



Determination of Intellectual Disability Best Practice Guidelines 2022

First Edition 2000

Revised 2016, 2018, 2022

This document is also available at:

<https://hhs.texas.gov/doing-business-hhs/provider-portals/long-term-care-providers/local-intellectual-developmental-disability-authority-lidda/did-best-practice-guidelines>



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Purpose and Scope

The purpose and scope of this document is to describe both guidelines and practice requirements, which will be clarified throughout the following sections. As provided in Title 26 of the Texas Administrative Code (TAC) Chapter 304, Subchapter D, §304.401(a)(1), Conducting a Determination of Intellectual Disability, an Authorized Provider (AP) employed by or contracted with a local intellectual and developmental disability authority (LIDDA) or a state supported living center (SSLC) must adhere to the *Determination of Intellectual Disability Best Practice Guidelines* (DID BPG) when conducting a DID assessment or endorsement and when writing a DID report.

The DID BPG was developed by the Texas Health and Human Services Commission (HHSC) with input from APs¹ around the state. The DID BPG is designed to provide effective procedures to APs associated with a LIDDA or SSLC when conducting a DID assessment or endorsement based on current best practices. The DID BPG provides guidance regarding Texas-specific eligibility criteria for intellectual and developmental disability (IDD) programs and services. The DID BPG is not intended to replace or supplant established clinical standards of practice. Adherence with the DID BPG will increase the quality and reliability of results in DID reports and endorsements.

The purpose of the DID process is to determine eligibility for IDD programs and services in the state of Texas. The DID assessment should always be approached as a clinical process to first determine whether the person has an intellectual disability (ID), autism spectrum disorder (ASD), or a qualifying related condition. To that end, the assessment must be driven by sound clinical practices for differential diagnosis and consideration of mitigating factors (e.g., mental health issues, situational factors) that can impact the person's cognitive and adaptive functioning. Once an accurate diagnosis is achieved, then service eligibility criteria can be applied, and eligibility can be determined along with recommendations.

DID assessments provide details regarding a person's strengths and their differences relative to developmental norms and social expectations, particularly regarding intellectual and adaptive skills. It is common for probate courts and family members to request DID assessments to assist in making determinations

¹ Associated with Tri-County Behavioral Healthcare, MHMR of Tarrant County, Central Counties Services, and the Harris Center for Mental Health and IDD.

about guardianship and decision-making. Criminal courts use DIDs for the purposes of decision-making and identifying appropriate services for individuals involved in the justice system. DIDs are also utilized by Texas Department of Family and Protective Services (DFPS) for cases of possible abuse, neglect, or exploitation of people with disabilities. HHSC supports LIDDAs that provide DID assessments to the courts and DFPS for these purposes.

HHSC has the authority to require a new DID assessment or endorsement to confirm eligibility for IDD services at its discretion.

Pathways to Eligibility

Diagnosis of Intellectual Disability

General Guidelines

The Texas Health and Safety Code (THSC) §591.003(7-a) statutory definition of intellectual disability* (ID) is “significantly subaverage general intellectual functioning that is concurrent with deficits in adaptive behavior and originates during the developmental period.”

THSC §591.003(20) defines “subaverage general intellectual functioning” as “measured intelligence on standardized psychometric instruments of two or more standard deviations below the age-group mean for the tests used.”

**Note:* While acknowledging that the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR) uses the term intellectual developmental disorder (IDD), this document is aligned with TAC and THSC thus using the term intellectual disability (ID).

An accurate diagnosis of ID requires clinical expertise and supportive evidence of the following fundamental criteria:

- deficits in intellectual functioning, defined as measured intelligence falling two or more standard deviations below the mean for an individual’s age group confirmed by both clinical assessment and individualized, standardized intelligence testing;
- deficits in adaptive functioning, defined as the degree to which a person displays deficiencies to meet the standards of personal independence and social responsibility expected of the person’s age and cultural group; and
- age of onset occurring during the developmental period. For the purposes of HHSC procedures, developmental period within the context of an ID diagnosis means before the 18th birthday, 26 TAC 304.102(7).

Clinical Diagnosis and Service Eligibility

The DSM-5-TR diagnosis of IDD (ID) is based upon comprehensive intellectual scores and adaptive behavior functioning. It requires the satisfaction of three

criteria: (A) deficits in intellectual functioning, (B) deficits in adaptive functioning, and (C) the onset of these deficits having occurred during childhood.

Texas HHSC IDD waiver and non-waiver service eligibility criteria require specific levels of intellectual and adaptive behavior functioning. This difference in clinical diagnosis, the THSC definition of ID, and service eligibility criteria may result in someone meeting clinical criteria for an ID diagnosis under the most current version of the DSM but not meeting service eligibility requirements. More information regarding eligibility requirements is found on page 60.

Diagnosis of Autism Spectrum Disorder

General Guidelines

Autism spectrum disorder (ASD) is a neurodevelopmental condition that is present in early childhood. 26 TAC §304.102(3) defines ASD as “a disorder characterized by persistent impairment in reciprocal social communication and social interaction and restricted, repetitive patterns of behavior, interests, or activities. These symptoms are present from early childhood and limit or impair everyday functioning.”

An accurate diagnosis of ASD requires clinical expertise and supportive evidence of the following fundamental criteria:

- persistent deficits in social communication and social interaction across multiple contexts;
- restricted, repetitive patterns of behaviors, interests, or activities; and
- age of onset occurring during the developmental period. For the purposes of HHSC procedures, developmental period within the context of an ASD diagnosis means symptoms must have manifested prior the person’s 22nd birthday, 26 TAC §304.102(22).

Manifestations of ASD will vary greatly depending on the severity of the traits themselves, the individual’s developmental level, and their chronological age. The stage at which impairment becomes obvious varies based on characteristics of the individual and the demands and expectations in their environment. Symptoms may impair daily functioning in social, academic, or occupational settings or other important areas. Families often report seeing signs of ASD in late infancy or the toddler years or report that the person developed typically for a couple of years and then lost speech and social reciprocity within a short period of time. However, there

is a subset of people with mild ASD whose symptoms may have been present since early childhood but may not have become fully manifest until social demands exceeded the person's limited capacities, or they may have been masked by learned strategies gained through interventions or supports. Individuals who have learned compensation strategies for social challenges may nevertheless experience anxiety in novel situations and suffer from the amount of effort needed to calculate what is intuitive for most people (e.g., when to join a conversation or what to say or not to say).

The person or family may report lifelong challenges with relationships, sensory idiosyncrasies, and understanding social rules. Families may report that the person struggled with an array of social challenges as a child (e.g., experienced bullying, had few or no friends). If the person progressed academically, school records are less likely to include a diagnosis of ASD. They may identify a Texas Education Agency (TEA) qualifying condition such as emotional disturbance (ED) or other health impairments (OHI) for academic purposes, or a diagnosis may not have been considered a condition warranting special education if the person progressed without supports. At times, a school may provide Section 504 accommodations but still not need to assess for or recognize a clinical diagnosis of ASD. This may result in a lack of previous testing or other forms of supporting documentation.

Due to the complexity of ASD, diagnosis should be based on multiple sources of information. A thoroughly documented history, clinical observations, caregiver reports, and, when possible, self-reports are indicated. Language abilities must be factored in as many individuals may include overly literal interpretations, poor receptive comprehension, stilted or echoed speech, or complete lack of speech which could be spoken or nonverbal. One-sided or non-reciprocal speech or use of labels and requests rather than commenting, sharing feelings, or back-and-forth conversation may be observed.



A thorough developmental and social history may assist in determining a diagnosis and establishing an age of onset when documentation is lacking for "high functioning" adults suspected of having ASD.

Another consideration is the changes made to the diagnostic criteria and specifiers with the publishing of DSM-5. For people with a well-established DSM-IV-TR diagnosis of Autistic Disorder, Asperger's Disorder, or Pervasive Developmental

Disorder Not Otherwise Specified (PDD-NOS), the DSM-5, and, subsequently, the DSM-5-TR, indicate that the person be given the diagnosis of ASD. For people who have marked deficits in social communication but whose symptoms do not otherwise meet ASD criteria, they should be evaluated for the diagnosis of Social (Pragmatic) Communication Disorder. Ultimately, the AP will need to contrast the most current DSM ASD criteria with reported information obtained through a careful developmental history that explores the person's early language and social development, direct observations, and interactions with the person before confirming an ASD diagnosis.

**Note: DSM-IV-TR code 299.8 subsumes Autistic Disorder, Asperger's Disorder, and PDD-NOS. The DSM-5/ICD-10 code F84.0 is assigned to autism spectrum disorder, which is to be used when entering diagnostic information on the ID/RC.*

Lastly, the severity specifiers on page 58 of the DSM-5-TR should be documented in the DID report. Recognizing this may fluctuate over time, the severity level may help inform the clinical decision-making process when establishing the individual's adaptive behavior level (ABL).

Training

Due to the complex nature of ASD, explicit on-going training in assessing ASD is strongly encouraged to stay up to date with field advancements. Additional training in differential diagnostic work—including the overlap and influences of other physical and mental health conditions, human development, ID, and speech and learning disorders—is necessary to ensure accuracy.

Test Selection

When evaluating for ASD, a multimodal and multisource assessment approach is necessary. Assessment batteries should include standardized measures of observation, performance, and informant and self-reports. Areas to assess should include cognition, executive functioning, social communication and responsiveness, expressive and receptive language, sensory functioning, and emotional and behavioral functioning. If possible, multiple observations of the individual in both the testing and natural environments are ideal.

Additionally, a validated ASD diagnostic assessment tool such as the most current version of the *Autism Diagnostic Observation Schedule (ADOS)*, *Autism Diagnostic Interview-Revised (ADI-R)*, *Childhood Autism Rating Scale (CARS)*, and *Gilliam*

Autism Rating Scale (GARS) are among those with proven utility in the differential diagnosis of ASD. Supplemental instruments such as the *Social Communication Questionnaire (SCQ)* or *Social Responsiveness Scale (SRS)* may also be employed at the clinical judgment of the AP. Screening tools such as the *Modified Checklist for Autism in Toddlers (MCHAT)* or *Screening Tool for Autism in Toddlers and Young Children (STAT)* may not replace the use of validated diagnostic assessment tools.

Academic achievement testing is not necessary for diagnosing ASD but can aid in identifying strengths and service planning. When assessing adults, personality and other psychological measures may be indicated to differentiate between ASD and personality disorders and other mental health conditions.

A note of caution is advised when assessing for ASD via audio-visual technology. Some ASD measures cannot be administered via telehealth (see the *Audio-Visual Assessment* subsection on pages 16-18). Physical interaction is not possible, limiting some aspects of testing that are necessary for an accurate diagnosis. The restricted frame of view limits the AP's ability to capture idiosyncratic movements and deficits in eye contact, joint attention, and aspects of speech and social interaction. When using telehealth, it is necessary to place greater emphasis on others' reports. Keep in mind, the appropriateness for assessing someone for ASD via telehealth is dependent upon the individual's unique presentation and circumstances.

Interpretation

Due to ASD's complexity, parsing out core symptoms from other conditions is important to ensure an accurate diagnosis is made, which ultimately influences the individual's treatment. APs are encouraged to rule out other conditions, evaluate for comorbid conditions, and search for underlying etiology (e.g., genetic syndromes, environmental opportunities). Differential diagnoses may include but are not limited to²:

- Attention-deficit hyperactivity disorder (ADHD)
- Anxiety disorders, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD)
- Avoidant-restrictive food intake disorder

² American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). <https://doi.org/10.1176/appi.books.9780890425596>

- Depressive disorders
- Developmental coordination disorder
- Fragile X syndrome
- Hearing impairment
- Intellectual disability
- Language disorders and social (pragmatic) communication disorder
- Learning disorders
- Reactive attachment disorder
- Rett syndrome
- Schizophrenia spectrum disorders
- Seizure disorders, epilepsy
- Selective mutism
- Sensory issues
- Stereotypic movement disorder

When making a differential diagnosis, age, developmental level, gender, trauma history, and environmental opportunities and expectations should also be considered.



Developing an assessment battery that includes a thorough developmental history, considers differential diagnoses, and is based on multiple sources of information are necessary for an accurate diagnosis when ASD is being considered.

Related Conditions

General Guidelines

If an individual is determined to be ineligible for IDD services as a person with ID or ASD, the AP should explore the possibility that the individual may be diagnosed with a related condition that may establish another path to eligibility.

The Code of Federal Regulations, Title 42, §435.1010 defines related conditions as a severe, chronic disability that meets all the following conditions:

- Is attributable to
 - ▶ Cerebral palsy or epilepsy; or
 - ▶ Any other condition, other than mental illness, found to be closely related to ID because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of people with ID, and requires treatment or services similar to those required for these people.
- It is manifested before the person reaches age 22.
- It is likely to continue indefinitely.
- It results in substantial functional limitations in three or more of the following areas of major life activity:
 - ▶ Self-care.
 - ▶ Understanding and use of language.
 - ▶ Learning.
 - ▶ Mobility.
 - ▶ Self-direction.
 - ▶ Capacity for independent living.

HHSC provides a list of Approved Diagnostic Codes for Persons with Related Conditions on the HHSC website, which spurs alternate means of eligibility for certain Medicaid programs. Consequently, the AP should *always* include questions about the person's health in childhood, adolescence, and early adulthood. Common medical conditions to explore include seizure disorders, various forms of traumatic brain injury, metabolic and chromosomal disorders, and other conditions that may have impacted early development. The AP should make careful notes of any diagnoses reported and compare them with the list of Approved Diagnostic Codes for Persons with Related Conditions.

Identifying Related Conditions

To identify a related condition, the AP should inquire about the individual's medical history. The AP may also review medical records provided by the individual or caregivers to identify potential qualifying diagnoses.

If eligibility for IDD services is based upon an individual having a related condition, the AP should ensure the following:

- the diagnosis appears on the HHSC Approved Diagnostic Codes for Persons with Related Conditions list, which is usually updated every October;
- the individual's record contains written documentation of a physician's diagnosis of the qualifying condition that manifested prior to the individual's 22nd birthday; and
- the individual's record contains a completed Form 8662, Related Condition Eligibility Screening Instrument (RCESI), that demonstrates substantial functional limitations in at least three areas of major life activity.

A signed attestation from a licensed medical physician is required to support the diagnosis of a related condition for the individual to meet eligibility for certain Medicaid programs. At times, an individual may present school records or family or caregiver reports of a qualifying related condition but does not have a physician's attestation of the condition. The AP should not confirm that the person is eligible for services but may explain in the DID report that eligibility is conditional upon a physician's confirmation of the qualifying diagnosis. The AP should indicate in the DID report that the person *may* be eligible for services if other eligibility criteria (i.e., IQ, ABL) are met.

An AP may assist in this process by providing the individual, family, and/or caregiver with the link³ to the HHSC Approved Diagnostic Codes for Persons with Related Conditions or with a hard copy of the document. The AP should refrain from suggesting diagnoses.



Always ask about the individual's medical history, going as far back as the prenatal period, if available. A number of health conditions can impact a person's development and may be on HHSC's Approved Related Conditions list.

³ HHSC Approved Diagnostic Codes for Persons with Related Conditions:
<https://www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/providers/health/icd10-codes.pdf>

General Assessment Guidelines

Clinical Judgment

The DID BPG is not intended to replace established clinical standards of practice nor is it meant to dictate every step in an AP's clinical decision-making. Rather, the DID BPG is a resource to be utilized by APs to increase the quality and reliability of the DID process so that the individuals who are truly eligible for IDD programs and services are appropriately identified and those who are not are referred to more appropriate services.

Test Selection

Selection of appropriate assessment tools requires an understanding of the person's specific circumstances. For this reason, any reference to a specific test throughout this document is to provide an illustrative example only and *should not be interpreted as an endorsement by HHSC for use in any specific situation*. Such a determination is best left to the AP who is familiar with the specific circumstances surrounding the person being evaluated and the measure under consideration. That said, use of certain assessment tools (e.g., abbreviated or brief measures) are limited to specific situations, which are addressed in upcoming sections of this document.

Deferring Assessment

Should situations such as active psychosis, crisis, or trauma render invalid and unreliable test results, the AP is encouraged to use their best clinical judgment to determine whether to defer the DID assessment to a time in which obtaining valid and reliable results is more likely. Should this be the case, the AP may:

- assist with obtaining continuity of care services through the LIDDA;
- help the individual access time-limited emergency services or respite care as described in 26 TAC §304.201;
- refer the individual to the local mental or behavioral health authority (LMHA or LBHA) to obtain behavioral health services; and/or
- refer the individual to other community-based services that may meet their immediate needs.

Deviating from Standardization

Standardization establishes uniform procedures for assessment administration and scoring so that any conclusions derived from the evaluation are as objective as possible as well as valid and reliable. Standard administration practices also satisfy widely accepted ethical standards and codes of conduct required of APs⁴.

Given the unique challenges that may be encountered in the assessment of intellectual and developmental disabilities, APs are reminded that standardized tests must be administered in a controlled setting. Should the AP observe any circumstances that deviate from a controlled setting (e.g., lack of privacy, telehealth administration, distractions), the AP must describe such variations in the DID report with an opinion on the effect that these variables may have had on the testing results.

Any test modifications, nontraditional approaches, or other forms of deviation from standardized administration procedures need to be clinically justified and explained in the DID report. A statement about its impact on the reliability and validity of the assessment results must be included as well. Some deviations from standardized administration procedures may include but are not limited to:

- administering a test over several days due to challenges with attention, behavior, or mental status;
- administering assessment tools via audio-visual technology;
- allowing the person to use alternative forms of communication (e.g., American Sign Language);
- using interpreters;
- altering administration to allow for the use of assistive technologies;
- administering only select subtests or an adaptive behavior measure to estimate cognitive functioning due to level of impairment(s); or
- providing positive reinforcement for staying on task.

It is important to not make assumptions about an individual's capabilities based on others' reports or initial impressions. The AP should be able to pivot efficiently mid-

⁴ Committee on Psychological Testing, Including Validity Testing, for Social Security Administration Disability Determinations; Board on the Health of Select Populations; Institute of Medicine (2015). *Psychological Testing in the Service of Disability Determination*, National Academics Press (US).
<https://www.ncbi.nlm.nih.gov/books/NBK305243/?report=reader>

assessment and alter testing plans based on the individual's abilities, needs, and performance. Also, while sampling the person's abilities beyond the limits of standardized practices can be helpful diagnostically, it can put tremendous stress on the individual, thus impacting their overall performance. This should be kept in mind when assessing an individual's current and potential functioning.



Any deviation from standardization, including audio-visual administration, must be explained in the DID report. Rationale and any possible impacts on test validity and reliability must be included in this explanation.

Considerations of Unique History

When evaluating for intellectual and developmental disabilities, the person's unique history and life circumstances should always be considered. A person's individual experiences impact their interaction with the AP and assessment tools as well as the AP's interpretation of the interview, observations, and test data. Elements the AP should consider include but are not limited to:

- cultural background;
- ethnic origin;
- primary language;
- environmental influences such as stressors or trauma;
- lack of opportunity; and
- mental health functioning.

How well rapport is established and maintained throughout the assessment is a critical element that must also be factored into the assessment process and conclusions generated from it.

Audio-Visual Assessment

Audio-visual technology may be used to conduct a DID as specified in the Diagnostic Assessment rule in 26 TAC §304.401(a)(2): *interview and observe the individual in-person or in real time using audio-visual technology*. Audio-visual technology provides flexibility that may be needed under some circumstances (e.g., insurmountable transportation barriers, participants who are geographically distant,

health issues that prevent in-person visits). Nevertheless, assessment via audio-visual technology may not always be appropriate as it may not present the most robust picture of the individual's functioning.⁵ In-person evaluation is the preferred assessment method. Also, some programs may require in-person assessment. Should APs use audio-visual technology, they must comply with federal and state laws and rules concerning use of audio-visual technology and with ethical and practice guidelines of their clinical license.

The AP should take into consideration the individual or family's preference for an audio-visual assessment. When audio-visual assessment is used in lieu of an in-person assessment, the AP should explain in the DID report the rationale for this chosen method. If an individual has previously been identified as having IDD using traditional methods and has been approved for services, any subsequent audio-visual assessment should *not* be used to disqualify the individual for services.

When using audio-visual methods, the AP should consider the following limitations that may impact the assessment^{6,7}:

- Audio-visual exchanges restrict the quality and extent of behavioral observations that inform the evaluation. The AP cannot interact directly with the individual (e.g., ask for objects, interact on a task), can only see what the camera captures, and may be observing behavior that is influenced by others out of the camera's view.
- When using audio-visual technology, it may also be difficult to identify cultural factors and other variables. The AP should be more attentive to such factors and be prepared to ask direct questions about variables that may otherwise be observable during in-person assessment.
- Audio-visual administration of standardized intelligence tests to individuals with IDD may be difficult or impossible. Individuals with IDD often lack the reading skills and focused attention necessary to complete online intelligence tests. Without a person trained in intelligence test administration being present with the individual to assist with instructions, manipulate the

⁵ Selick, A., Bobbette, N., Lunskey, Y., Hamdani, Y., Rayner, J., & Durbin, J. (2021). Virtual health care for adult patients with intellectual and developmental disabilities: A scoping review. *Disability and Health Journal*, 14(4), 1-10. <https://doi.org/10.1016/j.dhjo.2021.101132>

⁶ Wright, A.J., Mihura, J.L., Pade, H., & McCord, D.M. (2020). *Guidance on Psychological Tele-Assessment During the COVID-19 Crisis*. <https://www.apaservices.org/practice/reimbursement/health-codes/testing/tele-assessment-covid-19>

⁷ American Psychological Association. (2013). Guidelines for the practice of telepsychology. *American Psychologist*, 68(9), 791-800. <https://doi.org/10.1037/a0035001>

materials, and follow strict standardized procedures, test results can be questionable.

- The AP should *not* send test materials for unqualified examiners to assist in the evaluation. Test materials should *never* be out of the AP's control because test questions and supplies are not for public distribution. Ultimately, test security is the responsibility of the AP. Additionally, an untrained person is unlikely to maintain the rigor required to administer a test within the boundaries of standardization.
- If an AP determines that a test can be remotely administered for an individual, the AP must ensure that the individual's environment is free from distractions, including other people who could positively or negatively influence their test behavior.
- The security and privacy of information that the individual or caregiver provides could be limited by the presence of other people nearby (e.g., passersby at the caregiver's work setting). They may be less forthcoming about concerns if others are able to hear the conversation. This can deprive the AP of significant information about the individual.
- In practice, individuals will likely need to have family or other helpers facilitate the use of technology and sustain their attention. The AP should indicate in the DID report all parties present during the audio-visual assessment and their level and type of engagement with the administration process.
- Additionally, the AP must comply with all applicable requirements related to privacy and security of protected health information. As audio-visual technology continues to advance, APs are encouraged to seek information and education before using such technology for the purposes of DID testing.



While audio-visual technology may be used for some programs, in-person administration is the preferred method.

AP Experience and Training

Assessing young children and other IDD service populations requires experience and specialized training. APs must ensure they are competent to address the reason for referral and conduct the necessary assessments. If an AP does not have the necessary expertise and training, referral to an AP who is trained is recommended. If a referral to a more experienced provider is not possible, the AP should:

- consult with a colleague, professor, or other professional with relevant background and training in testing people in that specific service population (e.g., very young children, individuals with multiple impairments) to ensure that the individual's unique developmental issues are considered;
- reserve additional time for observation, gathering history, and reviewing reports of the individual's behaviors and performance in a variety of settings (e.g., community, home, and school) as much as is feasible;
- establish rapport and adjust the testing schedule to the individual's attention span and stamina as needed;
- recognize that a score based on a developmental assessment, abbreviated instrument, or subtests alone remains a partial assessment of cognitive ability that only approximates a composite intelligence quotient (IQ) score;
- interpret test results with caution when assessing young children, especially if the child is three years old or younger; and
- explain in the DID report any test modifications and how deviations from standardized administration procedures may impact the individual's performance and the validity and reliability of the scores obtained.

If a referral is made to an AP not affiliated with the LIDDA, the LIDDA is encouraged to work with this provider to obtain the best assessment possible that will meet the person's unique needs. The LIDDA is additionally encouraged to support their AP in obtaining additional training and assessment resources.

Explicit on-going training in ID and ASD assessments is strongly encouraged in order to keep pace with advancements in the field, including test development. The most up-to-date version of assessment tools must be used when conducting DID assessments.

Considerations Per Age Group

Early Childhood (0-5)

HHSC acknowledges the DSM-5-TR (page 46) recommendation of using a diagnosis of “Global Developmental Delay” (GDD) for children under the age of five years when the clinical severity level cannot be reliably assessed. Children to whom this diagnosis applies are those who are “...unable to undergo systematic assessments of intellectual functioning, including children who are too young to participate in standardized testing.” The DSM-5-TR specifies that this category requires reassessment after a period of time. Reevaluating one to two years after the assessment (or sooner if clinically warranted), depending upon the individual child’s development and exposure to intervention, may be prudent to further clarify the clinical picture.

Global Developmental Delay vs. Intellectual Disability

HHSC priority populations served by LIDDAs include children who are eligible for Early Childhood Intervention (ECI) services. Assignment of a diagnosis of ID for a child, especially a very young child, is often unreliable due to normal fluctuations in cognitive development, so the diagnosis of GDD is often appropriate. From a practical standpoint, the diagnosis of GDD presents a challenge for determining eligibility for HHSC services because GDD does not carry over for eligibility purposes after the child ages out of ECI.

When a child ages out of ECI services on their third birthday, the child is eligible to receive services funded by state general revenue *only* if the child meets criteria for one of the other priority populations as defined by 26 TAC §304.102(19) or an IDD waiver service *only* if the child meets service eligibility criteria as defined by 40 TAC §9.155 (HCS Program Services and CFC Services), §9.556 (TxHmL Program Services and CFC Services), §42.201 (DBMD and CFC Services), or §45.201 (CLASS and CFC Services). Should all other eligibility requirements be met, a formal diagnosis of ID at that time will ensure continuity of critical services; otherwise, service disruption will result until the diagnosis of ID is rendered.

Before the third birthday, children with disabilities are generally served in the ECI program. If the child’s parent or legally authorized representative (LAR) chooses to

seek additional services through an IDD waiver program, a DID must be conducted to demonstrate eligibility for some IDD waiver program services.

Diagnosing ID Before 5 Years of Age

Based upon clinical judgment, an AP has the discretion to render a diagnosis of ID rather than GDD for children under the age of five years. This applies if a current measure of intellectual functioning falls more than two standard deviations below the mean with commensurate adaptive functioning for the child's age. Additionally, given consideration of pertinent background variables, an AP may conclude that current deficiencies are a result of a condition that has life-long implications. Some of the conditions and events strongly associated with a life-long pattern of subaverage intellectual functioning include but are not limited to⁸:

- genetic disorders (e.g., Down syndrome, Fragile X syndrome, Williams syndrome, Prader-Willi syndrome, Angelman syndrome);
- prenatal exposure to alcohol or illicit substances;
- physical illness experienced by the mother during pregnancy;
- lack of oxygen to the brain during labor or delivery;
- extremely premature delivery and/or low birth weight;
- childhood illness (e.g., meningitis) and other types of infections;
- onset of seizure activity at or shortly following delivery;
- traumatic brain injury; or
- inexplicable regression of attained milestones during the first 18 months of life.

While parents may be reluctant for their child to be diagnosed with ID, if a young child has experienced one of the events or conditions listed above and otherwise meets diagnostic criteria, an ID diagnosis, when appropriate, will ensure service continuity.

ID should not be diagnosed when the AP has reason to believe that the condition and significantly low cognitive functioning will not endure. The child's situational

⁸ See the HHSC Approved Diagnostic Codes for Persons with Related Conditions, which is updated annually, for additional considerations.

context, such as lack of opportunity, environmental disruption, illness, or exposure to trauma, should be considered before giving a diagnosis of ID in young children.

In addition to Criteria A regarding intellectual functioning, the DSM-5-TR Criteria B emphasizes the importance of adaptive behavior functioning when determining an ID diagnosis. This is of particular importance when assessing young children because IQ scores are known to fluctuate. A robust adaptive behavior measure that assesses expressive and receptive language, fine and gross motor skills, social participation, and daily living skills is critical for this population.



Depending on medical history and situational context, a diagnosis of ID instead of GDD may be appropriate to ensure service continuity for children transitioning from ECI to an IDD program. When in doubt, consult with a colleague experienced with testing young children.

School-Age Children through Adolescence (6-17)

When a DID referral is made for a school-age child, it is typically not the first time the child has been evaluated by a professional. Children with disabilities are often provided services through ECI, Early Childhood Special Education (ECSE, formally known as Preschool Program for Children with Disabilities (PPCD)), and special education as well as by medical and other professionals. Access to their reports provides the AP the opportunity to review the child's early development. Response to interventions offers a view of the validity of previous conclusions and assumptions based on progress or the lack of it. This information can aid in establishing accurate diagnoses and eligibility as well as making recommendations and developing interventions.

For some children, however, symptoms may not be apparent until delays create a significant gap between functioning and developmental expectations. Impairments may be slower to surface and therefore noticed later by educators depending on the child's attributes (e.g., gender, personality). Social deficits may not be pronounced until the child reaches middle or high school. Life circumstances may also be influential. For these reasons, some children may not be referred for testing until they are further along in age.

Distinguishing ID Criteria: DSM, IDEA, and HHSC

Family reports regarding diagnoses and services, especially special education, can be useful, but the information may not be specific enough to reach a diagnosis such as ID. It is imperative that the AP be knowledgeable of other systems and their methods of classification.

For instance, special education assessments do not render diagnoses or fully depend on the DSM. Schools use Individuals with Disabilities Education Act (IDEA) criteria to determine eligibility for special education services. Intellectual Disability (ID) and Autism (AU) as special education categories are defined by similar but not identical criteria to the DSM diagnostic or HHSC eligibility criteria. Eligibility for special education services carries the additional specifier of “educational need.” A student may be clinically diagnosed as having ASD yet not be classified by the school as eligible for services based on ASD.

School psychologists and educational diagnosticians use different thresholds than APs who use HHSC criteria. School and other professionals may use Standard Error of Measurement (SEM) when drawing conclusions about intellectual scores. 26 TAC §304.102(25) does not allow APs to use SEM when determining eligibility for IDD services. For additional information about the SEM within the context of IDD program eligibility, see page 39.



A history of special education services does not automatically mean an individual is eligible for IDD programs and services. Schools have different eligibility criteria.

Influences on Functioning

APs also need to be mindful of other factors that can influence cognitive or adaptive functioning such as mental health status and quality of rapport. Differential diagnostic assessment may be necessary to rule in or out conditions such as depression, anxiety, or trauma. Another consideration is developmental stage (e.g., physical, personality, gender identity, social, etc.). All of these factors are important to consider when assessing this age group.

Adults (18-64)

IDD is usually identified during childhood or adolescence. However, it is not uncommon for DIDs to be requested for adults to determine eligibility for IDD services. Establishing eligibility for an adult involves testing for IQ and adaptive behavior level (ABL) scores as would be done for children and adolescents, but establishing age of onset can be particularly challenging. An AP must determine that ID was present before the person reached age 18 or an approved related condition manifested before the person reached age 22.

Establishing Age of Onset

The most common method for establishing age of onset for adults is to rely upon reports of previous assessments. Typically, APs request copies of school records with detailed listings of administered tests and test scores. However, most school districts dispose of these records a few years after students graduate. Records may no longer be available from the adult's previous schools. Furthermore, the person's family may not have maintained or may no longer be able to find records of special education services or assessments. Also, some people may not have attended traditional schooling (e.g., homeschool, outside of the United States) so alternative methods of collecting information may be needed to gather historical information. The AP may need to explore the person's educational history through careful interview and investigation.

Special Education Services

Participation in special education in itself does not establish that a person has ID or ASD, because students with ED, OHI, and several other TEA classifications that interfere with their learning are also enrolled in special education. Nevertheless, enrollment in special education establishes a starting point for the AP to ask more questions. With the person's written consent, the AP may interview family members, past teachers who remember the person, or other significant relatives or friends who are familiar with the person's earlier years.

The AP may inquire about an Individual Education Plan (IEP) or other aspects of their education such as:

- Curriculum and instruction – Did the person participate in typical high school classes such as algebra or in mostly functional skills classes such as daily living skills?

- Classroom – Did the person remain in the same classroom most of the day or attend school in a separate building with other students with special needs?
- Transportation – Did the person go to school in a smaller bus?
- Special services – Did the person receive physical, occupational, or speech therapy or behavioral services?
- Meetings – Did the person’s parents/guardians attend educational planning meetings to discuss progress and special services?

Answers to these questions by a knowledgeable informant may provide a picture of the person’s school experiences that support their education as a person with IDD.

Academic Sources

Although testing records may not be available, if the person attended high school in Texas, per 19 TAC §74.5, the state requires school districts to maintain a record of the classes as well as the type of classes taken (e.g., gifted, special education, etc.) and credit received during high school. This record is called the Academic Achievement Record (AAR). The AAR can be requested from the school district that the person attended. Although the AAR does not list the person’s qualifying special education category or diagnosis, it does designate if the person was enrolled in special education classes. By studying the AAR, an AP can identify if the person was participating in life skills classes, spent the full day in special education classes, and other details of the person’s student profile that could support enrollment in special education services as a person with IDD.

Another source that may be helpful is the Public Education Information Management System (PEIMS) Standard Reports made available by the TEA.

Family Interviews and Records

When school information is limited or unavailable, other sources of information may still provide a date of onset. Parents or caregivers who recall early developmental history or school experiences consistent with ID may be reliable historians. (The term “intellectual disability” is relatively recent, and families may not recognize it. The AP may need to use the outdated term “mental retardation” to ensure accurate communication.)

Information may be found in family records such as the person’s baby book, family journals or diaries, pediatric records, or even notations in a family Bible. These

older resources can be rich in details that were recorded at the time and give insight into the person's early development.

Life Experiences

Interviewing the person may yield pertinent information. The AP may be able to glean information from the person by exploring their life experiences. The information obtained may help to rule in or out IDD. For example, recollection of participation in the Special Olympics or other activities designed for individuals with developmental disabilities may provide insight into their developmental history.

Conversely, work history may indicate that the person held a job requiring high level skills that are inconsistent with the abilities of a person with ID (e.g., supervisor, accountant, attorney). In contrast, if the person only held part-time jobs, worked with the assistance of job coaches, or displayed an inability to secure and maintain employment independently, the possibility of ID may be supported. Open-ended questions allow for the person to expand on their life history. The AP should listen for details that may be consistent with, or may dispute, the presence of ID.



Thorough interviews from reliable historians may be sufficient for establishing an estimated age of onset.

Inability to Establish Age of Onset

There may be times when all sources of information, including data obtained from interviews, are insufficient to establish age of onset. Despite cognitive and adaptive behavior test results that may be within the ranges to suggest eligibility, without the corresponding age of onset, the person's eligibility cannot be confirmed. In that case, the DID report must reflect that the AP could not establish the age of onset during the developmental period. The AP may wish to indicate that should records establishing age of onset become available, the person's eligibility can be reconsidered.

If these records do become available and there is no indication that the person's level of functioning has changed since last evaluated, an additional assessment may not be needed so long as the assessment of record continues to meet clinical best

practice and 26 TAC §304.401. The DID report, then, must be amended to document this new information.

A signed attestation from a licensed medical physician is required to support the diagnosis of an approved related condition for the individual to meet eligibility for certain Medicaid programs.



A related condition must have manifested prior to the age of 22 years.

Older Adults (65+)

With improvements in medical science and community supports, people with ID and related conditions are living well into their older years. Also, older individuals are often seen when nursing homes refer people for assessments through the Preadmission Screening and Resident Review (PASRR) process.

Establishing Age of Onset

When an older adult requests services, a primary consideration is establishing the age of onset of the suspected condition, but age of onset may be particularly difficult to determine. Informants and records are often unavailable. Furthermore, older adults likely did not benefit from federally mandated special education since this legislation was not in effect prior to 1975. It is common to find that a person attended school for a few years but withdrew or attended school with a loosely defined modified program that does not resemble the special education structure with which the AP may be familiar.

The previously described process for establishing age of onset for adults becomes particularly important when an older adult is referred for a DID assessment. The AP may need to spend time exploring questions with a variety of relatives, caregivers, or significant parties in the person's background to obtain a full understanding of their condition and to target the likely timeframe of the disability's onset.

The AP should consider whether a diagnosis of ID that appears in a medical record for the first time in a person's older years may simply be how the person recently presented to a physician and not be indicative of their developmental history. For instance, should the individual experience a change in cognition as a result of

stroke or dementia and not due to a developmental disability, a decline in functioning may warrant a consultation with the person's current provider(s) or a referral to a specialist (e.g., neurologist). Again, focusing on the developmental period is important for this age group when determining eligibility.

An approach for making this differentiation is to compare the person's abilities years earlier to their current presentation. At times, this can be difficult if the person's caregivers only recently joined their lives (e.g., staff who are new to the person). It is often necessary to talk with relatives or significant others who have known the person for some time in order to have this retrospective comparison. Even so, retrospective analysis is difficult without a structured format. Measures to consider helping differentiate a lifelong disability from recent cognitive decline include the *National Task Group Early Detection and Screen for Dementia* or the *IQCODE-Short Form*.



When documentation is unavailable, interview relatives and significant others to better understand the person's history when trying to establish an age of onset.

Cognitive Testing Considerations

An AP may need to take into consideration specific aspects of aging when choosing an IQ test for an older adult. It is common for older adults to experience diminished visual or auditory abilities. Tests that rely on these modalities could disadvantage a person with reduced abilities. Additionally, the AP should obtain a detailed report of the person's medical history and current status to determine if there may have been recent health issues that could impact testing. Examples may include stroke, arthritis in the hands and fingers, and chronic pain that may make sitting uncomfortable. The AP may need to accommodate the person's needs by using different tests, taking frequent breaks, or conducting the assessment over more than one session.

It is important to understand the norms used in an IQ test to ensure the person's age group is part of the normative sample. Also, if there is a history of prior testing available, it may be beneficial to compare IQ scores with current functioning, particularly if a decline has been observed.

Adaptive Behavior Testing Considerations

When evaluating the adaptive behavior of an older adult, it is important to remember that onset of the impairment had to occur during the developmental period. Level of functioning during both the developmental period and current phase of life are important to capture, particularly if establishing eligibility for the first time. In older adults, these skills can change substantially from the person's previous abilities.

The AP should recognize it is common for informants to reflect on what the person could do in the past, which may inadvertently skew the assessment's outcome to a higher score. Recognizing this tendency may provide a greater understanding as to why a person may have difficulty accepting help in some areas where they may have once had greater independence. Obtaining additional reports from others who know the individual well, reviewing previous documents, conducting a functional performance assessment, or observing the person perform Basic or Instrumental Activities of Daily Living may assist in clarifying their current versus previous capabilities. APs should keep in mind that adaptive behavior measures should reflect the person's *current* skills and abilities.

Lastly, monitoring changes over time is an important consideration when developing recommendations and intervention plans. It may be beneficial for the AP to include examples of changes in the person's abilities in the DID report for this reason.

Diagnostic Overshadowing and Neurological Decline

A person's functional decline may be missed due to diagnostic overshadowing and attributed to other conditions associated with ID. It is important for an AP to differentiate if a person's abilities are typical of their developmental delay or if they became more pronounced over time, suggesting another type of neurological impairment. This information is important not only to inform the person's medical team but also to recommend services and supports within the IDD system that are appropriate for a person whose skills may be declining.

For instance, it is recognized that adults with Down syndrome are at a significantly higher risk of developing Alzheimer's disease as early as in their 40s. While not all individuals with Down syndrome experience this medical outcome, it is a condition

that APs should keep in mind when assessing an older adult with Down syndrome, especially if the caregiver reports they have observed behavioral or cognitive changes in the person.



Consider all possibilities when changes in cognition, mood, or behavior are observed.

Considerations for Motor & Sensory Impairments

General Considerations

Ensuring fairness in testing requires consideration of test accessibility, reliability, and validity, which, by definition, means recognizing the heterogeneity of the populations being served. Onset and degree of motor and sensory impairments, early access to language and intervention, use of assistive technology, and comorbid conditions must all be considered when preparing the test environment and planning modifications as well as during test selection, administration, and data interpretation.

Auditory and visual distractions should be kept to a minimum. Also, where the AP and interpreter, if used, are seated in relation to the individual and based on their roles should be carefully considered. There is not a single assessment approach that works for all individuals with motor or sensory impairments. Knowledge about and careful consideration of potential impacts on the person's development, as well as test performance, are therefore warranted.



Using referenced tests for each unique set of impairments is the preferred method. If not available, alternative methods may be used to ensure accessibility to services and supports.

Blindness and Other Visual Impairments

Before one can appropriately select a testing instrument, the AP needs to gather information about and implications of the visual condition. While reviewing records and collecting the person's medical and developmental histories, the AP is encouraged to ask if a Functional Vision Assessment or Learning Media Assessments have been completed and are available for review as these may offer insight into the person's learning abilities. Additional items to consider when interviewing the person or their LAR include:

- etiology;
- visual acuity;
- field restrictions;
- lighting needs;
- contrast sensitivity; and
- prognosis (e.g., stable vs deteriorating conditions).⁹

When selecting an appropriate testing instrument for an individual with blindness or other visual impairment, best practices indicate the use of a test normed for that population and on which the AP has been trained.

Haptics, or tactile-kinesthetic perception, is the sense of active touch and plays an important role in cognitive and perceptual development. It is also fundamental to individuals with visual impairment as it helps them gain knowledge about their external environment. Haptic assessment tools, therefore, are not reliant on vision and are performed using this modality. Example tests that use this modality and are standardized for individuals with blindness or other visual impairments are the haptic versions of the Wechsler intelligence scales, *Haptic Test Battery*, *3-D Haptic Matrix Test of Nonverbal Reasoning*, the *Tactile TONI*, and the *Tactile Wisconsin Card Sorting Test*.¹⁰

If an AP does not have expertise and training testing individuals with blindness or other visual impairments, referral to a professional who does have the expertise and training is strongly recommended.

If referral is not feasible, an AP may opt to administer select subtests (e.g., Wechsler Verbal Scales) from an array of instruments in combination with an adaptive behavior instrument. While these scores may be useful qualitatively when developing treatment or service plans, composite intelligence scores that are derived from visual-spatial and performance indices should not be considered valid for this population. Scaled scores may vary with visual acuity, particularly on timed tasks.

⁹ Pawletko, T., & Evans, C. (2021). Collaborative psychoeducational assessment of students with vision impairments. [Presentation]. 2021, May 10.

<https://nyc3.digitaloceanspaces.com/aph/app/uploads/2021/05/07155052/Collaborative-Assessment.pdf>

¹⁰ Mazella, A., Albaret, J.M., & Picard, D. (2014). Haptic tests for use with children and adults with visual impairments: A literature review. *Journal of Visual Impairment & Blindness*, 108(3), 227-237.

<https://doi.org/10.1177/0145482X1410800306>

Finally, although not recommended as the first choice for an initial evaluation because it is a screening instrument, the current version of the *Slosson Intelligence Test* contains materials and instructions with adaptations for use with people who have a visual impairment.

If the person's skills preclude the use of a verbal subtest and the above options are not available, an AP may use a rating scale (e.g., a developmental profile).

Physical, Mobility, or Motor Impairments

People with physical, mobility, or motor impairments may experience limitations in locomotion, manual dexterity, or coordination. They may experience stiffness, spasticity, tremors, restricted range of motion, muscle weakness or spasms, limited sensation, pain, or discomfort. If the severity of impairment is evident, the AP should ask about their use of assistive technologies and strategies that have proven helpful to mitigate these limitations and discomfort that may be experienced during test administration. Also, the AP may need to accommodate the person's needs by taking frequent breaks or conducting the assessment over more than one session.

Sometimes, the severity of impairment may not be as evident until after test administration begins. For instance, global intelligence measures have subtests that require the use of fine motor skills, and an individual with impairment of fine motor skills or hand-eye coordination may not be apparent until these tasks are attempted. The AP should be prepared to utilize alternate forms of assessment (e.g., verbal measures) in these instances.

Communication Impairments

When selecting assessment instruments to use with an individual who has a communication impairment, an AP should first carefully determine the individual's communication skills, hearing ability, and preferred style of communication. For example, an individual may not exhibit verbal language skills but may be able to point reliably, respond using a communication board, or gesture yes/no through head movements or eye gaze. Additionally, the AP should identify if the individual understands (receptive skills) but has difficulty producing (expressive skills) language.

If an individual is unable to provide an oral response to subtests but understands verbal direction, the performance or nonverbal sections of a comprehensive test of intelligence may provide a valid estimate of intellectual ability. In such cases, the

AP should consult the test manual to determine if using a portion of a test is endorsed by the test developer or if it contains specific recommendations regarding the use of the test with people suspected of ID or ASD. However, a test developed for individuals who are hearing impaired would be preferable, such as the *Leiter International Performance Scale*.

Deaf and Hard of Hearing

Members of the deaf and hard of hearing population may prefer a variety of communication methods. For example, they may prefer lip reading, using American Sign Language (ASL), English Sign Language (ESL), cued speech, or other methods. The AP should ask about their preferred communication method prior to initiating the evaluation. If their preferred language does not impact the administration of the assessment, test administration should be conducted in their preferred language. Consequently, the AP may need to arrange for an interpreter to be present. See page 38 for more guidance about using interpreters during evaluations.

For individuals who communicate primarily through sign language and whose tests are administered through an interpreter, even if verbal comprehension or reasoning items are appropriately translated, their results are likely not valid due to deviation from standardization. While the results may provide useful information in the context of developing treatment or service plans, verbal comprehension indices and composite IQ scores that are derived, in part, by such indices, should not be considered valid for most members of the deaf and hard of hearing community.¹¹

Using a norm referenced test for individuals with hearing impairment, such as the *Leiter International Performance Scale*, is the preferred testing method.

Alternatively, using other comprehensive nonverbal measures may be a clinically appropriate testing approach. Should these options not be readily available, an AP might choose to administer select subtests (e.g., *Wechsler Nonverbal Index*) from an array of assessment instruments in combination with an adaptive behavior instrument. The AP should keep in mind that even many nonverbal measures are often verbally mediated, thus requiring language-based reasoning strategies when

¹¹ Day, L.A., Adams Costa, E.B., & Engi Raiford, S. (2015). WISC-V technical report #2: Testing children who are deaf or hard of hearing. NCS Pearson, Inc. <https://www.pearsonassessments.com/content/dam/school/global/clinical/us/assets/wisc-v/wisc-v-technical-report-2.pdf>

comprehending test instructions. When selecting and interpreting assessment results, this is a confounding variable that must be considered.

If the individual's skills preclude the use of a performance-based scale, an AP may consider using a rating scale (e.g., a developmental profile).

Cognitive Assessment

Test Selection

The selection of the proper test to assess a person's abilities is an initial critical step in conducting a valid assessment. The most current versions of the *Standards for Educational and Psychological Testing* (American Psychological Association), the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association), *Diagnostic Manual – Intellectual Disability* (National Association for the Dually Diagnosed), and *Intellectual Disability: Definition, Classification and Systems of Supports* (American Association on Intellectual and Developmental Disabilities) should be used as references for practice. These references discuss the importance of selecting valid and reliable tests, use of clinical judgment, and addressing other critical considerations.

Valid and reliable standardized measures supported in the current literature for use with people with IDD are required. Also, an AP should be cognizant of specific test parameters. For instance, the AP will want to avoid using the same standardized cognitive assessment tool fewer than two years apart due to the increased risk of practice effect.

Use of Abbreviated and Brief Assessment Tools

Comprehensive standardized cognitive assessment tools are recommended when establishing initial eligibility for IDD programs and services. APs are discouraged from using abbreviated batteries (e.g., *Wechsler Abbreviated Scale of Intelligence*, *Stanford-Binet Abbreviated Battery*) and brief tests of intelligence (e.g., *Kaufman Brief Intelligence Test*, *Slosson Intelligence Test*) except in limited situations where an exception may be warranted. For example:

- the individual presents with a well-established and documented testing history based on comprehensive assessment tools; abbreviated and brief test results may be used if they are consistent with this testing history;
- the individual participated in multiple cognitive tests while in school that yielded consistent scores, yet a more current IQ score is required for program eligibility; or

- the individual does not have adequate attention and concentration to tolerate a more comprehensive measure, and their adaptive functioning and history are consistent with ID.

Situations in which using a brief or abbreviated assessment tool are not advisable include:

- the individual does not have a well-documented history of consistent test scores or has a history of testing with IQ scores that widely vary;
- when an abbreviated measure is uninterpretable due to a significant difference between subtests;
- when there has been a significant change in functioning (in either direction); or
- when the individual's IQ score on an abbreviated or brief measure is close to the eligibility criteria in either direction. For example, an individual's IQ score on an abbreviated measure yields a 71 but they must have an IQ score of 69 or below to establish or maintain eligibility.

If an AP uses a brief intelligence test or an abbreviated battery, the AP must explain the rationale for this choice and justify its use in the DID report.



If a person's testing history is inconsistent, subtests are significantly different, or the IQ score is within the SEM of the "cut-off" score, use of a comprehensive measure of intelligence is advisable.

Deviating from Standardization

In some situations, an individual's limitations may be so extensive that a full scale IQ score cannot be obtained from a standardized intelligence test. In these situations, an estimate of the individual's IQ score or IQ equivalent should be stated with clinical justification.

IQ Equivalent

If an individual's ability to comprehend oral instruction or visual demonstration is not adequate for a formal appraisal of general intellectual functioning, the use of

the Adaptive Behavior Composite provided by the most current version of the *Vineland Adaptive Behavior Scales* may serve as an estimate of the individual's intellectual functioning when accompanied by clinical justification explained in the DID report. However, not all measures of adaptive behavior (e.g., *ICAP*, *ABAS*, *Scales of Independent Behavior*) are appropriate for establishing an IQ score equivalent.

Age Equivalents

If an individual's intellectual functioning is severely or profoundly impaired, it may be necessary to use a developmental rating scale (e.g., *Developmental Profile*) in an effort to provide a profile of abilities. Even in cases in which age-appropriate norms are not available, the use of age equivalents may have merit in depicting an individual's range of competencies and deficiencies.

Age equivalents are norm-referenced scores, but they differ from standard scores and percentiles in that their purpose is not to indicate where the individual's raw score falls in relation to the distribution of scores for other individuals of the same age. Rather, age equivalents indicate the age range at which, on average, a person in the general population performs the same skills.

Age equivalents should be interpreted with caution to avoid suggesting that an individual "is like" someone at a younger chronological age and inadvertently promote situations in which adolescent or adult individuals are treated as if they were a child. Age equivalents should be explained in the context of specific skills rather than as a conclusion about general functioning.

Optional Use of Supplementary Tests

The use of supplementary tests creates a more detailed profile of an individual's unique set of relative strengths and weaknesses. When assessing individuals who have moderate or severe intellectual impairments, it can be advantageous to employ supplementary tests to assess related areas of functioning, such as:

- expressive language development (e.g., *Expressive One-Word Picture Vocabulary Test* or *Expressive Vocabulary Test*);
- receptive language development (e.g., *Receptive One-Word Picture Vocabulary Test* or *Peabody Picture Vocabulary Test*); or

- visual-motor integration (e.g., *Beery-Buktenica Developmental Test of Visual-Motor Integration* or *Bender Visual-Motor Gestalt Test*); or
- executive functioning (e.g., *Behavior Rating Inventory of Executive Function*).

The AP should also consider that while a person may be reported to be “nonverbal,” this may be true for oral expression but not written or gestural expression. In these situations, an AP should allow an individual the option to respond by using sign language, an electronic tablet, a communication board, or pen and paper.

While supplemental test results may not contribute to determining eligibility, they can provide valuable information for identifying age of onset and for developing recommendations that may inform subsequent treatment planning and service delivery decisions. Supplementary test information may be available through academic records as well. The AP may want to request reports from an individual’s school records to obtain a more complete picture of their skills and abilities.

Testing Individuals with Limited English Proficiency

When testing individuals with Limited English Proficiency (LEP), it is always preferable to test the individual using their primary language. This involves not only fluently speaking the language but also knowing the terminology to administer tests normed in their primary language.

While a number of tests have been developed in Spanish, there may not be tests available in other languages. In these situations, an interpreter may be used if allowed by the test developers. If an interpreter is not available or is not advised in the test manual, it may be justified to use the most current version of a nonverbal assessment instrument (e.g., *Wechsler Nonverbal Scale*, *Leiter International Performance Scale*, *Universal Nonverbal Intelligence Test*, or *Comprehensive Test of Nonverbal Intelligence*). The rationale for selecting a nonverbal measure should be explained in the DID report.

Other considerations should include:

- Identifying the individual’s preferred language, which may be different from the family’s primary language.

- The AP's competency to administer assessments in the individual's primary language.
- Using the clinical interview and feedback from the interpreter to gain a better understanding of the individual's comprehension of their reported preferred language. Talk with the interpreter after the session for feedback and impressions about the individual's communication skills, such as proficiency in vocabulary and grammar.
- Allowing the individual to move between languages if they feel more comfortable in one language for some items and another language for other items so that the results are truly indicative of their cognitive abilities. This modification should be noted in the DID report.

Considerations When Using an Interpreter

Best practice is to follow these guidelines for LEP as well as sign language interpretation. When using an interpreter:

- Use a professional interpreter who is a neutral party. Avoid using family members as culture, personal bias, or embarrassment may influence their translation.
- Talk with the interpreter before the assessment to establish expectations, boundaries, and rapport.
- The interpreter should translate as closely as possible to communicate the individual's response. This reveals not only content but also sophistication of the individual's communication skills. However, there may be idioms or other expressions that cannot be translated directly.
- The interpreter should not probe for more information or engage in additional conversation. The interpreter should only inquire in order to understand the individual. The individual's misunderstandings may also be informative about functioning and should be noted.
 - ▶ The AP should be prepared to interrupt the interpreter if it becomes an extended conversation or otherwise becomes apparent that deviation from test administration has occurred.
- Document in the DID report that the interpreter was present for the assessment. Also, document whether they participated in person, by phone, or by an audio-visual platform and describe their role during the assessment.

Interpretation

Diagnosing ID requires the use of a properly constructed and administered cognitive or intellectual measure. An AP must exercise sound clinical judgment to interpret the obtained scores in reference to the assessment instrument's strengths and limitations, age of norms used for validity, and other factors (e.g., practice effect, fatigue, difficulty sustaining focused attention, competing idiosyncratic thoughts).

Additionally, a full-scale IQ score is a composite of multiple subtests. If there is statistically significant variability in an individual's scores on particular subtests due to a known clinical condition (e.g., Traumatic Brain Injury), the full-scale IQ score may not be a valid summary measure of overall intellectual functioning. It is important that the AP describe relative cognitive strengths and limitations when interpreting these derived scores in order to provide an accurate depiction of functioning. This interpretation is useful for making recommendations and planning.

General Ability Index

The General Ability Index (GAI) is a composite IQ score provided by the Wechsler cognitive tests that describes an individual's general intellectual ability. It is less influenced by large variances in working memory and processing speed. The GAI can present a valid representation of composite intelligence in these circumstances. APs will need to refer to the Wechsler manuals for proper use.

Standard Error of Measurement

Another variable in the interpretation of test results is the Standard Error of Measurement (SEM). Developers of standardized tests provide information about the SEM to reflect the reliability (i.e., precision) of the scores derived from a test. The SEM is the variation around a "true score" (i.e., the score that would be obtained if the test had perfect reliability). Texas has established fixed IQ cut-off scores and other criteria to determine eligibility for IDD programs and services. SEM is *not allowed* to be used to determine eligibility per 26 TAC §304.102(25).

Adaptive Behavior Assessment

Test Selection

26 TAC §304.102(2) defines the term “adaptive behavior” as “the effectiveness with or degree to which an individual meets the standards of personal independence and social responsibility expected of the individual’s age and cultural group as assessed by a standardized measure.” The DSM-5-TR places greater emphasis on adaptive functioning compared to standardized IQ scores in the diagnosis of IDD (ID) by recognizing that adaptive functioning has greater practical significance because it is a better indicator of the individual’s ability to function in society.

Identification of ID requires the assessment of an individual’s adaptive behavior functioning. While there are many assessment tools available, the measure chosen should consider the individual’s unique abilities and situation. For instance, physical as opposed to cognitive limitations and contextual factors such as cultural norms, mental health status, and environment may constitute barriers to performing acquired skills.

Supplementary measures could also be employed to give the AP greater insight into the individual’s abilities, which may be particularly helpful when observations or informant reports yield discrepant results. A performance-based screener, verbal reasoning measure, comprehension measure, or observation of functional academic skills (e.g., counting money, reading an analog clock) may be used to help determine the ABL when test data is inconclusive. A multimethod approach will always yield the most robust information.

Whenever possible, including more than one informant can yield more in-depth information as well as validate self-reports. Consult the appropriate test manual when deciding the best informant(s). Consider how well the informant knows the individual, if they have directly observed them, and how long they have known them. Information reported should be based on current knowledge.

Interpretation

In accordance with 26 TAC §304.401 (Conducting a Determination of Intellectual Disability), an AP must assign an Adaptive Behavior Level (ABL) in the DID report. The AP uses a standardized measure in adaptive behavior to determine if an

individual has limitations and, based on their significance, assigns an ABL. Determining an ABL may require more than a single test, however.

The establishment of an ABL relies on sound clinical judgment. Test scores should be interpreted in relation to the individual's unique circumstances and factors previously mentioned that may influence opportunity to acquire and perform skills. A holistic view of the person's adaptive behavior is important. Multiple factors should be considered when establishing an ABL, such as the person's history, current results, other test results, ASD diagnostic severity level, rapport, and so forth. In some circumstances, performance in one area may carry more weight than the others (e.g., motor skills). When interpreting an adaptive behavior measure's results, it is also important to distinguish between deficits in performance versus deficits in developmentally acquired skills. For instance, an individual's mental health status may impact their performance of acquired skills, which is distinct from skills that they have not learned or need assistance with completing.



Interpret test scores within the context of the whole person when establishing an ABL.

Considerations for Performance Validity

Mental Health Conditions

The DID BPG does not formally require assessment of the individual's emotional status. Nevertheless, the *Validity* subsection on page 54 states that the DID report should describe a variety of conditions that could impact performance and results. These include emotional factors which can cause test results to be only situationally valid but not stable nor reliable. The AP should be aware and account for how an individual's mental health can negatively impact performance on intelligence tests as well as the execution of daily living skills. Some examples include:

- Depression can impede attention, concentration, motivation, and psychomotor performance.
- Anxiety can interfere with memory and attention and cause fatigue or other somatic complaints that can further hinder performance on tests.
- The presence of psychosis can interfere in a wide variety of ways, ranging from lack of responding to tangential or contaminated answers.

It is important to differentiate developmental disability behavioral characteristics from transient effects of mental health symptoms, medication side effects, substance use effects, and physical illness on presentation and test performance. Accounting for mental health conditions is also an important consideration when endorsing or validating previous test results for individuals who have a history that includes behavioral health issues.



A person's mental health functioning at the time of testing may negatively influence test performance, which should be factored into the AP's diagnostic conclusions.

Trauma History

Individuals who have experienced chronic early maltreatment and resulting complex trauma are at significant risk for a variety of behavioral, neuropsychological, cognitive, emotional, interpersonal, and psychobiological disorders. The physiological impact of traumatic experiences or prolonged exposure

to high-stress circumstances may manifest lower scores on verbal, perceptual, memory, and/or processing speed tasks. When reviewing cases of individuals with a history of trauma and particularly for those formally diagnosed with PTSD, it is important to consider the following to better understand the potential impact trauma may have on their test performance:

- the nature, severity, and chronicity of traumatic experiences;
- for DFPS referrals, the number of placements and the time between assessment and placement;
- if there is a consistent assessment history indicating significantly subaverage intellect with consistent academic scores or variability in testing scores over time;
- family history of developmental differences; and
- deficits in adaptive behavior due to cognitive impairments should be distinguished from behaviors associated with emotional disturbance.

Test results should be interpreted with caution as scores may underestimate the individual's true ability. Therefore, the DID assessment and report should account for the emotional status of the individual and its effects on their performance when drawing valid conclusions regarding eligibility. The appropriateness of not being able to make an eligibility determination based on the individual's current status and resulting scores should be considered. The AP must also decide whether testing should even be attempted in light of the individual's current emotional condition. Accounting for traumatic experiences and, consequentially, its impact on an individual's mental health, is also an important consideration when endorsing or validating previous test results. Refer to Section 9, *Trauma Informed Care in Assessment*, starting on page 46 for additional guidance.

Forensic Populations

APs working with forensic populations are encouraged to consider how the assessment process may be impacted by any emotional, behavioral, or psychiatric symptoms an individual is experiencing, make accommodations as possible, and consider such when interpreting and communicating the results of the assessment. APs should also acknowledge the possible impact of trauma in the areas listed in the previous section, *Trauma History*, on page 41.

In order to maximize the validity of assessment results, APs working with forensic populations should strive to conduct evaluations in settings that provide adequate comfort, safety, and privacy. If supervision of the individual is required, the AP should speak with the person supervising them before starting test administration to request that they not comment, assist with responses, or otherwise cause distractions that would interfere with testing.

APs working with forensic populations are encouraged to use all information available when making diagnostic decisions and recommendations. For example, the use of background information such as previous assessments, school records, and records of previous treatment as well as current observations by staff and other personnel familiar with the individual (e.g., probation and parole officers, counselors, corrections staff, resource officers for youth, etc.) are recommended in order to make an informed and unbiased decision. The AP should also review the criminal history for behavioral patterns that may indicate IDD and/or a mental health concern.

When conducting adaptive behavior assessments, the AP should ensure the informant is someone who is familiar with the individual's skills in their usual living environment. If the individual is not in the community and the only informants available are personnel who are not familiar with the individual's adaptive abilities within the community setting, the AP should interpret the results with caution and explain the limitations of the assessment in the report.

Secondary Gain

Secondary gain is defined as the advantage that occurs secondary to stated or real illness or condition. Types of secondary gain include using illness for personal advantage, exaggerating symptoms to appear more impaired than is true, consciously using symptoms for gain, and unconsciously presenting symptoms with no physiological basis.¹²

This situation may arise from court referrals where an ID diagnosis could result in an acquittal or dismissal of charges. It may also occur if the individual is seeking services and benefits obtainable only through a confirmed diagnosis.

¹² Bender, S.D., & Frederick, R. (2018). Chapter 3: Neuropsychological models of feigned cognitive deficits. In *Clinical Assessment of Malingering and Deception, Fourth Edition* (Eds. R. Rogers & S.D. Bender). The Guilford Press.

When interpreting evaluation data to determine eligibility, the AP should:

- determine consistency of current presentation with records and reports;
- inquire about the purpose of the referral to obtain a clearer picture of the motivation behind a diagnosis or seeking program services;
- look for inconsistencies in the current presentation (e.g., claiming visual impairment but drives without limitations or accommodations, ability to read anime novels but misses comparable verbal subtest items); and
- look for nonverbal communication between the accompanying person and the individual being evaluated in an attempt to influence the outcome.

If the AP doubts the outcome of a test(s), they may choose to administer additional measures to observe patterns of consistency, or inconsistency, across measures. If results remain questionable, a diagnosis may not be possible to confirm, and the DID report should reflect this inability.

Test Refusal or “Untestable”

Most individuals who present for an assessment participate willingly. However, at times, a person may refuse to cooperate with testing despite obtaining informed consent or appear unable to fully engage in the testing process.

Test Refusal

Sometimes, an individual may be unwilling to cooperate with testing or may begin the assessment and refuse to continue. If the individual is an adult and states that they do not want to be tested, and the AP cannot satisfactorily address their concerns and obtain consent to proceed, *the AP should discontinue the assessment*. The individual should be reassured that they can continue with the testing process in the future should they decide to do so.

At times, it may be necessary to conduct testing over two or more sessions to keep an individual engaged. The AP may also employ incentives, such as a token economy, frequent breaks, or other strategies to encourage cooperation with testing. These methods should be described in the DID report as they may deviate from standardized test administration. Additionally, they may provide insights that can inform future service planning.

When There is Not an Appropriate Test Available

Some individuals have a very limited ability to respond to test questions. The most basic test items may require reliable matching or pointing skills that the person may not yet have developed. If the individual is also nonverbal, standardized direct tests may be impossible to administer. In these cases, the person cannot complete a sufficient number of items to establish a basal level of correct responses that allow a valid score to be obtained. The individual's skills and abilities can still be assessed by using alternative methods.

The AP can use a measure of adaptive behavior that assesses the individual's abilities across domains (e.g., communication, socialization, daily living skills). Using the most current version of the *Vineland Adaptive Behavior Scales*, the Adaptive Behavior Composite score can be used as a substitute for an IQ score. The AP should examine differences across domains carefully to ensure that the overall score does not misrepresent domains of relative strengths and weaknesses. The DID report should describe the individual's skills in each domain and note significant differences in domain scores that could inform the individual's subsequent service plan by noting potential interests, preferences, needs, idiosyncrasies about communication, and so forth.

The AP may also use a test designed and normed for a younger population (e.g., *Battelle Developmental Inventory* or *Developmental Profile*). A test that is developed for younger children may allow an individual to demonstrate their skills and can yield an estimated age of cognitive functioning; however, the AP must exercise caution when interpreting results. The results are descriptive and not quantitative because there is not a normative sample against which the individual's performance can be compared. The use of a test that is not normed for the individual's population and a rationale for that choice should be explained in the DID report.

Trauma Informed Care in Assessment

The trauma-informed approach to care acknowledges how prevalent trauma is in the lives of the people who participate in DID assessments and the significance of its impact. While trauma-informed care crosses all aspects of the practice of psychology, this section is written with a focus specifically on assessment.

General Guidelines

A trauma-informed approach to assessment begins with the AP's own awareness of personal history and possible bias that may arise when interacting with the individual and other interviewees, when interpreting results (such as minimizing), and how findings might be expressed in the report.

The AP should build rapport in a manner that is sensitive to the individual's history. Interviewing, such as questions raised, should be done in a style that avoids retraumatizing the person. It is also prudent to form questions in a way that factors in current circumstances, such as who else is present in the room, as it might create embarrassment or inhibit responding. Adequate time should be allowed to conduct a thorough interview that includes events from early childhood through the present.

The person's responses should be interpreted within the context of historical life events and their effects upon present day functioning. The DID report should be written with similar considerations of the individual and who else might read the report.

Signs, Symptoms, and Diagnostic Overshadowing

In order to balance effective interviewing and motivating compliance with possible reluctance or distress, the AP needs to be knowledgeable of the signs and symptoms of trauma and the various ways they can manifest. This may depend upon the individual's developmental or chronological age at the time of the traumatic event(s) and their current age. For instance, intermittent eye contact, obsessive-compulsive behaviors, "meltdowns," and avoidance of or difficulties with close relationships may be characteristics of ASD but may also be manifestations of trauma.

Diagnostic overshadowing occurs when one attributes symptoms to a certain diagnosis, such as ID or ASD, without identifying other possible causes. A trauma-informed approach looks at all possible causes. Even the distress some people can experience during the assessment process itself is a consideration for interpreting results. The AP should always be aware that the individual's current state may make assessment far less than optimal at the time and perhaps even inappropriate.



Trauma may impact a person's ability to relate to others, regulate their emotions and behavior, and focus their attention. In young children, it may even manifest as perseveration and repetitive behaviors. It is therefore important to tease apart symptoms of trauma from ID and ASD.

Moving Forward or Delaying the Assessment

When trauma is identified as a current issue, the DID report should include recommendations with possible resources that may remediate the person's trauma. If behavioral health services through the LMHA or other community-based service is recommended, the AP is encouraged to assist with this referral process by making a warm hand-off to the next service provider.

Also, as mentioned in the *Clinical Judgment* subsection on page 14, APs should use their clinical judgment to determine whether delaying the DID assessment and assisting with accessing more appropriate services that address the individual's immediate needs is the most appropriate course of action. Should the DID assessment be deferred to a later date, reassure the individual and/or their family member or caregiver that they may continue the DID process in the future when valid and reliable results are more likely to be obtained.

Importance of Culture

The term “culture” refers not only to race, ethnicity, and ancestry but also to shared beliefs, values, customs, behaviors, and artifacts that individuals share with others within their community. This community may be based on shared experiences, residence, lifestyle, interests, or abilities. For instance, culture may be influenced by a disability, neurological or sensory difference, socioeconomic status, faith or spiritual beliefs, gender identification, sexual orientation, or age. Culture is part of our humanness, and it frames our worldview. An individual’s response on standardized measures may be influenced by values learned and experiences available to them. The AP should consider the individual’s culture when selecting test measures, scoring responses, and interpreting results as this must be done within the context of the whole person.

Because Texas is one of the most diverse states in the nation, APs will assess the abilities of a wide range of people who are often of different cultural and/or ethnic backgrounds than the AP. Furthermore, the American Psychological Association (APA) has designated Intellectual and Developmental Disabilities as a form of cultural diversity; therefore, the role of the AP is naturally embedded in clinical diversity. In accordance with multicultural guidelines published by the APA¹³ and THSC §592.018, APs are expected to adapt their techniques to the cultural background, language, and ethnic origin of the individual being evaluated. APs must exhibit awareness of diversity and exercise sensitivity, humility, and competence when faced with those differences.

Cultural Awareness

Cultural diversity is often equated with ethnic and racial differences that may be visible by skin color, style of dress, primary language, and other observable traits. When working with individuals who have disabilities, an AP must consider other less visible differences. These include but are not limited to sensory, learning, comprehension, mental state, and other internal processes that are part of the individual’s identity. For example, people with a hearing impairment may identify with the community of people who do not use manual sign language and may take offense at the assumption that they need an interpreter who uses ASL. Conversely, another person who communicates with manual sign language may be offended if

¹³ American Psychological Association. (2017). *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality*. <http://www.apa.org/about/policy/multicultural-guidelines.pdf>

an ASL interpreter is not provided. Similarly, people who have ASD differ on how they wish to be addressed (e.g., “person with autism” versus “autistic person”). Although one cannot know all of an individual’s preferences, the AP should be aware of possible differences within a person’s disability community as well as other traditionally recognized cultural differences (e.g., race, ethnicity, etc.) and exercise sensitivity in approaching the task of assessment.

Cultural Sensitivity

Cultural sensitivity is being aware that differences exist between people without assigning a value or judgment. In displaying cultural sensitivity, the AP understands that a person’s culture affects their worldview, values, learning, and behavior; however, different members of the same community may be affected in different ways. For example, in some cultures, a child’s disability is seen as punishment for the parents’ past deeds whereas, in other cultures, a child’s disability is viewed as a divine gift bestowed upon selected, fortunate parents. Understanding the cultural forces behind related feelings and beliefs can be informative in explaining family dynamics that impact the individual’s presentation or acquired skills. The AP must remain sensitive to the intersection between the norms of the person’s culture and the unique way in which the person may have experienced these norms. To understand these dynamics, it may be helpful to inquire directly about the impact of the disability in the context of the individual’s culture within their family and community.

Cultural Humility

Just as the individual who is being assessed has their cultural traits, so does the AP. The concept of cultural humility was introduced in 1988 as a dynamic, lifelong focus of self-reflection to identify and acknowledge one’s own perspectives and biases.¹⁴ The AP must practice reflection and self-awareness to avoid making judgments and reaching erroneous conclusions that are guided by the AP’s conscious or unconscious biases rather than the individual or family’s situation and experiences. In order to avoid this pitfall, the AP should exercise humility by asking the individual or family about their perspectives and remain open to learning the way that culture impacts their lives. APs should not make assumptions about one’s culture or stage of acculturation. APs should have the humility to consult with colleagues and leaders of the individual’s cultural community to achieve greater

¹⁴ Yeager, K.A., & Bauer-Wu, S. (2013). Cultural humility: Essential foundation for clinical researchers. *Applied Nursing Research*, 26(4), 251–256. <https://doi.org/10.1016/j.apnr.2013.06.008>

understanding. These leaders can include presenters who provide formal training; however, it may be very informative to reach out to local resources such as faith leaders, teachers, community organizers, or leaders of specific cultural and advocacy groups.

Cultural Competence

Cultural competence is generally considered to be the ability to engage knowledgeably with individuals of a given culture. It may be assumed to exist most clearly when an AP and the individual being assessed are members of the same cultural community. However, even the AP who is presumed to be culturally competent should continue to exercise awareness, sensitivity, and humility. Even with shared cultural knowledge and histories, the AP's personal experiences will differ from those of the individual and/or family in front of them. These differences will increase when a disability is added to the equation.

The AP should reflect on the following:

- Awareness of their personal views pertaining to the individual and/or family's characteristics
 - "Do I have biases?"
 - "Are my opinions or beliefs impacting my case conceptualization?"
- Familiarity or knowledge of the population being served
 - "What do I know about this culture?"
 - "What are some issues specific to this culture?"
- Awareness of the social context's impact on the individual and/or family
 - "How might this person believe I think about them?"
- Professional skills adequate for the specific individual and/or family
 - "Can I provide a fair assessment with the knowledge and skills I have?"
 - If not, "How can I accommodate, or should I consult or refer out?"



On-going self-reflection is necessary to competently serve Texas' diverse population.

The DID Report: Pulling it All Together

Elements of the DID Report

In 26 TAC §304.402, relating to The Determination of Intellectual Disability Report, the minimum requirements for a DID report are described but do not prescribe a particular format or outline. The following outline of reporting elements is offered to ensure the development of a comprehensive and quality DID report.

Information About the Individual

Provide the individual's name, date of birth, sex at birth, gender identity, date of assessment, age at time of the assessment, and other pertinent demographic information such as cultural identity, ethnicity, grade level, or marital status.

Reason for Referral

Provide the name of the person or entity that referred the individual for a DID assessment, the reason the referral was made, and the IDD waiver program in which the individual and/or LAR is most interested in pursuing, if known.

Note: Upon meeting the individual and gathering the history, if the AP suspects another qualifying diagnosis other than or in addition to the reason for which the person was referred, the AP is encouraged to test beyond the initial referral question. For example, if the referral question is ID but the AP suspects the individual also has ASD, the AP is encouraged to add ASD related testing measures to conduct differential testing. Doing so prevents the individual from having to return for additional testing at a later date. This is of particular importance given the recently approved Medicaid Autism Benefit.

Sources of Information

Include all sources of information used to inform the DID assessment. Examples include:

- Parties interviewed
- Name and version of assessment tools
- Behavioral observations

- Records reviewed (e.g., school, medical, LIDDA, CARE)

Relevant Background Information

Provide the following based on information from informant interviews and a review of formal, written records (e.g., LIDDA, medical, or school records or CARE):

- Prenatal, birth, and developmental histories, including ages at which milestones were met
- Medical history and current status
 - Diagnoses and any surgeries, treatments, or services received, including medications
 - Names of medical providers, if available
- Behavioral and psychiatric histories and current status
 - Diagnoses and any services received, including medications
 - Names of behavioral health providers, if available
- Related conditions
 - If applicable, based on documentation of a condition that appears on the HHSC Approved Diagnostic Codes for Persons with Related Conditions, document the diagnosis, most up to date version of the related ICD code, provider's name and credentials, and date of diagnosis.
 - If applicable, document a previous diagnosis of PDD-NOS, Asperger's Disorder, Autistic Disorder, or autism spectrum disorder, most up to date version of the related ICD code, provider's name and credentials, and date of diagnosis.
 - Cover all relevant information, including the results from a previously completed Form 8662, Related Conditions Eligibility Screening Instrument (RCESI).
- Education and employment histories and current status
- Legal history, if applicable
- Family history
 - Family structure and living situation
 - Culture, primary language

- Behavioral, learning, and psychiatric histories
- Legal history
- Areas of concern
- Strengths, preferences, and goals

Previous DID or Diagnostic Assessment Results

For each event, provide the name of the instruments used, date of testing, the individual's age at the time of testing, test results, and diagnostic conclusions. Each event should also include the provider's name and credentials.

Behavioral Observations

Describe the individual's presentation, physical characteristics, mobility and dexterity, social and communication skills, affect, ability to attend or be redirected when needed, perceived effort, quality of rapport, and other observations used to inform your conclusions. If possible, note whether the individual's behavior and level of engagement are typical. If applicable, describe elements of the individual's presentation that contribute to the determination of ASD as defined in the most current version of the DSM.

Validity

Make a statement regarding how the individual's behavioral presentation may or may not have impacted the validity of the test results. Other items to document and note whether they may have or have not impacted validity, when applicable, include:

- deviations from standardized test administration, including remote assessment, the use of audio-visual technology, and interpreters; and
- any impact of past or current trauma, mental status, or other situational factors.

Also, the AP should explain the rationale for using abbreviated or brief assessment measures, if applicable.

Current Assessment Results

Intellectual and Cognitive Ability

- Provide the name(s) of the instrument(s); date when instrument(s) are administered; overall intellectual functioning score; composite or full scale scores; cluster, area, and specific or subscale scores; and relative strengths and weaknesses for each test.
- Describe testing conditions, accommodations or technology used, and any factors that may have impacted test performance (e.g., cultural background, primary language, communication style, lack of rapport, physical or sensory impairments, motivation, attentiveness, and emotional factors).
- A narrative interpretation and description of strengths and limitations based on the findings should be included as well.

Adaptive Behavior

- Provide the name(s) of the instruments; date when instrument(s) were administered; overall adaptive score; composite or full scale scores; and individual subscale scores, if available.
- Describe all informants, including their relationship to the individual. Report the ABL based on your findings.
- Describe testing conditions, accommodations or technology used, and any other factors that may have impacted test performance (e.g., cultural background, primary language, communication style, lack of rapport, physical or sensory impairments, motivation, attentiveness, and emotional factors).
- A narrative interpretation and description of strengths and limitations based on the findings should be included as well. Be sure to include all domains:
 - Self-Care / ADLs
 - Receptive and Expressive Language
 - Learning
 - Mobility
 - Self-Direction
 - Capacity for Independent Living / IADLs

Social and Psychological Functioning

- When applicable, the AP should provide their findings based on the use of other assessment tools. These might include an ASD scale, mood or personality scale, projective measures, and so forth. Include a description of all informants and their relationship to the individual, if known.
- Use of social and psychological assessment measures are encouraged when emotional and psychological states might influence cognitive or adaptive behavior assessment results.
- A narrative interpretation and description of strengths and limitations based on the findings should be included as well.

Summary of Results

Integrated Summary

A person is more than a list of scores and diagnoses. A summary that describes the individual's strengths and limitations along with pertinent history, observations, evidence of age of onset, and test results is key when conceptualizing the individual's presentation and drawing conclusions about the presence or absence of diagnoses, their level of functioning, and recommendations.

If the person has a related condition, document the licensed physician who made the diagnosis.

Include a statement of eligibility. If the person does not meet eligibility criteria for ID, ASD, or a related condition, provide the rationale for this conclusion.

Diagnostic Information

List the eligibility diagnosis(es) with the most current version of the related DSM and ICD code(s), cognitive scores, ABL, Level of Care (LOC), and, if applicable, Level of Need (LON). If the eligibility diagnosis is ASD, include the appropriate severity level.

List other diagnosis(es), including the most current version of the related DSM and ICD code(s), as applicable, being sure to distinguish between current assessment results that do not pertain to eligibility yet warrant further attention (e.g., Borderline Intellectual Functioning) and historical diagnosis(es) that continue to be

relevant to the person's functioning (e.g., ADHD, seizure disorder, anxiety or mood disorder).

Recommendations

Recommendations should be responsive to the identified purpose of the assessment, eligibility, and presenting questions. They should be clearly supported by information contained in the DID report.

Recommendations may include other services for which the individual may be eligible, regardless of funding stream, if determined to be ineligible for the specific program to which they were referred. For example, if a person is referred for HCS services but is found to be ineligible, they may be eligible for GR funded services, CFC, or CLASS. Some individuals may be referred to behavioral health services through their LMHA or LBHA.

Other recommendations may be included based on the AP's professional judgment.

Communicating Results

A clear interpretation and summary of findings helps in communicating the results of testing to the individual and to the family or other interested parties. This should include the results of the testing, an explanation of the current diagnoses, description of the individual's strengths and limitations, and eligibility status.

After the DID report is complete, the individual and others should be offered time to ask questions to gain a better understanding of the findings. The AP should provide their contact information for additional questions that may arise after the results are presented.

Due to the differences in the eligibility criteria for services funded by GR and Medicaid, it may be important to explain how these differences apply to the individual's situation. For instance, eligibility for GR services as a person with ASD does not consider an individual's IQ score or ABL compared to Medicaid programs which consider one or both, depending on the program and an individual's LOC. The different eligibility requirements can be confusing; therefore, providing a clear explanation serves to minimize misunderstandings.

Validation of Previous Assessment and Test Results

Per 26 TAC §304.401(c), a previous diagnostic assessment, social history, or relevant record from another entity or authorized provider may be used if the AP who is conducting the DID considers the previous assessment information to be a valid reflection of the individual's current level of functioning.

Validation refers to accepting the results of one or more specific assessment measures that were administered by another professional and incorporating these results into the DID assessment and report. For example, an AP may use a cognitive assessment recently completed by a school district, if deemed still valid, while conducting an additional adaptive behavior assessment and other relevant methods to complete the DID assessment in full.

When considering whether to validate previous test results, an AP must consider:

- how old the testing is;
- developmental and physical/mental health changes that have occurred since the testing;
- if the instrument used was appropriate for the individual; and
- if there are inconsistent intellectual or functional ability scores.

Endorsement of Previous Evaluations

Endorsement of a previous assessment is the process of accepting the assessment and the findings of a previous DID or diagnostic assessment report without changes or additions. When appropriate, an endorsement can be completed in lieu of a DID.

The previous assessments subject to endorsement may have been completed by a school district, a public or private agency, an AP associated with a different or the same LIDDA, or other source (e.g., a managed care organization or state agency). In all cases, the endorsed DID or diagnostic assessment report should be determined to be an accurate reflection of the individual's current abilities. All required elements of a DID report described in 26 TAC §304.402 must be present in the DID or diagnostic assessment report if being endorsed.

Before determining whether to endorse a previous assessment, an AP must interview and observe the individual while considering:

- how old the testing is;
- developmental and physical/mental health changes that have occurred since the testing;
- if the instruments used were appropriate for the individual;
- if all the necessary elements are present;
- if there are inconsistent intellectual or functional ability scores; and
- the purpose for which the assessment will be used.

When conducting an endorsement, it is required that the AP complete a clinical interview and behavioral observations with the individual and, as needed, interview the LAR and others familiar with the individual. This assists the AP in determining whether the previous assessment results are currently valid. A brief summary of this step must be included in the DID endorsement report as justification for the endorsement. The endorsement report must also include a statement attesting to the DID or diagnostic assessment report being accepted, and the previous report must be included with the endorsement.



Interviews and observations must occur and be summarized in a DID report when validating previous assessments or endorsing previous DID reports.

The DID endorsement is not considered a valid endorsement without this brief summary or without the previous assessment report accompanying or attached to it.

Establishing Adaptive Behavior Level (ABL)

An ABL assignment based on the following levels and descriptors is necessary to establish a level of care (LOC):

- ABL 0 = less than “mild” deficits or limitations in adaptive skills;*
- ABL I = “mild” deficits or limitations in adaptive skills;
- ABL II = “moderate” deficits or limitations in adaptive skills;

- ABL III = “severe” deficits or limitations in adaptive skills; or
- ABL IV = “profound” deficits or limitations in adaptive skills.

*Deficits in adaptive skills are less limiting than what is defined as “mild” impairment in the DSM-5-TR for the diagnosis of ID. Deficits may be limited to only one or two major areas of life functioning.

See *Section 7: Adaptive Behavior Assessment* that begins on page 40 regarding test selection and interpretation for further guidance. When an AP determines it is appropriate to assign an ABL that is inconsistent with score interpretations, the AP must explain the rationale and clinical justification in the DID report.

Establishing Level of Care (LOC)

As required by 26 TAC §261.244 concerning ICF/IID programs, a LIDDA may request enrollment of an applicant by HHSC in the Intermediate Care Facility for Individuals with an Intellectual Disability and Related Conditions (ICF/IID) Program.

Eligibility for the ICF/IID program requires an individual to meet one of the following two Levels of Care (LOC):

- **LOC I** criteria as described in 26 TAC §261.238:
 - full scale IQ score of 69 or below; or
 - full scale IQ score of 75 or below with a primary diagnosis by a licensed physician of an HHSC approved related condition; and
 - ABL of I, II, III, or IV (i.e., mild to extreme deficits).
- **LOC VIII** criteria as described in 26 TAC §261.239:
 - primary diagnosis by a licensed physician of an HHSC approved related condition; and
 - ABL of II, III, or IV (i.e., moderate to extreme deficits)

When determining an individual’s LOC, an AP must conduct a DID assessment or endorsement as described previously in this document.



Remember: IQ SEM is not to be considered when determining Level of Care per 26 TAC §304.102(25).

The state maintains the HHSC Approved Diagnostic Codes for Persons with Related Conditions, which is posted at www.hhs.texas.gov. These codes are based on the federal definition of a “related condition” and the most current version of ICD codes. It is updated annually in October.

A diagnosis of ASD, per se, does not appear on the HHSC Approved Diagnostic Codes for Persons with Related Conditions. Therefore, a diagnosis corresponding to ASD must be used for ICF/IID eligibility. Examples of a possible corresponding diagnosis include Autistic Disorder, Asperger’s Disorder, or PDD-NOS, depending on the individual’s presentation as determined by a licensed physician. It is suggested to add the corresponding diagnosis in parenthesis following ASD to ensure both clinical and procedural integrity.

Establishing Level of Need (LON)

As required by 26 TAC §261.244, Level of Need (LON) must be established when being considered for enrollment into a Medicaid waiver or non-waiver program. The LON must be stated in the DID report.

According to 26 TAC §261.241, LON is assigned as one of the following:

- LON 1 = intermittent; ICAP service level 7, 8, or 9;*
- LON 5 = limited; ICAP service level 4, 5, or 6;*
- LON 8 = extensive; ICAP service level 2 or 3;*
- LON 6 = pervasive; ICAP service level 1;* or
- LON 9 = assigned by HHSC due to extremely dangerous behavior.*

*See 26 TAC §261.241 for specific details regarding establishing LON, including when medical or behavioral needs warrant a higher degree of support than the ICAP service level suggests.

Use of the DID Report

IDD Waiver and Non-Waiver Services

Eligibility

HCS/TxHmL

The Home and Community-based Services (HCS) waiver program rules in 40 TAC Chapter 9, Subchapter D and Texas Home Living (TxHmL) waiver program rules in 40 TAC Chapter 9, Subchapter N require an AP to conduct a DID assessment or endorsement on behalf of the requesting LIDDA for individuals enrolling in the HCS or TxHmL waiver programs.

Eligibility criteria for HCS and TxHmL require individuals to meet the ICF/IID LOC I criteria with one exception. Per 40 TAC §9.155(a)(2)(B) and §9.556(a)(2)(B)(ii)(II), if an individual is transitioning from a nursing facility or at imminent risk of entering a nursing facility, eligibility for HCS or TxHmL may be determined based on the individual meeting the ICF/IID LOC VIII criteria. See the Establishing LOC section on page 60 for additional information.

CFC Non-Waiver

Eligibility for Community First Choice (CFC) with an ICF/IID LOC requires a DID assessment or endorsement conducted by an AP on behalf of the requesting LIDDA. To be eligible for CFC provided through a Medicaid Managed Care Organization (MCO), an individual must meet ICF/IID LOC I or LOC VIII criteria.

ICF/IID

Eligibility for Community-Based ICF/IIDs requires a DID assessment or endorsement conducted by an AP on behalf of the requesting LIDDA. Per 26 TAC §261.236(a), to be eligible for a Community-Based ICF/IID, the individual must meet ICF/IID LOC I or LOC VIII criteria. Each ICF/IID can determine additional admission criteria.

Frequency of DID Assessments and Endorsements

Eligibility requirements vary by Medicaid service. 26 TAC Chapter 304, Diagnostic Assessment, does not detail a specific cadence for when DID assessments must be updated. Different services may require specific components to be updated.

The Intellectual Disability/Related Condition (ID/RC) Assessment (Form 8578) must be completed annually or when there is a significant change in functioning for all IDD Waiver and Non-Waiver Programs. It is the LIDDA's responsibility to keep documentation supporting the findings reported on the ID/RC Assessment, which may be requested by HHSC at any time.

For an individual in the HCS waiver program, an LOC Redetermination is required when an individual's LON changes to 1. Per 40 TAC §9.161, a new DID must be completed when an HCS recipient's LON is changed to 1.

Following a determination of eligibility for CFC non-waiver services provided through a Medicaid MCO, the state requires an AP associated with a LIDDA to conduct a standardized measure of adaptive behavior once every 5 years. That is, an individual's ABL is reassessed every 5 years, but a full DID assessment is not necessary unless clinically indicated. Updated guidance is that a DID *may but is not required* to be completed if the age of the person at their most recent testing was under 22 years and the testing was completed more than 5 years ago.

40 TAC §9.568 stipulates that, for TxHmL, the ICAP must be readministered every 3 years. It must also be readministered if there has been a significant change in functioning or when the individual's skills and behavior are inconsistent with their assigned LON. Reevaluating by way of a full DID assessment is not necessary unless it is clinically warranted.

In all other cases, the necessity of endorsing a previous DID report or conducting a new DID assessment is based on the AP's clinical judgment. When deciding whether another DID assessment or endorsement is needed, the AP should consider the individual's age, developmental stage, diagnosis, level of functioning, mental health, changes in health or neurological status, environmental factors, and other individual and contextual variables. The comprehensiveness, overall quality, and validity of previous testing should also be considerations.

For example, if a waiver slot has been released for a 9-year-old and the most recent DID on record is from when they were 3 years old, conducting a new DID to obtain updated information is likely needed. As another example, if a waiver slot has been released for a 35-year-old and the most recent DID on record is from when they were 18 years old, a new DID may or may not need to be conducted depending on their current functioning and other contextual variables compared to the last time testing was conducted.



If not stated in TAC, the decision to re-evaluate an individual is based on the AP's clinical judgment and not solely on diagnosis or age at the time of the person's most recent testing.

General Revenue Services

LIDDAs offer a variety of services and supports that are based on local needs and are funded by General Revenue (GR) to members of the IDD priority population.

Intellectual Disability

Eligibility for services funded by GR requires an IQ of 69 or below, which became effective on April 1, 2016. Prior to April 1, 2016, the IQ cut-off score for GR funded services was 70. The change to an IQ of 69 aligns GR with Medicaid program requirements described elsewhere in this document.

Note: If an individual was determined eligible for GR services based on an IQ score of 70 that was documented before April 1, 2016, the individual will remain eligible if the most recent DID report or endorsement indicates an IQ not above 70 as determined by an AP associated with the LIDDA providing a GR funded service.

Autism Spectrum Disorder

A diagnosis of ASD must be based on the most current version of the DSM as noted in 26 TAC §304.102(3).

In contrast to Medicaid program eligibility described elsewhere in this document, eligibility for GR funded services based on an individual having ASD is *not* based on the IQ score or ABL. That is, a person with ASD is eligible for GR funded services regardless of their IQ score or ABL.

Note: If an individual was determined eligible for GR services based on a diagnosis of PDD-NOS or Asperger's Disorder before November 15, 2015, the individual will remain eligible if the most recent DID report or endorsement indicates that the PDD-NOS or Asperger's Disorder diagnosis remains valid as determined by an AP associated with the LIDDA providing a GR funded service.

Nursing Facility Residents

If a DID is requested to determine a nursing facility (NF) resident's eligibility for IDD specialized services, an AP must conduct a DID in accordance with the DID requirements described elsewhere in this document.

PASRR

Individuals who are referred for eligibility determination under the Preadmission Screening and Resident Review (PASRR) program are typically adults. Often, relatives may not be available to provide information about the individual's developmental history, creating difficulty for establishing an age of onset for ID or a related condition. Additionally, people who are in NFs have experienced medical challenges that can impact their performance on tests. Their stamina may be reduced, senses may be impaired, and medical events (e.g., strokes) can produce results that mirror ID but resulted from a neurological insult that occurred well into adulthood.

It is necessary for the AP to gather as much information as possible about the individual's history and avoid relying solely on the medical records at the NF, which may document ID or a related condition based only on the individual's current presentation. The considerations mentioned in the subsection that reviews testing adults 65+ (pages 27-29) apply to PASRR referrals and can support the AP in the process of obtaining the most thorough developmental information available.

Occasionally, a minor will be referred for a PASRR assessment. Establishing age of onset with a child or adolescent is easier than with adults. However, medical conditions can also impact the ability of a youth to reliably respond to direct assessment tools. In addition to requesting prior assessments from the youth's school or other providers, the AP may need to consider physical and/or sensory deficits that could create barriers for testing. As such, the AP may need to utilize testing methods or modifications discussed in *Section 5: Considerations for Motor & Sensory Impairments* that begins on page 30 of this document.

Guardianship

When an interested party applies for guardianship in Texas and an intellectual disability is the basis for the incapacity, the applicant must comply with the requirements in Estates Code §1101.104, which states the applicant must present to the Court a written letter or certificate that:

- complies with §1101.103 (a) and (b) requirements for a Certification of Medical Examination (CME);
- shows that, not later than 24 months before the guardianship hearing date, the individual was examined by a licensed physician or psychologist who meets the requirements of §1101.104(2)(A), and the physician or psychologist's written findings and recommendations include a DID; or
- a physician or psychologist who meets the requirements in §1101.104(2)(B) endorses a prior DID report in writing.

In accordance with the Estates Code §1101.104, the judge for the Court with jurisdiction for granting guardianship will accept a CME, a DID report, or a DID endorsement.

In addition to conducting or endorsing a DID for submission to the Court, the AP may be asked to complete and submit HHSC Form 2190, Capacity Assessment for Self-Care and Financial Management.

Criminal Justice

APs should be aware that, pursuant to Code of Criminal Procedure (CCP) Art. 16.22(a)(1), a magistrate may request that a LIDDA interview and collect information to determine if a person in jail is a person with ID. The LIDDA must provide a report to the magistrate on the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCCOOMI) Screening Form. This is not intended to be a full DID report.

APs should also be aware that courts may request a competency evaluation to be completed for individuals who may be incompetent to stand trial. Competency evaluations may only be conducted by qualified experts. To qualify, the AP must be a Texas licensed psychiatrist or psychologist who either:

- has a doctoral degree in psychology and is certified by the American Board of Psychiatry and Neurology with added or special qualifications in forensic psychiatry;
- is certified by the American Board of Professional Psychology in forensic psychology; or
- has at least 24 hours of specialized forensic training related to incompetency or insanity evaluations and at least 8 hours of continuing education related to forensic evaluations completed in the past 12 months.

The AP must also have completed at least 6 hours of continuing education in forensic psychiatry or psychology in the past 24 months. APs should ensure that they meet the required qualifications before agreeing to complete a competency evaluation. The expert qualifications are found in CCP Art. 46B.022.

Unlike a DID, the purpose of a competency evaluation is to determine if the individual has sufficient present ability to consult with their attorney with a reasonable degree of rational understanding and a rational as well as factual understanding of the proceedings against the person. The legal requirements for the examination and the report can be found in the CCP, Chapter 46B, Subchapter B – Examination.

The court, prosecuting attorney, or defense attorney may request that the LIDDA complete a DID if a competency evaluation indicates that the defendant is a person with an intellectual disability. Eligibility for services factors into whether the criminal case may be dismissed, bond conditions imposed, or other alternative disposition explored.



An AP cannot render an opinion about a person's competency to stand trial without meeting specific forensic training requirements and credentials per CCP Art. 46B.022. A DID, however, may be used to assist in determining eligibility for IDD services and supports.

Child Protective Services

Child Protective Services (CPS) may request a LIDDA to conduct a DID for a person placed in its care or a person referred for guardianship with Texas HHSC. These individuals may not have informants who can provide developmental histories or

may have severed relationships with those informants by personal choice, by the informants' choice, or by legal mandate.

Often, there are annual psychological evaluations submitted by CPS. These evaluation reports usually include an abbreviated cognitive measure, but adaptive behavior is sometimes not assessed. These reports can be a good source of background and mental health information; however, the AP may want to lean more towards a full cognitive assessment along with the required adaptive behavior assessment.

When CPS requests a DID, the LIDDA must¹⁵:

- conduct the DID assessment and provide the DID report to CPS as soon as possible but no later than 6 months after receiving the request;
- adhere to the requirement of providing the written report to the person who requested the DID within 30 days of completing the interview and assessment; and
- complete the LIDDA section of Form 1051, Request for DID, after conducting the DID and completing the DID report.

Adult Protective Services

The Adult Protective Services (APS) section of DFPS may seek supports for an adult who is suspected of having ID or ASD by referring the individual to the LIDDA. These individuals may not have informants who can provide developmental histories or may have severed relationships with those informants by personal choice, by the informant's choice, or by legal mandate. The considerations mentioned in the subsections that review testing adults 18-64 (pages 23-26) and 65+ (pages 27-29) apply to APS referrals and can support the AP in the process of obtaining the most thorough developmental information available.

¹⁵ Texas HHSC. (2019). *LIDDA Handbook: 11100, DFPS Request for DID*. <https://www.hhs.texas.gov/handbooks/local-intellectual-developmental-disability-authority-handbook/11000-determination-intellectual-disability>

Appendices

Appendix A. Definitions

Appendix B. Eligibility Criteria

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Appendix A. Definitions

The following words and terms have the following meanings, unless the context clearly indicates otherwise. These are also found in 26 TAC §304.102, Definitions.

ABL--Adaptive behavior level. The categorization of an individual's functioning level of adaptive behavior into one of five levels ranging from minimal limitations (0) through profound limitations (IV).

Adaptive behavior--The effectiveness with or degree to which an individual meets the standards of personal independence and social responsibility expected of the individual's age and cultural group as assessed by a standardized measure.

ASD--autism spectrum disorder. As described in the most current Diagnostic and Statistical Manual of Mental Disorders (DSM), a disorder characterized by persistent impairment in reciprocal social communication and social interaction and restricted, repetitive patterns of behavior, interests, or activities. These symptoms are present from early childhood and limit or impair everyday functioning.

Asperger disorder--A neurodevelopmental disorder characterized by severe, sustained, clinically significant impairment of social interaction or communication skills and restricted, repetitive, and stereotyped patterns of behavior or interests. Symptoms may present later during the individual's development. Since the expanded definition of ASD in the DSM, effective 2013, Asperger disorder is subsumed under the diagnosis of ASD.

Authorized provider--A person who is:

- a physician licensed to practice in Texas;
- a psychologist licensed to practice in Texas; or
- a certified authorized provider.

Certified authorized provider--A person who is certified by the Texas Health and Human Services Commission (HHSC) as described in 26 TAC §304.302.

Developmental period--The period of time between birth and before the individual reaches 18 years of age.

Diagnostic assessment--An assessment, including a determination of intellectual disability (DID), conducted to determine if an individual meets the criteria for a diagnosis of intellectual disability (ID), ASD, or a related condition.

Diagnostic assessment report--The written report from a diagnostic assessment not conducted by an authorized provider employed by or contracting with a local intellectual and developmental disability authority (LIDDA) or state supported living center (SSLC), including reports completed by private entities or schools.

DID--Determination of intellectual disability. An assessment conducted in accordance with 26 TAC §304.401 by an authorized provider to determine if an individual meets the criteria for a diagnosis of intellectual disability.

DID report--Determination of intellectual disability report. The findings of the DID conducted by an authorized provider employed by or contracting with a LIDDA or SSLC written in accordance with 26 TAC §304.402.

DSM--The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

Endorsement--The process by which a previous assessment report, including a DID report, which meets the requirements in 26 TAC §304.402, is determined by an authorized provider to be a current representation of the individual's functioning for the purposes of diagnosis and service eligibility. When appropriate, an endorsement is completed in lieu of a DID.

HHSC--Texas Health and Human Services Commission.

ID--Intellectual disability. Consistent with Texas Health and Safety Code (THSC), §591.003, significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

Individual--A person who is the subject of a diagnostic assessment or who has been determined to be in the LIDDA priority population.

LAR--Legally authorized representative. A person authorized by law to act on behalf of an individual with regard to a matter described in this chapter, and who may be a parent, guardian, or managing conservator of a minor individual, or a guardian of an adult individual.

LIDDA--Local intellectual and developmental disability authority. An entity designated in accordance with THSC, §533A.035(a).

LIDDA priority population--Local intellectual and developmental disability authority priority population. A group comprised of people who meet one or more of the following descriptions:

- a person with an ID;
- a person with ASD;
- a person with a related condition on the current HHSC-approved list of related conditions, available on the HHSC website, who is eligible for and enrolling in services in the Intermediate Care Facilities for Individuals with an Intellectual Disability (ICF/IID) Program, the Home and Community-based Services (HCS) Program, the Texas Home Living (TxHmL) Program or other HHSC-approved programs;
- a nursing facility resident who is eligible for specialized services for an ID or a related condition pursuant to §1919(e)(7) of the Social Security Act (United States Code, Title 42, §1396r(e)(7));
- a child who is eligible for Early Childhood Intervention services through HHSC; or
- a person diagnosed by an authorized provider as having a pervasive developmental disorder (PDD) or Asperger disorder through a diagnostic assessment completed before 2013.

LIDDA services--Local intellectual and developmental disability authority services. Services provided by or through a LIDDA that are funded with general revenue pursuant to a performance contract with HHSC.

PDD--Pervasive developmental disorder. A severe and pervasive impairment in the developmental areas of reciprocal social interaction skills or communication skills, or the presence of stereotyped behaviors, interests, and activities manifested during the individual's development. Since the expanded definition of ASD in the DSM, effective 2013, PDD is subsumed under the diagnosis of ASD.

Related condition--As defined in the Code of Federal Regulations (CFR), Title 42, §435.1010, a severe and chronic disability that:

(A) is attributable to:

(i) cerebral palsy or epilepsy; or

(ii) any other condition, other than mental illness, found to be closely related to an ID because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of people with ID, and requires treatment or services similar to those required for people with ID;

(B) is manifested before the person reaches age 22;

(C) is likely to continue indefinitely; and

(D) results in substantial functional limitation in three or more of the following areas of major life activity:

(i) self-care;

(ii) understanding and use of language;

(iii) learning;

(iv) mobility;

(v) self-direction; and

(vi) capacity for independent living.

Residential care facility--A facility defined in THSC, §591.003.

SSLC--State supported living center.

Subaverage general intellectual functioning--Consistent with THSC, §591.003, measured intelligence on standardized general intelligence tests of two or more standard deviations (not including standard error of measurement adjustments) below the age-group mean for the tests used.

TAC--Texas Administrative Code.

THSC--Texas Health and Safety Code.

Appendix B. Eligibility Criteria

Funding Source/Program	LOC	IQ	Related Condition	ABL	Reference
General Revenue (GR)					
ID Before April 1, 2016		≤70	N/A	I, II, III, or IV	DSM-IV-TR, DSM-5, DSM-5-TR
ID After April 1, 2016		≤69	N/A	I, II, III, or IV	DSM-IV-TR, DSM-5, DSM-5-TR
PDD/Asperger Before Nov. 15, 2015		N/A		N/A	DSM-IV-TR
Autism Spectrum Disorder		N/A		N/A	DSM-5, DSM-5-TR
Medicaid Waiver					
HCS, TxHmL	I VIII*	≤69 ≤75 N/A	N/A + +	I, II, III, or IV I, II, III, or IV II, III, or IV	DSM-5, DSM-5-TR, ICD-10, ICD-11
Medicaid Non-Waiver					
CFC, ICF/IID	I VIII	≤69 ≤75 N/A	N/A + +	I, II, III, or IV I, II, III, or IV II, III, or IV	DSM-5, DSM-5-TR, ICD-10, ICD-11
SSLC	I	≤69	N/A	I, II, III, or IV	DSM-5, DSM-5-TR, ICD-10, ICD-11

**For HCS and TxHmL, an applicant who meets LOC VIII criteria must be transitioning or diverting from a nursing facility to be eligible.*

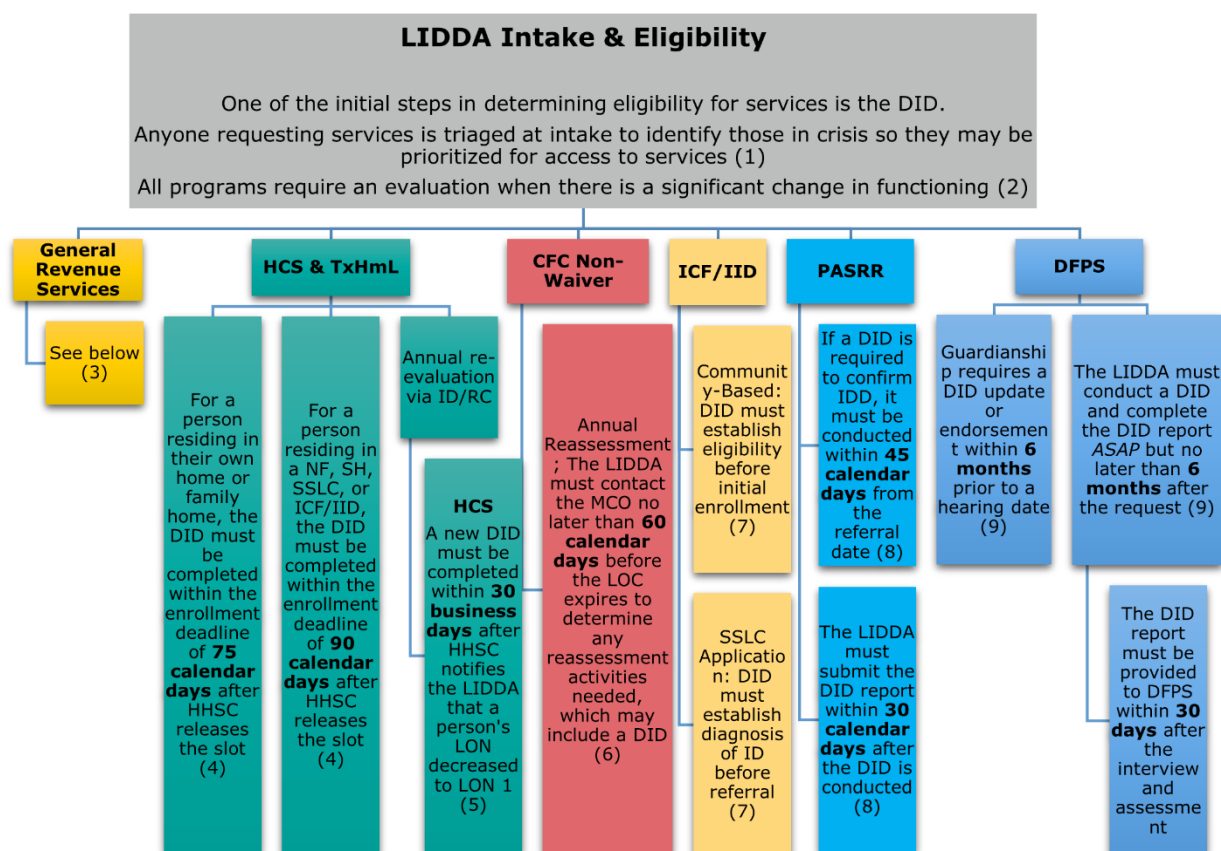
Appendix C. Levels of Severity

The following table is meant to act as a helpful tool when conceptualizing an individual's ABL. The ABL ranges *do not account* for elevated scores due to significant maladaptive behaviors (e.g., ICAP Maladaptive Behavior Index) or scatter of skills as is often the case for ASD and several related conditions. All descriptions are relative to chronological age.

Level of Severity	IQ Range	ABL Range	General Description ¹⁶
Borderline	70-80	0, I	May have received special education services while remaining mainstreamed; may need assistance with complex tasks, navigating social nuances, judgment, and decision-making; age appropriate personal care but may need support with complex living tasks
Mild	55-70	I, II	Concrete problem-solving approach; planning/organizing, memory, and use of academic skills in daily life are impaired; somewhat socially immature; impaired judgment and decision-making; age appropriate personal care but needs support with complex living tasks
Moderate	40-55	II, III	Academic skill development is typically at an elementary level; marked difference in social and communicative behavior from peers; social judgment and decision-making abilities are limited; while personal needs and household tasks can be completed with extensive teaching, ongoing supports will typically be needed
Severe	20-40	III, IV	Little understanding of the written language or of concepts involving numbers, quantity, time, and money; spoken language may be limited; needs extensive supports for problem solving, social judgment, and decision-making; requires support for all personal care and daily living activities; skill acquisition involves long-term teaching and ongoing support
Profound	≤20	IV	Conceptual skills generally involve the physical world (e.g., objects in place of symbols); limited understanding and use of verbal communication/language; dependent on others for all aspects of daily care; those without physical limitations may assist with some simple daily tasks at home

¹⁶ American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. <https://doi.org/10.1176/appi.books.9780890425596>

Appendix D. Timeline Requirements



- (1) 40 TAC §2.307(b)(1)(C) Access, Intake, and Enrollment Related Responsibilities
- (2) See DID BPG, p. 62, Section 12. Use of the DID Report
- (3) 40 TAC §2.307(c)(1)
- (4) LIDDA Handbook, Section 13231 Enrollment Due Dates
- (5) 40 TAC §9.161(i)(1)(A) LOC Determination
- (6) LIDDA Handbook, Section 17200 Annual Reassessment; TAC §2.307(g)
- (7) 26 TAC §261.244 Applicant Enrollment in the ICF/MR Program
- (8) IDD PASRR Handbook, Section 2430.7 When a DID is Required to Adequately Complete the PE; 40 TAC §2.307(j)
- (9) LIDDA Handbook, Section 11000 DFPS Request for DID

Appendix E. Helpful Resources

Practice Resources

**These resources are offered as helpful guides and should in no way be interpreted as an endorsement by HHSC.*

American Association on Intellectual and Developmental Disabilities

<https://www.aaidd.org/>

APA Professional Practice Guidelines

American Psychological Association (2022)

<https://www.apa.org/practice/guidelines/>

Guidelines for Assessment and Intervention with Persons with Disabilities

American Psychological Association (2022)

<https://www.apa.org/pi/disability/resources/assessment-disabilities>

Guidelines for the Practice of Telepsychology

American Psychological Association (2013)

<https://www.apa.org/practice/guidelines/telepsychology>

Guidelines for Psychological Assessment and Evaluation

American Psychological Association (2020)

<https://www.apa.org/about/policy/guidelines-psychological-assessment-evaluation.pdf>

Mental Health and Developmental Disabilities National Training Center

<https://www.mhddcenter.org/>

Mental Health Wellness for Individuals with IDD

<https://training.mhw-idd.uthscsa.edu/>

National Association for the Dually Diagnosed

<http://thenadd.org/>

Government Resources

Code of Federal Regulations – Title 42

<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483?toc=1>

Texas Administrative Code – Diagnostic Assessment

[https://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac_view=4&ti=26&pt=1&ch=304](https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=26&pt=1&ch=304)

Texas Behavioral Health Council

<https://www.bhec.texas.gov/>

Texas HHSC – Handbooks

<https://www.hhs.texas.gov/regulations/handbooks>

Texas Health and Safety Code – Mental Health and Intellectual Disability

<https://statutes.capitol.texas.gov/Docs/HS/htm/HS.591.htm>

IDD Waiver and Non-Waiver Services

Facility-Based Programs

Intermediate Care Facilities (ICFs)

<https://www.hhs.texas.gov/providers/long-term-care-providers/intermediate-care-facilities-icfiid>

Nursing Facilities (NFs)

<https://www.hhs.texas.gov/providers/long-term-care-providers/nursing-facilities-nf>

State Supported Living Centers (SSLCs)

<https://www.hhs.texas.gov/services/disability/intellectual-or-developmental-disabilities-idd-long-term-care/state-supported-living-centers-sslcs>

Non-Waiver Programs

Community First Choice (CFC)

<https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/community-first-choice-cfc>

General Revenue Services (GR)

<https://www.hhs.texas.gov/handbooks/local-intellectual-developmental-disability-authority-handbook/20000-general-revenue-services>

Preadmission Screening and Resident Review (PASRR)

<https://www.hhs.texas.gov/services/disability/intellectual-or-developmental-disabilities-idd-long-term-care/pasrr-families-caregivers>

Waiver Programs

Community Living Assistance and Support Services (CLASS)

<https://www.hhs.texas.gov/providers/long-term-care-providers/community-living-assistance-support-services-class>

Deaf Blind with Multiple Disabilities (DBMD)

<https://www.hhs.texas.gov/providers/long-term-care-providers/deaf-blind-multiple-disabilities-dbmd>

Home and Community-based Services (HCS)

<https://www.hhs.texas.gov/providers/long-term-care-providers/home-community-based-services-hcs>

Medically Dependent Children Program (MDCP)

<https://www.hhs.texas.gov/providers/long-term-care-providers/medically-dependent-children-program-mdcp>

STAR+PLUS HCBS

<https://www.hhs.texas.gov/providers/long-term-care-providers/long-term-care-provider-resources/home-community-based-services-hcbs>

Texas Home Living (TxHmL)

<https://www.hhs.texas.gov/providers/long-term-care-providers/texas-home-living-txhtml>

Appendix F. Sample Report Template

In 26 TAC Chapter 304, Subchapter D, relating to The Determination of Intellectual Disability Report, the minimum requirements for a DID report are described, but it does not prescribe a particular format or outline. This sample template is offered as a guide to ensure the development of a comprehensive and quality DID report and should in no way be interpreted as the required report format. APs are given full discretion when designing their DID assessment and endorsement reports so long as all required elements are included, and it clinically makes sense for the person's unique situation.

Name:

Date of Birth:

Date(s) of Evaluation:

Date of Report:

Age:

Grade: (if applicable)

Evaluator(s):

Reason for Referral

Purpose of the assessment, presenting question(s), referral source, IDD program of interest

Sources of Information

Parties interviewed

Tests administered/attempted

Behavioral observations

Records reviewed

Background and Relevant History

Developmental, Medical, and Psychiatric History

Prenatal, perinatal, and postnatal history; sex at birth; gender identification; developmental milestones; medical conditions and procedures; medications; behavioral, psychiatric, and learning disorders or diagnoses; diagnosed related conditions or ASD

Social and Family History

Family structure, living situation, stability, culture, language(s), CPS/APS involvement (if applicable)

Relevant family history

Educational, Employment, and Legal History

Educational classification, experience, graduation

Military service, types of employment, stability (if applicable)

Illegal drug use, interactions with police/justice system (if applicable)

Testing History

Chronological list of previous DIDs, educational, and/or private testing – date and age at testing, instruments used, scores, conclusions, names and credentials of evaluators

History of Treatment, Services, and Supports

Behavioral/psychiatric and rehabilitative/habilitative services and supports

Current Concerns and Preferences

Areas of concern

Strengths, preferences, and goals

Behavioral Observations

The individual's presentation, physical appearance/characteristics, rapport, social and language skills, affect, mood, attention, testing conditions, test accommodations/technology used, and other observations used to inform the assessment conclusions, including those that may have influenced test performance

Validity

Rationale if deviated from standardization or used abbreviated/brief measures, behavioral observations or other factors that may/may not have impacted the validity and reliability of this evaluation

Current Assessment Results***Intellectual and Cognitive Ability***

Name of assessment(s) used; overall intellectual functioning score; composite or full scale scores; cluster, area, specific, and/or subscale scores; factors that may have impacted test performance; narrative interpretation with relative strengths and limitations

Adaptive Behavior

Name of assessment(s) used; overall adaptive behavior functioning score; composite score; subscale scores; factors that may have impacted test performance; narrative interpretation with relative strengths and limitations and consideration for all six adaptive behavior domains

Social and Psychological Functioning

Name of assessment(s) used, scores, and narrative interpretations if applicable, including ASD assessment tools, psychological scales, projective measures, informants and their relationship to the person, etc.

Summary of Results

Integrative summary that describes the individual's strengths and limitations along with pertinent history, observations, evidence of age of onset, and test results used to conceptualize their presentation and draw conclusions about the presence or absence of diagnoses, level of functioning, and recommendations; if there is a related condition, include the name of the physician who made the diagnosis

Diagnostic Information

Diagnosis related to eligibility

Age of Onset

IQ Score

ABL

LOC

LON

Diagnosis not related to eligibility (as applicable)

Eligibility

State if the person meets or does not meet eligibility criteria for ID, ASD, or a related condition and provide rationale for this conclusion

Recommendations

Recommendations that are responsive to the identified purpose of this assessment, including other potential services if found ineligible for the specific program to which they were referred, and other recommendations as deemed appropriate based on clinical judgment

Signature

Include name, credentials, licensure/certification number, title

Appendix G. FAQs

General Guidelines

If I diagnose a client with ID per DSM standards at age 17 and they don't currently qualify for services, can they qualify for services in the future if the IQ and adaptive behavior level meet the standards?

If upon initial testing, an individual's IQ score does not meet or fall below the maximum allowed IQ score to be eligible but does so in subsequent testing, the DID report should describe the previous test results and provide an explanation or justification why current results are considered valid and thus an accurate reflection of the individual's level of functioning.

Which adaptive behavior tests are accepted?

There are many assessment tools available. The measure that is chosen should consider the individual's unique abilities and situation. Tests of adaptive functioning include but are not limited to current versions of the *Vineland Adaptive Behavior Scales*, *Adaptive Behavior Assessment System*, *Inventory for Client and Agency Planning*, and *Scales of Independent Behavior*. These measures satisfy the professional standards for validity and reliability required for their use with persons who have ID (IDD).

Is the Leiter International Performance Scale a nonverbal test for kids who are very young, and is it an acceptable test?

Yes, the Leiter may be used if clinically appropriate.

Use of Brief Assessment Instruments and Tests

When would a brief IQ test be used?

Use of brief tests of intelligence is discouraged to establish an individual's initial eligibility for IDD programs. However, in limited situations, exceptions may be warranted. For example, if an individual has a well-established, documented testing history based on broad-based batteries and brief test results are consistent with this testing history, then a brief measure may be adequate for eligibility purposes.

Another example may be when an individual does not have adequate attention and concentration to tolerate a more comprehensive measure and their adaptive functioning and history are consistent with intellectual disability.

Is the Slosson Intelligence Test still acceptable for use with individuals who are unable to take a more comprehensive assessment such as the WAIS or WISC? It is the only test that we have found so far that gives IQ scores within the lower severe and profound IQ ranges and measures both verbal and nonverbal abilities.

Comprehensive standardized cognitive assessment tools are recommended when establishing initial eligibility for IDD programs and services. There are certain limited situations in which a brief test, including the *Slosson*, may be warranted. APs must explain the rationale for this choice and justify its use in the DID report.

When a Standardized Intellectual Assessment Cannot be Successfully Administered

Is a CAP allowed to exercise clinical judgment in the selection of appropriate adaptive instruments when conducting DID assessments and the need for an “estimated” IQ occurs? For instance, we find the ABAS-3 to be a highly useful instrument that yields rich information regarding the various domains of an individual’s adaptive functioning. It appears to us that it would be an acceptable instrument to provide an “estimated” IQ.

If an individual’s ability to comprehend oral instruction or visual demonstration is not adequate for a formal appraisal of general intellectual functioning, the use of the Adaptive Behavior Composite provided by the most current version of the *Vineland Adaptive Behavior Scales* may serve as an estimate of the individual’s intellectual functioning when accompanied by clinical justification explained in the DID report. However, not all measures of adaptive behavior (e.g., *ICAP*, *ABAS*, *Scales of Independent Behavior*) are appropriate for establishing an IQ score equivalent.

Do current DIDs with a diagnosis of Unspecified ID require a VABS-III be completed to give an estimated IQ score instead of using 19 as done previously?

If a standardized intellectual assessment cannot be successfully administered, an AP shall provide an estimated IQ score using the Adaptive Behavior Composite provided by the most current version of the *Vineland Adaptive Behavior Scales*.

Establishing the Origination of ID During the Developmental Period

Can evidence of onset be based on verbal feedback provided by family if no actual documentation is available (especially when assisting older individuals whose records may no longer be available)? Can a family member's information be accepted for an older person if there was no testing or verification of the age of onset?

The most common method for establishing age of onset of ID is to rely upon reports of previous assessments. When records are no longer available or the individual may not have been in a traditional school setting (e.g., homeschool, outside of the United States), alternative methods of collecting information may be needed to gather historical information. An AP may use reports by other people, including the individual's family and friends who know their history well. The DID report should provide specific examples as evidence (e.g., developmental delays, functional skills classes, inconsistent work history). The AP is reminded to rule out other possible causes of current functioning (e.g., neurological insult).

Should "provisional" IDD be used if the only source of developmental history is the client themselves?

A DID is used to determine eligibility, and HHSC would be unable to accept a DID report with findings that are inconclusive or a provisional diagnosis is given.

An AP must make every effort to obtain as much supporting evidence as possible and include in the DID report a detailed description of the information and references used to make a determination. Absent any record, an AP may use collateral information from reliable historian(s). The AP must use sound clinical judgment when deciding whether this is reliable information that can be used to support diagnostic conclusions.

Endorsement of a Previous Assessment

If a client's IQ is in the normal range and there is no question of ID, is it okay to endorse a brief IQ test?

If an individual's IQ is clearly in the average range and their testing history consistently demonstrates this, then validating a brief cognitive measure or endorsing a previous assessment report that used a brief cognitive measure may be sufficient depending on the age of the individual, how old the testing is, and whether they have experienced any mental or physical health changes since then.

Is a non-video telephone interview acceptable for endorsement if a face-to-face interview cannot occur?

When an AP endorses a previous assessment, they are accepting the assessment and findings of a previous DID or diagnostic report without changes or additions. When conducting an endorsement, it is required that the AP complete a clinical interview and behavioral observations with the individual and, as needed, interview the LAR and others familiar with the individual. This aids in determining whether the previous results are currently valid. Audiovisual technology may be used if this is the individual's preference and there are factors impeding their ability to meet in person; however, behavioral observations of the individual that corroborate the verbal interview must occur to confirm the data being considered for endorsement.

To clarify, testing is required for all individuals under the age of 22 for all programs across the board and not just CFC non-waiver, correct?

A DID *may but is not required to* be completed if the age of the person at their most recent testing was under 22 years and the testing was completed more than five years ago for HCS, TxHmL, CFC, and ICF/IID. The necessity of endorsing a previous DID report or conducting a new DID assessment is based on the AP's clinical judgment.

When deciding whether another DID assessment or endorsement is needed, the AP should consider the individual's age, developmental stage, diagnosis, level of functioning, mental health, changes in health or neurological status, environmental factors, and other individual and contextual variables. The comprehensiveness, overall quality, and validity of previous testing should also be considerations. For example, if a waiver slot has been released for a 9-year-old and the most recent DID on record is from when they were 3 years old, conducting a new DID to obtain

updated information is likely needed. As another example, if a waiver slot has been released for a 35-year-old and the most recent DID on record is from when they were 18 years old, a new DID may or may not need to be conducted depending on their current functioning and other contextual variables compared to the last time testing was conducted.

Can a state hospital assist a LIDDA in completing a DID?

An AP employed by or contracted with a LIDDA may endorse a diagnostic assessment report from a qualified AP, including those employed by or contracted with a State Hospital, so long as this report includes all elements of a DID report required by 26 TAC §304.401 and §304.402 and the AP endorses this report per 26 TAC §304.403.

ICF/IID LOC I and LOC VIII

Does an individual transitioning from a NF have a different IQ requirement when enrolling in Medicaid Waivers such as HCS? I recall years ago that some information at that level had been discussed during a PASRR training.

An individual who enrolls in HCS by way of diverting or transitioning from a Nursing Facility (NF) must meet ICF/IID LOC I or LOC VIII criteria. LOC VIII does not have an IQ requirement but does have diagnostic and ABL requirements. For any other individual who is attempting to enroll into HCS, eligibility must be based on LOC I criteria, which includes an IQ requirement.

If an ICF/IID provider has accepted individuals into their facility, do they have to arrange for the individuals to see us as the LIDDA before we can authorize the ID/RC?

Yes. Per 26 TAC §261.244 (a) Except as provided in subsection (b) of this section, only a LIDDA may request enrollment of an applicant by HHSC. (b) A program provider may request enrollment of an applicant by HHSC in accordance with subsection (k) of this section if the applicant: (1) has received ICF/MR services from a non-state operated facility during the 180 days before the enrollment request; and (2) is not moving from or seeking admission to a state school or state center.

The DSM-IV diagnosis of Asperger's assumes a higher IQ. If eligibility under LOC I is limited to a diagnosis of an RC with an IQ of 75 or less, would a person with Asperger's be ineligible for services?

If a person is diagnosed with Asperger's disorder based on ICD-10 F84.5 and currently meets DSM diagnostic criteria for ASD, they may be eligible if they meet the IQ and ABL criteria as required per LOC I or LOC VIII. In this example, if the person's IQ score is over 75, they would not meet LOC I criteria.

However, if the same person has an ABL of II, III, or IV, they may meet LOC VIII criteria. Also, they may be eligible for GR funded services as a member of the LIDDA priority population regardless of IQ and ABL scores.

If an individual has been diagnosed with autism with an IQ of 85 but has an ABL of II, will they meet the criteria for LOC VIII?

Correct. A person meets LOC VIII criteria if they have an approved related condition diagnosed by a physician that manifested before the age of 22 years, including ASD, and have an ABL of II, III, or IV regardless of IQ score.

Would you explain LOC VIII and how a person does not need to have a diagnosis of ID to be eligible for services? Since LOC VIII requires a physician's diagnosis, does the diagnosis or physician's statement stand alone, without the AP needing to follow up with testing?

LOC VIII is based on the person having a primary diagnosis of an approved related condition diagnosed by a licensed physician that substantially impacts their functioning and manifested before the age of 22 years. Although IQ is not part of the determination of LOC VIII, a DID assessment or endorsement must be conducted in accordance with 26 TAC Chapter 304, Subchapter D to determine eligibility for some IDD waiver and non-waiver programs.

Eligibility for GR Services

If someone is coming in for a GR evaluation, should I be listing whether or not they are eligible for Medicaid Waiver programs?

APs offer recommendations responsive to the identified purpose of the evaluation. In the example given, we assume the person has not received an offer of waiver services and is not a member of an HCS waiver program target group. If this is the case, addressing an individual's eligibility for a Medicaid program in advance of an

offer to enroll would be premature. However, if the person is likely a part of this target group, the AP is encouraged to refer them to the interest list.

Is the RCESI required for eligibility for GR services?

No, the RCESI is not required for GR services. The presence of a related condition is only applicable to Medicaid programs.

Eligibility for Services Based on ASD

What exactly is meant by structured observation for ASD diagnosis?

Due to the complexity of ASD, this diagnosis should be based on multiple sources of information and not simply a checklist of criteria. When evaluating for ASD, a multimodal and multisource assessment approach is necessary. Assessment batteries should include standardized measures of observation, performance, and informant and self-reports. Areas to assess should include cognition, executive functioning, social communication and responsiveness, expressive and receptive language, sensory functioning, and emotional and behavioral functioning. If possible, multiple observations of the individual in both the testing and natural environments are ideal. Parsing out core symptoms from other conditions is important to ensure an accurate diagnosis is made, which ultimately influences the individual's treatment. APs are encouraged to rule-out other conditions, evaluate for comorbid conditions, and search for underlying etiology (e.g., genetic syndromes, environmental opportunities).

What are best practices for ASD determination? ASD evidence + IQ possibly above 69, but ABL at least Level 1?

An individual diagnosed with ASD based on DSM criteria may be determined eligible for GR-funded services without regard to the IQ score or ABL. In contrast to Medicaid program eligibility, eligibility for GR services based on an individual's having ASD does not require the individual to have a particular IQ score or ABL. For certain IDD waiver and non-waiver program eligibility, a person with ASD must meet LOC I or LOC VIII criteria.

If ASD is used as the RC for eligibility under LOC VIII, must the ASD be diagnosed by a physician? Must every RC be diagnosed by a doctor?

Any time eligibility is based wholly, or in part, on an approved related condition, including ASD, a licensed physician must attest to this diagnosis as required by TAC 26 §261.238 and §261.239.

Eligibility for Services Based on an Approved Related Condition

What if there is a conflict between physician's diagnosis and AP's assessment?

The AP should not confirm that the person is eligible for services but may explain in the DID report that eligibility is conditional upon a physician's confirmation of the qualifying diagnosis. The AP should indicate in the DID report that the person *may* be eligible for services if other eligibility criteria (i.e., IQ, ABL) are met.

An AP may assist in this process by providing the individual, family, and/or caregiver with the link to the HHSC Approved Diagnostic Codes for Persons with Related Conditions or with a hard copy of the document that they can then review with their physician. The AP should refrain from suggesting diagnoses.

Is it sufficient for a physician to give an attestation with just the name of the diagnosis but no code?

The physician's attestation of the diagnostic name/description may be sufficient if the diagnosis is based on the most recent version of ICD and the LIDDA staff is able to locate the correct, corresponding ICD diagnostic code.

Does it matter if the medical documentation is old?

Old medical documentation may assist efforts to establish an age of onset. However, names and corresponding ICD codes used for determining eligibility must be up to date and, if a related condition, must be attested to by a licensed physician.

When determining eligibility for a related condition, will I need to use Form 8662 for any program?

Per Form 8662 instructions, the RCESI is used to determine programmatic eligibility for the ICF/IID program, ICF/IID waiver programs (HCS, TxHmL, CLASS, and DBMD), and CFC non-waiver services, when the applicant does not have a diagnosis

of ID at the time of application. This form is not used to determine eligibility for GR-funded services.

Who would complete Form 8662, psychologist or LIDDA?

A LIDDA may delegate this task to whomever the LIDDA deems appropriate, including but not limited to an AP or service coordinator.

Does a medical diagnosis for a NF resident need to be done by a physician instead of sending the consumer for testing with a psychologist who is going to defer to the physician anyway?

The diagnosis of an approved related condition must be made by a licensed physician. A DID assessment or endorsement must be conducted in accordance with 26 TAC Chapter 304, Subchapter D to determine eligibility for IDD waiver and non-waiver programs. Therefore, an AP would still need to evaluate this individual.

DID Report Elements

I had a client come in who was born male, but identifies as a female. What gender do I put in the system?

In the TMHP and CARE systems, the only available options are Male, Female, and Other. When an individual applies for Medicaid, the only available options to designate gender are Male and Female. To avoid a possible disruption in Medicaid services, it is recommended to enter in the TMHP and CARE systems the name and gender identification that is consistent with the individual's government records and legal documents (e.g., official government ID, Medicaid application).

Because the ID/RC and DID report must match, it is recommended that the AP document both the individual's assigned sex at birth as well as their gender identity in the DID report.

If an AP identifies an RC but does not yet have the physician's attestation and cannot obtain it within the 30 days by which the DID report must be completed, should the AP conclude the person is ineligible or state the person is eligible, pending the attestation?

The AP should not confirm that the person is eligible for services but may explain in the DID report that eligibility is conditional upon a physician's confirmation of the

qualifying diagnosis. The AP should indicate in the DID report that the person *may* be eligible for services if other eligibility criteria (i.e., IQ, ABL) are met.

An AP may assist in this process by providing the individual, family, and/or caregiver with the link to the HHSC Approved Diagnostic Codes for Persons with Related Conditions or with a hard copy of the document that they can then review with their physician. The AP should refrain from suggesting diagnoses.

Miscellaneous

What is a DID "update"? That term is used here when we are required to do an update for enrollment in HCS or TxHmL.

A DID update is an unofficial term sometimes used to refer to a re-evaluation, either through conducting a new DID assessment or endorsing a previous DID report. The term does not appear in rule, statute, or HHSC handbooks.

How do we stay informed on the most up to date information regarding the use of technology and other items related to DIDs?

Subscribe to GovDelivery to receive important broadcasts from HHSC (<https://service.govdelivery.com/accounts/TXHHSC/subscriber/new>).