

CLIENT DEVELOPMENT EVALUATION REPORT
(CDER) UPDATE BULLETIN
DIAGNOSTIC ELEMENT

MAJOR CLARIFICATION - CORRECT AT ONCE

Items 12a, 12b, 13, 18a, etc. Etiology: ICD-9-CM Codes

Q: Isn't it an error to use 999.99 as "unknown" in CDER items calling for ICD-9-CM codes since, in ICD-9-CM itself, 999.9 means "other and unspecified complications of medical care, not elsewhere classified"?

A: The digits 999.99 were selected by data processing staff because of the traditional use of 9-codes to signify "unknown." It is an artificial code as there currently is no 5-digit 999.99 code in ICD-9-CM. However, because the 4-digit 999.9 code in ICD-9-CM does signify an unspecified complication of medical treatment, the code of 799.9 should be used for unknown rather than 999.99. ICD-9-CM defines 799.9 as "other unknown an unspecified cause."

This applies to all "Etiology" or "contributing factor" items requiring ICD-9-CM codes (12a, 12b, 13, 18a, 18b, 24a, 24b, 30a, 30b, and 34a, 34b).

Please correct your Manual pages for these items. (A sample corrected page [page VI.5.5] is attached.)

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MAJOR CLARIFICATION - CORRECT AT ONCE

Item 27b, 28b, 29b Seizure Frequency

Q: Which is right, the CDER Form or the CDER Manual? On the form, seizure frequency has values of "one to six per year" and "seven to 11 per year"; the Manual has only "1 - 11 per year." Which is right?

A: The form is correct. Manual page VI.8.6 is incorrect. Please correct this Manual page with the following correct codes for seizure frequency:

- 1 History of seizures, none in two years
- 2 History of seizures, none in one year
- 3 One to six per year
- 4 Seven to 11 per year
- 5 One per month (approximate)
- 6 One per week (approximate)
- 7 One per day (approximate)
- 8 More than one per day
- 9 Frequency undetermined

Also correct your Manual on page VI.8.7, where the frequency codes in the first example should be changed to:

Seizure Frequency

| 6 |

| 5 |

[A replacement page for the Manual is attached]

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MAJOR CLARIFICATION

Item 33a - 34b Other Type of Developmental Disability

Q: In the Manual page VI.9.1 your definition of Other Type of Developmental Disability differs from that which appears in regulations or the law. As defined, this could open the door for all kinds of eligibility questions. Shouldn't you have used what is in law or regulation?

A: As has been mentioned elsewhere, CDER is NOT to be used for determining eligibility. Eligibility decisions are made separate from, and usually prior to, completion of the CDER. The CDER category of Other Type of Developmental Disability was included so that there would be a place to enter the conditions of those eligible clients who have "other conditions similar to mental retardation that require treatment similar to that required by mentally retarded persons" (Title 17, Section 54000). The statement on page VI.9.1 of the Manual was just a paraphrase of the regulations. There was no intention here to modify or expand upon the statements about eligibility that appear either in the Title 17 regulations or in the law [Welfare and Institutions Code Section 5412(a)].

Because of the confusion that has occurred over the Manual statement, the statement on this Manual page has been revised to reflect the Title 17 regulations; the revised page is attached.

Q: Isn't "Other Type of Developmental Disability" an incorrect title for what we used to call "Other Handicapping Conditions"? Doesn't this title imply we are allowing or generating a new eligibility category?

A: No, to both questions. The term "Other Type of Developmental Disability" was used for purposes of data tabulation only, so there would be a space on the CDER form for the diagnoses of clients with conditions other than Mental Retardation, Epilepsy and so forth as defined in Title 17, Section 5400 (see previous questions and answer). The CDER Manual does not authorize categories of service, which are spelled out in the Welfare and Institutions Code and Title 17. Similarly, CDER does not imply anything about eligibility. CDER is a document upon which data are recorded about clients who have been found eligible for regional center services.

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MAJOR CLARIFICATION - CORRECT AT ONCE

Evaluation Element (Multiple Items)

- Q: There is a difference between the Manual and the form on many Evaluation Element items -- e.g., all items in the Independent Living Domain, many in the Emotional Domain and two in the Communication Domain -- regarding the use of "Y," "N," and "D" codes. Which is correct?
- A: The Manual is correct; the "alpha" codes were inadvertently omitted from the CDER forms. The CDER Form, DS 3573, should be changed to conform with the Manual. Attached is the CDER Answer Sheet with all correct codes indicated for each item. Definitions of the alpha codes can be found in the Manual. The CDER Form will be corrected as soon as possible to reflect these codes, until then please ensure that everyone uses the Manual version.

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Item 11 Mental Retardation

Q: In response to an issue that was brought up during the training related to clients with borderline intellectual functioning, I personally agree with your position that borderline intellectual ability is not mental retardation and is of itself not an eligible condition. I would agree with it not being coded under the mental retardation section. If borderline intelligence is one of the factors considered in determining someone eligible under the category of [Other Type of Developmental Disability], then it would be my position that it should be coded there.

A: Borderline mental retardation is not "Mental Retardation" according to current definitions of that condition and, accordingly, should not be coded in the Mental Retardation section unless other conditions also apply. One such condition or circumstance would be when the client tests as "borderline" on measures of IQ but his/her adaptive behavior is so low or poor that, on average, his/her overall mental retardation level, which takes both IQ and adaptive behavior into account, is something less than borderline.

If the client has a borderline IQ and good adaptive functioning (moderate or better), then the person should not be considered as Mentally Retarded. If such persons are regional center clients they must have some other condition that makes them eligible -- Cerebral Palsy, epilepsy or some other developmental disability that results in substantial handicap. If the person has none of these conditions then he/she is not eligible and should not be receiving regional center services.

Q: How do we code children under age 3 who clearly have Downs Syndrome but who have not yet displayed the mental retardation that can be expected to show up later (as it does in about 99% of the cases of Downs Syndrome)?

A: Consensus among physicians was to use code 319, unspecified level of Mental Retardation, in such situations. A different coding convention may be developed at a later date when the proposed "Infant (child under 3 years) CDER" is completed.

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Items 12a, 12b, 13, 18a, etc. "Etiology"

Q: By requiring entries under the title of "Etiology" aren't you requesting the physician to make definitive statements that could have legal implications? Aren't the physicians leaving themselves open to lawsuits?

A: "Etiology" on the CDER form refers to those factors that may have contributed to or been associated with the client's developmental disability or medical condition. Recording a factor or condition in the "Etiology" spaces on CDER is not a statement of definitive causation in any medical-legal sense. These factors or associated conditions are to be used for review and statistical purposes only and do not constitute a diagnostic opinion as to the exact cause of a developmental disability or medical condition.

Q: What if you are not sure what the etiological factors are, how should you code these items?

A: Code only those conditions which you are reasonably sure were associated with the developmental disability. Do not speculate. If you do not feel reasonably certain about the associated factor, code 799.9 for "unknown."

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Items 12a, 12b, 13, 18a, etc. ICD-9-CM Codes

Q: How do you convert the AAMD code for "psychosocial conditions" (80.810) into ICD-9-CM?

A: You don't. Psychosocial factors are not sufficient conditions for eligibility. Presumably, the client has some kind of developmental disability that makes him/her eligible and that is coded on the CDER form in ICD-9-CM terms. Psychosocial factors should be entered under "Risk Factors," item 44, "Psychosocial (environmental deprivation)," and not as an ICD-9-CM code. While the ICD-9-CM code V62.4 could be used, we are discouraging the use of V codes on CDER.

Q: Aren't you going beyond actual ICD-9-CM codes in Attachment III (Manual page VI.21.1 ff)?

A: Yes. ICD-9-CM codes for chromosomal anomalies have been expanded to allow more precise diagnostic coding. These expanded codes were developed in conjunction with the Birth Defects Monitoring Program. When new additions or further expansions of ICD-9-CM are developed, we will send the expanded lists to all of you to ensure that everyone uses the same coding system. (We also will incorporate any expansions into the computer software.)

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Item 15 Intelligence Test Name

Q: Please add an item to the IQ test list: Wechsler Pre-School and Primary Scale of Intelligence

A: For now, code it as "22," other intelligence test. This test, and others that may be suggested over time, will be included in a subsequent revision of CDER.

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Item 16 Adaptive Behavior

Q: May regional centers enter the client's Adaptive Behavior rating in item 16?

A: Yes. Items 14-16 are optional for regional centers. They may be used if you desire, but they are not required for regional centers.

Q: Shouldn't we use "mental age" rather than "adaptive behavior"?

A: As the Department uses the AAMD definition of mental retardation, see Manual page VI.5.2, and as that definition contains both Intelligence Quotient and Adaptive Behavior components, adaptive behavior is used on the CDER. "Mental age," furthermore, would be no different from IQ: as mental age is just another system for classifying persons on whatever dimensions are measured by intelligence tests, it would not be a substitute for adaptive behavior.

Q: What does the Department consider to be legitimate tests of adaptive behavior?

A: As we did not plan to collect data on adaptive behavior instruments, we included only a few basic tests of adaptive behavior on the IQ Test Name list (Manual, page VI.5.9) for those situations in which it was impossible to use traditional IQ tests. Since there is a lot of research and test activity in the field of adaptive behavior testing any list would be outdated quickly. We wanted to give the psychologist in the field the flexibility to use the most appropriate instrument for the particular client. Any major, well-normed instrument would be acceptable to DDS. The AAMD's Adaptive Behavior Scale (ABS) is commonly used.

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Item 17 Presence of Cerebral Palsy

Q: Under the category of Cerebral Palsy in the Manual, you gave in the very first paragraph a very clear and concise definition of Cerebral Palsy and one that is consistent with the application of [the regional center]. That section goes on then to describe other motor dysfunctions that can be misconstrued as being defined as eligible conditions. I believe that Cerebral Palsy is the eligible condition and that any other motor dysfunctions would fall under the category of "solely physical in nature", or need to qualify in association with other conditions that qualify as a "condition similar to mental retardation", etc. My suggestion is that other motor dysfunctions be coded under Major Medical Condition not to confuse the category of Cerebral Palsy and the definition that you have applied to it. Having other motor dysfunctions coded under this diagnostic section of Cerebral Palsy will in fact be misconstrued by already confused regional centers. In addition, it will certainly be used by advocacy agencies to bring in all persons who have a physical dysfunction into the regional center system.

AND

Q: Aren't we devising a new eligibility category with the Cerebral Palsy definition and codes in the Manual, page VI.6.1?

A: There was no intention to expand or influence definitions of eligibility with item 17 of the CDER Diagnostic Element. This item was written to include "Cerebral Palsy-like" conditions so that it would be possible to obtain descriptive data -- level, location, type - not only about Cerebral Palsy itself but also about other motor dysfunctions of eligible regional center clients. We were not implying with this item that anyone with a motor dysfunction is eligible for regional center services. What we are saying is that some eligible regional center clients have significant motor dysfunctions and that it is important to obtain accurate, descriptive data about those dysfunctions.

The particular condition that makes the client eligible will be documented in the client's case record in accordance with the regional center's standard eligibility-determination procedures. CDER simply records data about clients who have been found to be eligible.

Persons with significant motor dysfunctions that are not Cerebral Palsy per se could have a variety of conditions that make them eligible for regional center services, and these conditions could be

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tem 17 Presence of Cerebral Palsy (cont.)

entered in any, or on several, of the items on the CDER Diagnostic Element. Persons with conditions "similar to mental retardation that require treatment similar to," for example, would be entered in "Other Type of Developmental Disability (items 33a - 34b) as well as in items 17 - 22 if these conditions involve motor dysfunctions.

Q: Don't we need to know about Cerebral Palsy alone, per se, rather than as part of "motor dysfunctions" in general? Shouldn't they be separated on the form?

A: It will be possible to differentiate Cerebral Palsy from other "Cerebral Palsy-like" significant motor dysfunctions through the ICD-9-CM code that is entered in item 18a. We will consider establishing a separate code for the "Cerebral Palsy-like" conditions in a subsequent revision of the CDER Diagnostic Element.

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Item 23 Autism

Q: I do not think that the description in the Manual clarifies enough the issue of autistic-like characteristics or autisms. There are many clients who are not suspected of being autistic but who do present autistic characteristics or autisms. The Manual needs to clarify that "autism suspected" as it relates to autistic-like behaviors should only be coded when the team suspects that in fact the person may be autistic. Autistic-like behavior or autisms should not, of themselves, be coded under the diagnosis of autism.

A: The Manual did not mean to imply that any person with autistic-like characteristics should be coded in the Autism item, either as a 9 or in any other way. The "9" code should be used only for what it says "Autism suspected, not diagnosed." "Suspected [but] not diagnosed" would occur, for example, when a general screening has indicated the person was Autistic and the client has been referred to a qualified physician or psychologist for specialized testing.

The last paragraph on page VI.7.2 of the Manual should be changed to read:

If the client is suspected to have Autism but has not yet been tested to confirm that diagnosis, code "9," Autism suspected, not diagnosed.

If the client is mentally retarded and also has autistic characteristics, code the retardation in item 11 and code item 23 as "9," Autism suspected, not diagnosed, if the client has been referred for further testing to determine the accuracy of the suspected autism diagnosis.

Q: Aren't there other Evaluation Element items that could be used to describe autistic behaviors better than "depressive-like" or "resistiveness" (on page VI.7.3)?

A: Yes. Along with repetitive body movements, persons with Autism are likely to manifest behaviors that could be coded under Evaluation Element items 35 or 36 (Frequency and Severity of Self-Injurious Behavior), item 44 (Hyperactivity), and item 62 (Expressive Language, especially code 3 for echolalia).

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Items 27a, 28a, 29a Seizures

Q: The Department of Motor Vehicles requires us to report to them any client who drives a vehicle and who has a seizure condition. How does the new CDER form affect that?

A: DMV's reporting requirements should be followed in usual ways. The new CDER does not change or affect those requirements.

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Item 27b, 28b, 29b Seizure Frequency

- Q: How do we code it if a client hasn't had a seizure for more than 2 years, for 10 years, say?
- A: Code it as "1." Code 1 should be used for any client who has a history of seizures but who has not had a seizure for 2 years or more.

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Item 32 Status Epilepticus

Q: Isn't there more up-to-date definitiona material on Status Epilepticus than appears in the CDER Manual?

A: Yes. A June, 1982 article in the New England Journal of Medicine presents three categories of Status Epilepticus, as follows:

"Thus, status epilepticus is presently classified as 1) convulsive status epilepticus, in which the patient does not recover to a normal alert state between repeated tonic-clonic attacks; 2) non-convulsive status epilepticus, such as absence status and complex partial status in which the clinical presentation is a prolonged "twilight" state; or 3) continuous partial seizures or "epilepsia partialis continuans", in which consciousness is preserved."

Ref: Delgado-Escueta, A.V., et al. (1982) "The Management of Status Epilepticus," New England Journal of Medicine, 306, #22: 337.

The article is attached for your information.

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Item 33a - 34b Other Type of Developmental Disability

Q: In the section of the Diagnostic coding under "other handicapping conditions", you have given examples of two conditions which the [regional center] specifically does not accept as clients unless they are eligible for other reasons. One of these examples is spina bifida. To the best of my knowledge (and that of my diagnostic team), spina bifida does not routinely result in a condition similar to mental retardation, nor do [clients with this condition] routinely require treatment similar to the mentally retarded. Because of the frequency with which mental retardation is associated with spina bifida, I think it is an inappropriate example to give in the CDER tool and does imply that spina bifida is by definition an eligible condition. I think that it needs to be eliminated from the Manual.

Another example given in the Manual is Werdning-Hoffman's disease. Werdning-Hoffman's disease, to the best of my knowledge, is a purely physically handicapping condition (a neurological condition) and mental retardation is not routinely associated with it, nor do those persons require treatment similar to the mentally retarded. This example needs to be changed.

A: The basic statement that needs to be made regarding CDER and eligibility issues is that CDER is only a document on which data are recorded for clients found to be eligible for regional center services. Eligibility determination is a separate phenomenon.

The Spina Bifida and Werdning-Hoffman examples in the CDER Manual were only that -- examples. It was assumed that the clients with these conditions would have been found eligible for regional center services through the regional centers' normal review processes and that the clients, accordingly, would "require treatment similar to that required by mentally retarded persons."

There was no intention, in these examples, to imply that either Spina Bifida or Werdning-Hoffman's disease made the clients "by definition" or automatically eligible.

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Item 50a - 53c Mental Disorders

Q: Who is to do the diagnosing of mental disorders? The Manual, page VI.11.2, says the psychologist or psychiatrist.

A: Although diagnoses of mental disorders are most commonly made by psychiatrists or psychologists, the Manual should have stated that other persons are also qualified to make mental disorder diagnoses. Among those "other qualified persons" are those physicians and Licensed Clinical Social Workers who have been trained to do mental disorder diagnoses.

Q: Can we use V codes on DSM III for the mental disorder items?

A: While the "V" codes are included in the computer program for DSM III, we expect that they will NOT be used except in extremely rare instances; we are, therefore, discouraging the use of DSM III (and ICD-9-CM) "V" codes.

Q: We have 318.2 (Profound mental retardation) entered as Axis I in the Mental Disorders section (in an old record). Isn't this duplicating what goes in item 11?

A: Yes. You should NOT enter developmental disabilities diagnoses in the Mental Disorder section. This section is for mental disorders, such as psychotic or other conditions in a client who is "dually diagnosed." Although some developmental disability conditions appear in DSM III, they should not be entered in this section as that would be a duplication of information that appears elsewhere in the CDER Diagnostic Element.

Q: Why wasn't Axis III included on the CDER?

A: The committee thought that even getting accurate Axis I and II diagnoses would be a major accomplishment, so it chose to focus on them. Additionally, Axis III is for medical conditions, and medical issues are addressed in CDER in another section (see items 54a - 59b).

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Items 86 - 94 Special Conditions or Behaviors

Q: Please clarify time-frames for special conditions; why are the time-lines so variable?

A: Items 86, 87 and 94 -- maladaptive sexual behavior, serious assaultive behavior, and fire setting -- were given no time lines because of the seriousness of these behaviors. It would be important to know about such behaviors regardless of when they last occurred.

Other items on the group were given either five-year or three-year limits for reasons related to the severity of the condition or behavior and to "statute of limitations" notions.

If you think these time limits should be different, let us know and we will consider changing the Manual.

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Item 99 Special Legal Conditions, Conservatee Under Probate Court

Q: Does item 99 mean any client with a conservator, or [in developmental centers] does the conservatorship have to be a condition of admission?

A: Item 99 should be coded "yes" for any adult client who has a conservator, regardless of legal "commitment" status. "Voluntary" clients can have either a Probate Court or a LPS conservator, or they may have neither.

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General Questions

Confidentiality

Q: Can we devise systems whereby the regional centers and the developmental centers share more client (diagnostic and assessment) information than they do now, or are there legal reasons why this can't be done? Aren't we all part of the same system?

A: Welfare and Institutions Code ("Lanterman Act") Section 4514 defines confidential information and conditions under which information may be disclosed. Under Section 4514(a) information can be shared "between qualified professionals in the provision of intake, assessment, and services or appropriate referrals. . ." However, client consent is necessary if the information is disclosed to a "professional not employed by the facility who does not have medical responsibility for the care of a person with a developmental disability."

This seems to mean that diagnostic and other assessment information can be sent between developmental/regional centers, as long as the information moves between "qualified professionals," particularly from physician to physician.

We encourage regional centers and developmental centers to share pertinent information on clients, as long as they abide by the provisions of Welfare and Institutions Code, Section 4514.

The text of this entire section is attached.

Q: How is confidentiality going to be handled with the CDER form as Form 3753 (the booklet or packet) does not include a confidentiality statement?

A: The revision of the Diagnostic Element of CDER does not change in any way the confidentiality with which CDER is held. Both the CDER answer sheet and the CDER Profile, which will be generated by the computer, contain confidentiality statements as these are the documents that will be entered into the client's record.

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Data Output: Profiles

- Q: When Profiles are printed with diagnostic and etiological information, how will non-medical personnel know what the information means, so it can be used for IPP-purposes?
- A: Although systems to handle this problem should be worked out at the local level, we would suggest that (1) a person with health care experience and background be designated to review the Profiles; (2) this review takes place as soon as possible after the Profiles are developed; (3) the review identifies those clients whose health care needs are such that they should be considered in developing IPPs; and (4) the designated reviewer discusses these health care issues with the client's case manager both to educate the case managers on the meaning of the health-care terminology that appears on the Profile and to ensure that the implications of the clients' health care needs are understood so that appropriate individual program planning can occur.

Data Output: Rate Level

- Q: If the rate level is not on the Profile, how will the regional center know what the rate level is?
- A: The rate level was downloaded with the regional center CDERs in September. A software program to allow local generation of the rate level will be installed on the System 36s during the month of October.

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Eligibility

Q: (Shouldn't) whatever is put into the CDER Manual as an eligibility description also be reflected in the RCOM [Regional Center Operations Manual] - diagnostic section?

A: No, for two reasons. First, the CDER Manual is not going to contain an "eligibility description." Second, the RCOM - diagnostic Section [Section 5400] does not pertain to the eligibility/lack of eligibility determination that results from diagnostic activity; rather, Section 5400 simply defines diagnosis as a regional center responsibility and outlines of what it consists. There are no plans to revise the Diagnostic section of the RCOM such that it includes a description or definition of eligibility.

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Implementation: Developmental Centers

Q: Can't we devise a system to get the "holding charts" back to the [developmental center] units so that the old information can be reviewed?

A: Rhonda Anderson says the holding charts can be brought back to the unit whenever they are needed, such as prior to annual reviews; call your Client Records Office to have them delivered or to pick them up at a given time. However, they cannot be kept permanently on the unit because (1) most units do not have space, and (2) Client Records is responsible for maintaining them, which it could not do if the charts were kept on the units.

Implementation: Regional Centers

Q: For regional centers implementing only "new clients," who is a new client? Is a person who has been a "high risk" client, and who is determined to be developmentally disabled, considered a "new client"?

A: A "new client" is a client who, on or after October 1, 1986, is:

- (1) a totally new admission,
- (2) a prevention client who is found to be developmentally disabled and who, therefore, is changed on the CMF from status code 1 (at risk infant) to status code 2 (active client), or
- (3) a client who has been "inactive," whether from this regional center or another, and who is re-activated.

Q: What do the regional centers do with the CDERs of clients who enter the system as "new clients" between August 22 and October 1, 1986?

A: As the Memorandum of Understanding between ARCA and DDS states that the new CDER Diagnostic Element (CDER Form DS 3753, 3/86) is to be used after October 1, 1986, it is not mandatory that the revised CDER be used prior to October 1. For clients entering the system between August 22 and October 1, asterisks (***) may be entered in ICD-9-CM fields on the form.

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Training

Q: Can't we train people (physicians, psychologists, licensed clinical social workers) to do proper DSM III diagnoses? Only a few people have been trained recently and many need to be updated.

A: DSM III update training can be provided if there is a real need. We will survey regional centers and developmental centers to determine the extent of the need for this training and plan accordingly.

Q: Will there be another training session for physicians on the new CDER diagnostic?

A: None is contemplated at this time. If physicians have questions that cannot be answered at the local level they should be called into or mailed to Roberta Marlowe, or Mary Lu Hickman, and answers will be given both verbally and in written form.

If, after some experience with the CDER Diagnostic, physicians feel that additional training or group discussion is needed, it will be arranged.

Q: May the regional center physicians borrow the AIMS tapes for their next meeting?

A: Yes. Mary Lu Hickman is making the arrangements to have not only the tapes but also a person from the AIMS project at the next meeting to provide an overview of the AIMS issue.

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Data Output: CRS vs CDER in Developmenta Centers)

Q: How will the developmental centers' Cost Reporting System interface with the CDER file?

A: The developmental centers' Cost Reporting System, (CRS) is being revised. During the revision, attempts will be made to eliminate redundancy among the various electronic data bases at the developmental centers, including the duplication of diagnostic data in the CRS and CDER.

Data Output: "Priority" for Placement (from Developmental Centers

Q: The "priority for placement" system (DCD's 1-10 priorities) doesn't always work very well; ADL scores on that system are not consistent with the client's CDER scores. Is something messed up in the computer program?

A: The priority for placement program uses data directly from the CDER. The priorities are determined using age and specific diagnostic and evaluation items as indicators. In the "ADL" area, only toileting and eating skills are included as these were considered key indicators of self-care ability. Therefore, there may be differences between the full range of self-care abilities as measured by a whole series of CDER items and the "ADL priority" as measured only by eating and toileting. If our assumption of the "key" nature of eating and toileting is not correct, and some other method of indexing self-care ability would be more accurate, please let OPPD know.

Eligibility Determination and CDER: The CDER is not an eligibility-determination document. Decisions about the client's eligibility for services are made separately, by the persons designated by the regional center to make such decisions, and usually prior to completion of the CDER form. CDER is only a document on which data are recorded for clients found to be eligible for regional center services through other mechanisms. The various categories of information included on the CDER form are not intended to define eligibility, either for the system or for individual clients. CDER simply provides a descriptive data base about clients; neither the individual items nor the particular examples of coding that are included in the CDER Manual should be interpreted as guidelines for eligibility decisions.

Etiology: The term "Etiology" on the CDER form refers to those factors that may have contributed to or been associated with the client's developmental disability or medical condition. Recording a factor or condition in an "Etiology" item on CDER is not a statement of definitive causation in any medical-legal sense. These factors or associated conditions are to be used for review and statistical purposes only and do not constitute a diagnostic opinion as to the exact cause of a developmental disability or medical condition.

12a. and 12b. ETIOLOGY OF MENTAL RETARDATION

Items 12a and 12b. are to be used to record the major cause(s) of the client's Mental Retardation. ICD-9-CM codes are to be used.

If the client is not mentally retarded, enter 000.00 in Item 12a and leave Item 12b blank.

If the client is mentally retarded and the cause or contributing factor is known, enter the appropriate ICD-9-CM code in Item 12a; if more than one causal factor is known, record the additional factor in item 12b using the appropriate ICD-9-CM code.

If the ICD-9-CM code is less than five digits, for example 317, leave the remaining digits blank but be sure to justify the number entered in relation to the decimal point.

If the client is mentally retarded but etiological factors are not known, enter code 799.9 in Item 12a and leave Item 12b blank.

27b.-29b. SEIZURE FREQUENCY

These items provide an indication of how often the client experiences seizures and whether the client has experienced seizures in the past. Enter the approximate frequency as listed below for each type of seizure that the client currently experiences or has experienced in the past two years; for example, enter the frequency of seizure disorder in 27b for the seizure type indicated in 27a, the frequency of seizure disorder entered in 28b for the seizure type indicated in 28a, etc.

Seizure Frequency Codes

- 1 History of seizures, none in two years
- 2 History of seizures, none in one year
- 3 One to six per year
- 4 Seven to 11 per year
- 5 One per month (approximate)
- 6 One per week (approximate)
- 7 One per day (approximate)
- 8 More than one per day
- 9 Suspected, frequency undetermined

If the client does not have a seizure disorder, leave these items blank.

OTHER DEVELOPMENTAL DISABILITY

This section is for identifying and recording other conditions that can be considered to be developmental disabilities according to Title 17. "Other" developmental disabilities are those handicapping conditions which are "similar to mental retardation that require treatment similar to that required by mentally retarded individuals."* Treatment is defined as care and management. "Other developmental disability" does not include handicapping conditions that are solely physical in nature

In addition, these handicapping conditions must:

1. occur before age 18;
2. result in a substantial handicap as defined in Title 17;
3. be likely to continue indefinitely; and
4. involve brain damage or dysfunction.

Examples of conditions that might be included in this section, providing all of the above criteria are met, are intracranial neoplasms, degenerative brain disease, and brain damage associated with accidents.

*Title 17, California Administrative Code, Section 54000