



**STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF MENTAL RETARDATION SERVICES
ANDREW JACKSON BUILDING, 15TH FLOOR
500 DEADERICK STREET
NASHVILLE, TN 37243**

TITLE: Level of Care Reevaluations

POLICY #: P - 016

A. PURPOSE: This policy outlines the process for performing annual level of care reevaluations to ensure more consistent application of the Medicaid level of care criteria for continuation of services through a Home and Community-Based Services (HCBS) waiver.

B. APPLICABILITY: This policy applies to those individuals (i.e., Qualified Mental Retardation Professional, registered nurse, or physician) responsible for performing annual level of care reevaluations for continuation of services through an HCBS waiver.

C. DEFINITIONS

1. **"HCBS waiver"** or **"waiver"** means a Home and Community-Based Services waiver for persons with mental retardation that includes the following;
 - a. Home and Community-Based Services Waiver for the Mentally Retarded and Developmentally Disabled (#0128.90.R2A.02) and any amendments thereto;
 - b. Home and Community-Based Services Waiver for Persons with Mental Retardation (#0357.90.02) and any amendments thereto; and
 - c. Self-Determination Waiver Program (#0427.R01) and any amendments thereto.
2. **"Pre-Admission Evaluation"** or **"PAE"** means the Medicaid data collection form used to document that the service recipient meets the initial level of care criteria for reimbursement of services through an HCBS waiver, an ICF/MR, or a nursing facility.
3. **"Qualified Mental Retardation Professional"** means a Qualified Mental Retardation Professional as defined in 42 CFR 483.430.

D. DESCRIPTION OF POLICY

1. In order for a service recipient to continue to receive services through an HCBS waiver program, a reevaluation must be performed to ensure that the service recipient continues to need the level of care being provided.
 - a. The reevaluation shall be performed at a minimum every 12 months.
 - b. The reevaluation shall be performed by one of the following individuals:
 - (1) Qualified Mental Retardation Professional;

- (2) Registered nurse; or
- (3) Physician.

c. The reevaluation shall determine whether or not the service recipient continues to meet all of the four Medicaid level of care criteria:

- (1) The service recipient needs the level of care being provided and would, but for the provision of waiver services, otherwise be institutionalized in an ICF/MR; and
- (2) The service recipient requires services to enhance functional ability or to prevent or delay the deterioration or loss of functional ability; and
- (3) The service recipient has a significant deficit or impairment in adaptive functioning involving communication, comprehension, behavior or activities of daily living (i.e. toileting, bathing, eating, dressing/grooming, transfer or mobility); and
- (4) The service recipient requires a program of specialized supports and services provided under the supervision of a Qualified Mental Retardation Professional.

d. The annual level of care evaluation shall be performed in accordance with the guidelines listed in Appendix A (*Guidelines for Performing Level of Care Reevaluations*).

2. If the service recipient is determined not to meet one or more of the level of care criteria for continuation of services through an HCBS waiver, the person performing the reevaluation shall notify the DMRS Regional Director or designee promptly so that appropriate action can be taken.

E. ATTACHMENTS:

- 1. Appendix A: *Guidelines for Performing Level of Care Reevaluations*
- 2. Appendix B: *Annual Reevaluation of Level of Care Form*

F. PREVIOUS POLICY: Not applicable

G. DATE APPROVED BY TENNCARE: October 30, 2008

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H. POLICY APPROVAL

Joanna Demmons by W Moore
 Signature of Assistant Commissioner
 Office of Policy, Planning, and Consumer Services

12/3/2008
 Date

Stephen H. News
 Signature of Deputy Commissioner
 Division of Mental Retardation Services

12/5/2008
 Date

Appendix A

Guidelines for Performing Level of Care Reevaluations

	Level of Care Criterion	Guidelines for Review
1.	The service recipient needs the level of care being provided and would, but for the provision of waiver services, otherwise be institutionalized in an ICF/MR.	<p>Review the PAE and supporting documentation to verify the diagnosis of mental retardation and to determine if the deficits in adaptive functioning, which served as the basis for the approved PAE, still persist.</p> <p>(Note: If the PAE was approved by TennCare based on a deficit in comprehension and a diagnosis of mental retardation, the deficit in comprehension shall be considered to still persist.)</p> <p>If there is lack of documentation of both mental retardation and significant deficits in adaptive functioning, the service recipient may not meet this criterion.</p>
2.	The service recipient requires services to enhance functional ability or to prevent or delay the deterioration or loss of functional ability.	<p>Review the PAE, the ISP and amendments since the previous ISP, and current assessments to determine if the service recipient's current services are enhancing functional ability, maintaining the current level of functional ability, or delaying or preventing the deterioration or loss of functional ability.</p> <p>If there is lack of documentation to show that one of the above criteria has been met, the service recipient may not meet this criterion.</p>
3.	The service recipient has a significant deficit or impairment in adaptive functioning involving communication, comprehension, behavior or activities of daily living (i.e. toileting, bathing, eating, dressing/grooming, transfer or mobility)	<p>Review the PAE to determine the deficits in adaptive functioning that were listed on it.</p> <p>Review the ISP and amendments since the previous ISP for documentation that significant deficits in adaptive functioning still persist.</p> <p>If the service recipient does not continue to have significant deficits in adaptive functioning, the service recipient may not meet this criterion.</p>
4.	The service recipient requires a program of specialized supports and services provided under the supervision of a Qualified Mental Retardation Professional	<p>Determine if the service recipient is utilizing waiver services (excluding Support Coordination) and, if not, why waiver services are not being utilized.</p> <p>If the service recipient is persistently not utilizing waiver services (excluding Support Coordination), the service recipient may not meet this criterion.</p>

APPENDIX B

HOME AND COMMUNITY-BASED SERVICES WAIVER

ANNUAL REEVALUATION OF LEVEL OF CARE

Name of Service Recipient _____

Social Security Number _____ Date of Birth _____

By my signature I certify that the service recipient:

1. Needs the level of care being provided and would, but for the provision of waiver services, otherwise be institutionalized in an ICF/MR;
2. Requires services to enhance functional ability or to prevent or delay the deterioration or loss of functional ability;
3. Has a significant deficit or impairment in adaptive functioning involving communication, comprehension, behavior, or activities of daily living (i.e., toileting, bathing, eating, dressing/grooming, transfer, or mobility); and
4. Requires a program of specialized supports and services provided under the supervision of a Qualified Mental Retardation Professional.

Name

Agency

Signature

Date

Title: [] Qualified Mental Retardation Professional

[] Registered Nurse

[] Physician