCBS waiver services. However, if the hab provider has it or can get it from the MSC provider and have it available to show the OMIG auditors, it will be acceptable if it is properly completed, signed and dated. If the form is not available at all or is defective, the OMIG auditors will examine other documentation including MD's notes to make the determination. In other words it will make things much easier for the provider if they have the form but it is not an absolute must if there is adequate alternative documentation. In 2004, CMS responded to questions from the NYS AG asking whether the absence or omission of the LCED automatically triggers a disallowance for participation in the waiver. CMS responded as follows, "In the event of a missing LCED, CMS would review a participant's file including plans of care, budgets, prior LCEDs, HCBS waiver application to substantiate participation or continued participation in the waiver. "
30.	620/621 Eligibility	What is 620/621 Eligibility?	620/621 status refers to a person who had five or more years of continuous inpatient service in a state facility. 620 eligibility refers to individuals meeting this status beginning before 1/1/1969; 621 eligibility refers to individuals meeting this status from 1969 forward. Additional information can be found in the Benefits Resource Guide found on the OPWDD website at: http://www.opwdd.ny.gov/wt/publications/msc/images/wt_benefit_resourceguide.pdf If a person's 620/621 eligibility status is not known, "unknown" can be written in the corresponding box on the form.