GEORGIA DEPARTMENT OF COMMUNITY HEALTH

PART II
Information Manual

TEFRA/KATIE BECKETT DEEMING WAIVER

Division of Medicaid

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I. TEFRA/KATIE BECKETT MEDICAID COVERAGE (ALSO KNOWN AS DEEMING WAIVER)

A. Background

The Department of Community Health (DCH) provides Medicaid benefits under the TEFRA/Katie Beckett Medicaid program as described under §134 of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248). States are allowed, at their option, to make Medicaid benefits available to children (age 18 or under) at home who qualify as disabled individuals under §1614(a) of the Social Security Act, provided certain conditions are met, even though these children would not ordinarily be eligible for Supplemental Security Income (SSI) benefits because of the deeming of parental income or resources. The specific statutory provisions establishing this option are contained in §1902(e) of the Social Security Act.

To establish Medicaid eligibility for a child under this program, it must be determined that:

- If the child was in a medical institution, he/she would be eligible for medical assistance under the State plan for Title XIX;
- The child requires a level of care provided in a hospital, skilled nursing facility, or intermediate care facility (including an intermediate care facility for the mentally retarded);
- It is appropriate to provide the care to the child at home; and
- The estimated cost of caring for the child outside of the institution will not exceed the estimated cost of treating the child within the institution.

The Department reviewed the procedure for determining which children qualify medically for the TEFRA/Katie Beckett coverage in 2003. A sub-committee comprised of legal, clinical and eligibility staff met over several months to revise the criteria used in making the medical necessity and level of care determinations.

In the past, the same medical criteria was used for adults and children. The criteria used to determine a child's eligibility in the program is found in Title 42 Code of Federal Regulations. Medical necessity is **not** based on specific medical diagnoses. The reviewer must review all available medical information to determine whether services are medically necessary. In addition, the reviewer must determine whether the child requires the level of care provided in a hospital, nursing facility, or intermediate care facility (including an intermediate care facility for the mentally retarded). DCH has developed standardized forms to be used in obtaining the information needed for the disability, level of care and cost effectiveness determinations. Georgia Medical Care Foundation (GMCF) the vendor responsible for making the level of care determinations, and the Right From the Start Medicaid (RSM) Centralized Katie Beckett Team are trained on the criteria.

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The Level of Care criteria review guidelines have been revised to reflect more examples of pediatric-specific cases. The Level of Care criteria is used for all Initial applications submitted to GMCF. The Level of Care criteria is also used for the periodic review of medical eligibility. Once the child's records have been reviewed, a Level of Care determination is made by the Katie Beckett Review Team at GMCF. Parents /caregivers will be notified via a Letter of Determination. Information regarding the Right to an Appeal will accompany all Letters of Determination. Parents not satisfied with the determination regarding the level of care have the right to request an Administrative Review or an Administrative Hearing. Refer to Section III regarding the Hearing and Appeals Process.

B. What is TEFRA/"Katie Beckett"?

TEFRA is section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) allowing states to make Medicaid services available to certain disabled children who would not ordinarily be eligible for Supplemental Security Income (SSI) benefits because of their parents' income. Income qualifications for TEFRA/"Katie Beckett" are based solely on the child's income, but a number of different factors are considered for approval. If approved, the same eligibility for health coverage will be available to the child as to other Medicaid members.

1. Eligibility for Medicaid under TEFRA/"Katie Beckett" will only be approved if **ALL** of the following conditions are met:

Rev 07/01/13

- Child is under 18 years of age.
- Child meets the federal criteria for childhood disability.
- Child meets an institutional level of care criteria.
- Even though the child may qualify for institutional care, it is appropriate to care for the child at home.
- The Medicaid cost of caring for the child at home does not exceed the Medicaid cost of appropriate institutional care.

The childhood disability determination is completed by the Georgia Medical Care Foundation Medical Review Team.

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The child must require an institutional level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded as defined in 42 C.F.R. 435.225(b) (1).

The child's physician is required to certify that it is appropriate to provide care for the child in the home setting. The Medicaid cost of caring for the child at home must be less than the cost of caring for the child in an institution. The RSM Katie Beckett (KB) Team will be responsible for the cost-effective determination task.

C. Policy and Procedural Changes

1. No procedural changes were made in the categorical eligibility determination section in 2003.

2. Level of Care Determinations

Rev. 01/01/2011 Georgia Medical Care Foundation (GMCF) determines whether the child requires a level of care (LOC) provided in a hospital, skilled nursing facility, or intermediate care facility (including an intermediate care facility for the mentally retarded) for the TEFRA/Katie Beckett Medical program. The Department developed a new DMA-6 form specifically for children – *Pediatric DMA-6(A), PHYSICIAN'S RECOMMENDATION CONCERNING*
Rev. 01/01/2011 *NURSING FACILITY CARE OR HOSPITAL CARE (Pediatric DMA-6(A)).* HP stocks the form DMA-6(A). The form may be reproduced locally.
The Department is also working on making the form interactive within
Rev. 01/01/2011 the GAMMIS web portal. www.mmis.georgia.gov/portal

To make the LOC determination, the KB Medicaid Specialist must submit a complete packet of documents to GMCF, consisting of the Pediatric DMA-6(A), Medical Necessity/Level of Care Statement, Individualized Family Service Plan (IFSP), Individualized Education Plan (IEP), and Psychological Evaluation, if necessary. These documents must be completed and submitted to GMCF as part of the LOC determination. In most cases, the family will be responsible for submitting this information to the KB Team. However, there may be instances when the KB Medicaid Specialist must assist the family in obtaining the necessary information.

3. Application Requirements for LOC Review

- Pediatric DMA-6(A) Form

  The Pediatric DMA-6(A) form has been developed to appropriately capture pertinent information regarding the medical needs and care of the child. The DMA-6(A) form must be completed in its entirety, signed and dated by the physician and parent prior to being submitted to GMCF. The 30-day period of validity has been changed to 90 days.

  Instructions for completion of the DMA-6(A) form are included in the appendices of this manual. The DMA-6(A) form must be completed at the time of application, and at the annual redetermination of eligibility. Clinical information obtained from the DMA-6(A) is used to determine level of care.

- Medical Necessity/Level of Care Statement

The Medical Necessity/Level of Care Statement form must be completed, signed and dated by the physician and the primary caregiver at a minimum. Other members of the planning team may participate in the completion of this form. The planning team may include, but is not limited to, the child's primary and secondary caregivers, physician, nursing provider, social worker, and therapist(s) (i.e., physical, occupational, speech). A copy of the Medical Necessity/Level of Care Statement is included in the appendices of this manual. A current Medical Necessity/Level of Care Statement plan must be completed at the time of application and at each periodic redetermination of eligibility.

- Psychological Assessment

An evaluation is performed by a licensed certified professional to assess the child's level of intellectual capacity. If the child has a diagnosis or condition that results with cognitive impairment Georgia Medical Care Foundation (GMCF) will request that the caregiver obtain and submit a psychological or developmental assessment. The following diagnoses require a psychological or developmental assessment:

- Cerebral Palsy
- Developmental Delay
- Autism
- Autism-Spectrum Disorder
- Asperger Syndrome
- Pervasive Developmental Disorder
- Mental Retardation
- Epilepsy
- Down's Syndrome, and
- Any diagnoses related to the above listed diagnoses.

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A comprehensive psychological evaluation must be performed and the level of mental retardation with appropriate treatment intervention must be stated. The psychological evaluation must be completed by a licensed professional and is required every three (3) years. Licensed professionals approved to do this testing include Developmental Pediatricians and Ph.D. Psychologists. Psychological evaluations completed by school psychologists with M.Ed., Ed.S. or Ed.D degrees are also accepted. Developmental Evaluations done by Early Interventionist with Babies Can't Wait are accepted for children with an Individualized Family Service Plan (IFSP). Also an IFSP or an Individualized Education Plan (IEP) must be submitted, if in place. All of the above documents and the psychological assessment may be used to determine level of care.

II. INSTITUTIONAL LEVEL OF CARE (LOC) CRITERIA

As provided in 42 C.F.R 435.225(b) (1), the child must require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF/MR).

A. Nursing Facility

1. Nursing facility level of care is appropriate for individuals who do not require hospital care, but who, on a regular basis, require licensed nursing services, rehabilitation services, or other health-related services *ordinarily provided in an institution.* For an individual who has been diagnosed with a mental illness or mental retardation, nursing facility level of care services are usually inappropriate unless that individual's mental health needs are secondary to needs associated with a more acute physical disorder.

2. The criteria set forth herein encompass both "skilled" and "intermediate" levels of care services.

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3. A nursing facility level of care is indicated if all the conditions of Column A or Column B are satisfied. Conditions are derived from 42 C.F.R. 409.31 409.34.

B. Intermediate Care Facility/Mental Retardation (ICF/MR)

1. ICF/MR level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and rehabilitative services to persons with mental retardation or related conditions.

2. An ICF/MR level of care is indicated if one condition of Column A is satisfied in addition to meeting all the conditions Column B and Column C. Conditions are derived from 42 C.F.R. 440.150, 435.1009 and 483.440(a).

C. Hospital

1. Hospital level of care is appropriate for individuals who continuously require the type of care ordinarily provided in an institution for the care and treatment of inpatients with disorders other than mental diseases.

2. A hospital level of care is indicated if all the conditions of Column A, Column B, and Column C are satisfied. Conditions derived from 42 C.F.R 440.10.
3. As derived from 42 C.F.R. 440.10, the child requires the type of care ordinarily furnished in a hospital for the care and treatment of inpatients, other than that for mental diseases, under the direction of a physician or

dentist. Hospital level of care screen: This is a new responsibility as far as Katie Beckett is concerned. GMCF will determine if the clinical information provided meets Pediatric Interqual criteria. The responsibility is identical to the pre-certification process on behalf of adults. The review is to be done at the time of the initial application, and for children who qualified by meeting the hospital level of care, every thirty (30) days thereafter.

D. Level of Care Determination Routing Form

The Level of Care Determination ***Routing Form 705*** must accompany all the child's information and documents submitted to GMCF. It is imperative that identifying information such as Social Security number and Medicaid identification remain consistent whenever communicating with GMCF to ensure adequate tracking for the child's case.

E. Cost-Effectiveness Determination

The estimated Medicaid cost of caring for the child outside the institution must not exceed the estimated Medicaid cost of appropriate institutional care. The Physician's Referral Form has been replaced with the **TEFRA/Katie Beckett Cost-Effectiveness Form-704**. The revised form includes places for the physician to include the estimated cost for therapy(s) and skilled nursing services and will assist the Department in establishing a process for providing the actual cost of services provided to a child that will be used during the periodic redetermination. However, until the process has been established, workers will continue to use the TEFRA/Katie Beckett Cost-Effectiveness Form-704 at the time of initial application and the periodic redetermination of eligibility to complete the cost-effectiveness determination.

Until the Department provides an amount to be used for the hospital level-of-care-cost-effective determination, please have workers submit the completed form DMA-704 to:

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Division of Medicaid
Attention: Policy/Eligibility Unit
Department of Community Health
2 Peachtree Street, NW 39th Floor
Atlanta, GA 30303-3159

A copy of the TEFRA/Katie Beckett LOC Routing Form 705 must be attached when submitting Form DMA-704 to the Department.

The amounts listed below are the averaged amounts to be used for completion of the nursing facility and ICF/MR level-of-care cost-effectiveness determination.

Level-of-Care	**Monthly Amount (average Medicaid rates)**
▪ Skilled Nursing Facility	$4,332.00
▪ ICF/MR	$8,895.00

III. HEARING AND APPEALS PROCESS

Due process rights associated with the denial of admission to the "Katie Beckett" program begin after the level of care assessment and disability assessment by GMCF. Participants in the "Katie Beckett" program are subject to periodic assessments by GMCF. Should the level of care assessment or disability assessment result in the denial of admission/continuation into the Katie Beckett program, GMCF will forward an "Initial Denial of Admission/Continued Stay" to the family (with a copy to the KB Medicaid Specialist). This notice informs the parents of the reason for the denial and their administrative review rights.

The Department offers the opportunity for administrative review to any applicant or recipient against whom it proposes to take an adverse action, unless otherwise authorized by law to take such action without having to do so. Parents may request an administrative review of the level of care assessment and/or the disability assessment within thirty (30) days "Initial Denial of Admission/Continued Stay." The request must include all relevant issues in controversy and must be accompanied by any additional medical information and explanation that the applicant or recipient wishes the Department to consider. The additional documentation will be considered to determine the appropriateness of the initial denial. Georgia Medical Care Foundation personnel should instruct parents to supply the additional documentation to GMCF for consideration during the administrative review process. If the parent fails to request an administrative review or if the parent fails to submit additional documentation, the initial denial will become final on the 30th day after the date of the "Initial Denial of Admission/Continued Stay" notification.

The Georgia Medical Care Foundation must *receive* requests for administrative review within the 30-day time limit. When counting days, allow the parents a two (2) day time period for receipt of the letter. Then, beginning on the third day after the date of the letter, regardless of whether that day is a weekend or holiday, count thirty (30) days. However, if the 30th day falls on a weekend or holiday, the next full business day is counted as the 30th day.

Upon completion of the Administrative Review, GMCF will notify the parents of the results of the review, with a copy to the KB Medicaid Specialist . Should GMCF uphold the initial decision and the family fails to request an administrative review or fails to submit additional documentation, then a "Final Denial of Admission/Continued Stay" letter is sent to the parents with a copy to the KB Medicaid Specialist. This notice informs the parents of the reason for the denial and their hearing rights. The Legal Services Section of DCH must receive a parent's request for a hearing (and continuation of services, if applicable) before an administrative law judge within thirty (30) days of the date of the "Final Denial of Admission/Continued Stay" letter. The hearing request must state the specific reasons for requesting the hearing. Parents must also state whether they would like a continuation of services pending the outcome of the hearing. This option is only available for those members requesting continued stay in the program. However, these members must be cautioned that should the Department prevail, the Department may seek reimbursement for services rendered during the appeals period.

Additionally parents must include a copy of the "Final Denial of Admission/Continued Stay" letter with their hearing request.

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After receiving the hearing request, Legal Services will e-mail a request for documentation to GMCF. Legal Services will also notify the Eligibility Section of a parent's request for a continuation of services. Upon receiving the file from GMCF, Legal Services will prepare the file to be assigned to an attorney and forward the appropriate documentation to the Office of State Administrative Hearings for scheduling. Files submitted to Legal Services must contain, among other things, DMA-6(A), any additional documents submitted during the administrative review process, the initial and final determination letters, the parent's hearing request, the contact information for the KB Medicaid Specialist and the contact information for the GMCF assessor. The GMCF assessor will work with the DCH attorney to prepare for the hearing. If the denial of eligibility issued by the KB Team is solely based upon the level of care determination, the DCH Policy Specialist will be required to testify regarding the denial of eligibility determination. This will prevent the need for two hearings, since the denial of eligibility and the level of care determination are intertwined.

If the administrative review decision is upheld at the hearing, the parents will be notified and a copy will be sent to the KB Medicaid Specialist. The decision will include a ruling on the denial of eligibility, if the denial was based solely upon the level of care determination and/or disability determination. The KB Medicaid Specialist will send notice to parents of the denial of eligibility and close the case. The decision from the Administrative Law Judge will include appeal rights for any party dissatisfied with the decision. If the Administrative Law Judge determines that the level of care criteria and/or disability criteria have been met, a written decision will be forwarded to the parent, with a copy to the KB Medicaid Specialist. At this time, the KB Medicaid Specialist will use the level of care and/or disability determinations with other information to render an eligibility decision.

A denial of eligibility based upon factors not associated with the level of care or disability will create additional due process rights. However these hearings are handled by the Department of Human Services/Right From The Start Medicaid Project and may occur subsequent to or concurrent with the level of care hearings. The timing of these hearings is based upon the timing of the decision on eligibility.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

NOTICE OF YOUR RIGHT TO A HEARING

You have the right to a hearing regarding this decision. To have a hearing, you must ask for one **in writing.** You must send your request for a hearing, along with a copy of the adverse action letter, within **thirty (30) days** of the date of the letter to:

Department of Community Health
Legal Services Section
Two Peachtree Street, NW 40th Floor
Atlanta, Georgia 30303-3159

If you want to maintain your services pending the hearing decision, you must send a written request **before** the date your services change. **If the denial is upheld by a hearing decision, you may be held responsible for the repayment of continued services that were provided during the appeal.**

The Office of State Administrative Hearings will notify you of the time, place and date of your hearing. An Administrative Law Judge will hold the hearing. In the hearing, you may speak for yourself or let a friend or family member to speak for you. You also may ask a lawyer to represent you. You may be able to obtain legal help at no cost. If you desire an attorney to help you, you may call one of the following telephone numbers:

1. **Georgia Legal Services Program**
   1-800-498-9469
   (Statewide legal services, EXCEPT for the counties served by Atlanta Legal Aid)

2. **Georgia Advocacy Office**
   1-800-537-2329
   (Statewide advocacy for persons with disabilities or mental illness)

3. **Atlanta Legal Aid**
   404-377-0701 (DeKalb/Gwinnett counties)
   770-528-2565 (Cobb County)
   404-524-5811 (Fulton County)
   404-669-0233 (So. Fulton/Clayton counties)
   678-376-4545 (Gwinnett County)

4. **State Ombudsman Office**
   1-888-454-5826
   (Nursing Home or Personal Care Home)

504. Medicaid Member Administrative Law Hearings (Fair Hearings)

A. This section does not apply to PeachCare for Kids® members. PeachCare for Kids members should consult Appendix D of Part 1, Policies and Procedures Manual, for the Review and Appeal Process.

B. Children participating in the Georgia Pediatric Program (GAPP) or the TEFRA/Katie Beckett Program shall participate in the administrative review process prior to an Administrative Law Hearing. Parents may request an administrative review within 30 days of the date the initial decision is transmitted to the parent. During the administrative review additional documentation may be considered to determine the appropriateness of the initial decision. Parents will be instructed in the initial decision letter to supply the additional documentation to the appropriate personnel at the Georgia Medical Care Foundation. If the parent fails to submit additional documentation, the initial decision will become final on the 30th day after the date of the initial decision. At the end of the administrative review, the member will be sent a notice of the Department's final decision.

C. Should the Department's decision be adverse to the member, the parent may request a hearing before an Administrative Law Judge. A hearing must be requested in writing. Members must send the request and a copy of the final decision letter, within thirty (30) days of the date that the notice of action was mailed, to the following address:

Georgia Department of Community Health
Legal Services Section
Rev. 01/01/2011 **Division of Medicaid**
2 Peachtree Street, NW 40th Floor
Atlanta, Georgia 30303-3159

D. Members may continue their services during the appeal if they submit a written request for continued services before the date that the services change. If the
Rev. 01/01/2011 Administrative Law Judge rules in favor of the Department, the member may be required to reimburse the Department for the cost of any Medicaid benefits continued during the appeal.

E. The Office of State Administrative Hearings will notify the member of the time, place and date of the hearing.

Rev. 10/01/12

1. When an initial technical denial and a final technical denial have been issued and the parent subsequently fails to respond by requesting a hearing but rather submits the requested information to ***GMCF*** **more** ***than 30 days after the date of the final technical denial,*** GMCF will not accept the additional information. A hearing request must be submitted to DCH Legal Services **within 30 days of the date of the final technical denial** or a new application may be filed for services. If a hearing request is submitted to Legal Services within 30 days of the date of the final technical denial, the request will be processed and the case will be sent to the Office of State Administrative Hearings. Legal Services will assign an attorney to represent the respondent (DCH).

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2. When an initial technical denial and a final technical denial have been issued and the parent then submits the requested information to ***GMCF within 30 days of the date of the final technical denial***, GMCF will not accept the additional information. A hearing request must be submitted to Legal Services *within 30 days of the date of the final technical denial* or a new application may be filed for services. If a hearing request is submitted to Legal Services **within 30 days of the date of the final technical denial**, the request will be processed and the case will be sent to the Office of State Administrative Hearings. Legal Services will assign an attorney to represent the respondent (DCH).

3. If the parent has requested and been granted an extension by the DCH Member Services and Policy Section all appropriate parties will be notified.

Rev. 01/01/07

505. Commissioner's Review for a Member

Should the Administrative Law Judge's decision be adverse to a member, the member may file a written request to the DCH Commissioner for an agency review within thirty (30) days of receipt of the decision.

IV. APPENDICES

TEFRA/Katie Beckett
Level-of-Care and Disability Determination Routing Form/Checklist
Routing Form 705

DATE SENT: _____

TO: **Georgia Medical Care Foundation (GMCF)**
ATTN: TEFRA/Katie Beckett
P.O. Box 105406
Atlanta, GA 30348-5406

FROM: **Katie Beckett Medicaid Team**

Medicaid Specialist's Name: _____ Direct Phone #: _____

Medicaid Specialist's E-mail Address: _____

Medicaid Specialist's Mailing Address: _____

_____

RE: Applicant's Name: _____

Applicant's Address: _____

_____

Applicant's SSN: _____

Parent/Guardian Name: _____

Physician Name: _____

A complete packet must be submitted to GMCF for a review the Level of Care Determination review. A complete packet consists of the following with:

____ DMA-6(A)*
____ TEFRA/Katie Beckett Medical Necessity/Level of Care Statement*
____ Psychological, IQ test or Adaptive Functioning Evaluation -- only required for children with mental retardation or related conditions such as Cerebral Palsy, Epilepsy, Autism, Autism-Spectrum Disorder, Asperger Syndrome, Down's Syndrome, Pervasive Developmental Disorder or other Developmental Delays (required with initial application for ICF/MR determinations and again every three years)
____ IEP or IFSP if one is in effect*
____ Rehab Therapy/Nursing Notes (if applicable)

* Required for all level of care determinations

Type of Program: ☐ Nursing Facility ☐ GAPP ☐ TEFRA/Katie Beckett

PEDIATRIC DMA 6(A)

PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

Section A – Identifying Information

1. Applicant's Name/Address:
Name: _____
Address: _____
_____
DFCS County: _____

2. Medicaid Number: _____

3. Social Security Number

4. Sex Age 4A. Birthdate

5. Primary Care Physician: _____

6. Applicant's Telephone # _____

7. Does guardian think the applicant should be institutionalized? ☐ Yes ☐ No

8. Does child attend school? ☐ Yes ☐ No

9. Date of Medicaid Application _____/_____/_____

Name of Caregiver #1: _____ Name of Caregiver #2: _____

I hereby authorize the physician, facility or other health care provider named herein to disclose protected health information and release the medical records of the applicant/beneficiary to the Georgia Department of Community Health and the Department of Human Services, as may be requested by those agencies, for the purpose of Medicaid eligibility determination. This authorization expires twelve (12) months from the date signed or when revoked by me, whichever comes first.

10. Signature: _____ 11. Date: ____/____/____
(Parent or other Legal Representative)

Section B – Physician's Report and Recommendation

12. History: *(attach additional sheet if needed)*

13. Diagnosis — 1. ICD | 2. ICD | 3. ICD

1) _____ 2) _____ 3) _____
(Add attachment for additional diagnoses)

14. **Medications**

Name	Dosage	Route	Frequency

15. **Diagnostic and Treatment Procedures**

Type	Frequency

16. Treatment Plan **(Attach copy of order sheet if more convenient or other pertinent documents)**

Previous Hospitalizations: _____ Rehabilitative Services: _____ Other Health Services: _____

Hospital Diagnosis: 1) _____ 2) Secondary _____ 3) Other _____

17. Anticipated Dates of Hospitalization: _____

18. Level of Care Recommended: ☐ Hospital ☐ Nursing Facility ☐ IC/MR Facility

19. Type of Recommendation:
☐ Initial
☐ Change Level of Care
☐ Continued Placement

20. Patient Transferred from (check one):
☐ Hospital ☐ Another NF
☐ Private Pay ☐ Lives at home

21. Length of Time Care Needed ____ Months
1) ☐ Permanent
2) ☐ Temporary_____estimated

22. Is patient free of communicable diseases?
☐ Yes ☐ No

23. This patient's condition ☐ could ☐ could not be managed by provision of ☐ Community Care or ☐ Home Health Services

24. Physician's Name (Print): _____

Physician's Address (Print): _____

25. I certify that this patient requires the level of care provided by a nursing facility, IC/MR facility, or hospital

_____ **Physician's Signature**

26. Date signed by Physician ____/____/____

27. Physician's Licensure No. _____

28. Physician's Telephone #: _____

Section C– Evaluation of Nursing Care Needed (check appropriate box only)

29. Nutrition	30. Bowel	31. Cardiopulmonary Status	32. Mobility	33. Behavioral S tatus
☐ Regular ☐ Diabetic Shots ☐ Formula-Special ☐ Tube feeding ☐ N/G-tube/G-tube ☐ Slow Feeder ☐ FTT or Premature ☐ Hyperal ☐ IV Use ☐ Medications/GT ☐ Meds	☐ Age Dependent Incontinence ☐ Incontinent - Age > 3 years ☐ Colostomy ☐ Continent ☐ Other _____	☐ Monitoring ☐ CPAP/Bi-PAP ☐ CP Monitor ☐ Pulse Ox ☐ Vital signs > 2/days ☐ Therapy ☐ Oxygen ☐ Home Vent ☐ Trach ☐ Nebulizer Tx ☐ Suctioning ☐ Chest - Physical Tx ☐ Room Air	☐ Prosthesis ☐ Splints ☐ Unable to ambulate > 18 months old ☐ Wheel chair ☐ Normal	☐ Agitated ☐ Cooperative ☐ Alert ☐ Developmental Delay ☐ Mental Retardation ☐ Behavioral Problems (please describe, if checked) ☐ Suicidal ☐ Hostile
34. Integument System	**35. Urogenital**	**36. Surgery**	**37. Therapy/Visits**	**38. Neurological Status**
☐ Burn Care ☐ Sterile Dressings ☐ Decubiti ☐ Bedridden ☐ Eczema-severe ☐ Normal	☐ Dialysis in home ☐ Ostomy ☐ Incontinent – Age > 3 years ☐ Catheterization ☐ Continent	☐ Level 1 (5 or > surgeries) ☐ Level II (< 5 surgeries) ☐ None	Day care Services ☐ High Tech - 4 or more times per week ☐ Low Tech – 3 or less times per week or MD visits > 4 per month ☐ None	☐ Deaf ☐ Blind ☐ Seizures ☐ Neurological Deficits ☐ Paralysis ☐ Normal

39. Other Therapy Visits	40. Remarks
☐ Five days per week ☐ Less than 5 days per week	

41. Pre-Admission Certification Number: _____ 42.Date Signed ____/____/____

43. Print Name of MD or RN: _____

Signature of MD or RN: _____

DO NOT WRITE BELOW THIS LINE

44. Continued Stay Review Date: _____ Admission Date: _____ Approved for _____ Days or _____ Months

45. Are nursing services, rehabilitative services or other health related services requested ordinarily provided in an institution? ☐ Yes ☐ No	46A. State Authority MH & MR Screening Level I/II Restricted Auth. Code Date 46B. This is not a re-admission for OBRA purposes
47. Hospitalization Precertification ☐ Met ☐ Not Met	Restricted Auth. Code Date

48. Level of Care Recommended by Contractor ☐ Hospital ☐ Nursing Facility ☐ IC/MR Facility

49. Approval Period	50. Signature (Contractor)	51. Date	52. Attachments (Contractor)
	_____	____/____/____	☐ Yes ☐ No

PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

INSTRUCTIONS FOR COMPLETING THE PEDIATRIC CARE FORM DMA-6(A)

It is important that EVERY item on the DMA- 6(A) is answered, even if it is answered as N/A (not applicable). Make sure that the physician or nurse who completes some of the sections is aware of this requirement. The form is only valid for 90 days from the date of the physician's signature. The form should be completed as follows:

Section A - Identifying Information

Section A of the form should be completed by the parent or the legal representative of the Katie Beckett child unless otherwise noted. All reference to "the applicant" means the child for whom Medicaid is being applied for.

Item 1: Applicant's Name/Address
Enter the complete name and address of the applicant including the city and ZIP code. For DFCS County enter the applicant's county of residence.

Item 2: Medicaid Number
To be completed by county staff.

Item 3: Social Security Number
Enter the applicant's nine-digit Social Security number.

Item 4 & 4A: Sex, Age and Birthdate
Enter the applicant's sex, age, and date of birth.

Item 5: Primary Care Physician
Enter the entire name of the applicant's Primary Care Physician.

Item 6: Applicant's Telephone Number
Enter the telephone number, including area code, of the applicant's parent or the legal representative.

Item 7: Does guardian think the applicant should be institutionalized?
If the Katie Beckett applicant were not eligible under this category of Medicaid, would s/he be appropriate for placement in a nursing facility, hospital or institution for the mentally retarded. Check the appropriate box.

Item 8: Does the child attend school?
Check the appropriate box.

Item 9: Date of Medicaid Application
To be completed by county staff.

Fields below Item 9:
Please enter the name of the primary caregiver for the applicant. If a secondary caregiver is available to care for the applicant, include the name of the caregiver.

Read the statement below the name(s) of the caregiver(s) and then;

Item 10: Signature
The parent or legal representative for the applicant should sign the DMA-6 (A) legibly.

Item 11: Date
Please record the date the DMA-6 (A) was signed by the parent or the legal representative.

Section B - Physician's Examination Report and Recommendation
This section must be completed in its entirety by the Katie Beckett child's Primary Care Physician. No item should be left blank unless indicated below.

Item 12: History (Attach additional sheet(s) if needed)
Describe the applicant's medical history (Hospital records may be attached).

Item 13: Diagnosis (~~A~~dd attachment(s) for additional diagnoses)
Describe the primary, secondary, and any third diagnoses relevant to the applicant's condition on the appropriate lines. Please note the ICD code. Depending on the diagnosis, a psychological evaluation may be required. If you have an evaluation conducted within the past three years, include a copy with this packet.

Item 14: Medications (~~A~~dd attachment(s) for additional medication(s))
The name of all medications the applicant is to receive must be listed. Include name of drugs with dosages, routes, and frequencies of administration.

Item 15: Diagnostic and Treatment Procedures
Include all diagnostic or treatment procedures and frequencies.

Item 16: Treatment Plan (Attach copy of order sheet if more convenient or other pertinent documentation)
List previous hospitalization dates, as well as rehabilitative and other health care services the applicant has received or is currently receiving. The hospital admitting diagnoses (primary, secondary, and other diagnoses) and dates of admission and discharge must be recorded. The treatment plan may also include other pertinent documents to assist with the evaluation of the applicant.

Item 17: Anticipated Dates of Hospitalization
List any anticipated dates of hospitalization for the applicant. Enter N/A if not applicable.

Item 18: Level of Care Recommended
Check the correct box for the recommended level of care; hospital, nursing facility, or intermediate care facility for the mentally retarded. If left blank or N/A is entered, it is assumed that the physician does not deem this applicant appropriate for institutional care.

Item 19: Type of Recommendation
Indicate if this is an initial recommendation for services, a change in the member's level of care, or a continued placement review for the member.

Item: 20: Patient Transferred from (Check one)
Indicate if the applicant was transferred from a hospital, private pay, another nursing facility or lives at home.

Item 21: Length of Time Care Needed
Enter the length of time the applicant will require care and services from the Medicaid program. Check the appropriate box for permanent or temporary. If temporary, please provide an estimate of the length of time care will be needed.

Item 22: Is Patient Free of Communicable Diseases?
Check the appropriate box.

Item 23: Alternatives to Nursing Facility Placement
The admitting or attending physician must indicate whether the applicant's condition could or could not be managed by provision of the Community Care or Home Health Care Services Programs. Check in the box corresponding to "could" and either/both the box(es) corresponding to Community Care and/or Home Health Services if either/or both is appropriate. Check the box corresponding to "could not" if neither is appropriate.

Item 24: Physician's Name and Address
Print the admitting or attending physician's name and address in the spaces provided.

Item 25: Certification Statement of the Physician and Signature
The admitting or attending physician must certify that the applicant requires the level of care provided by a nursing facility, hospital, or an intermediate care facility for the mentally retarded. **This must be an original signature; signature stamps are not acceptable.** If the physician does not does not deem this applicant appropriate for institutional care, enter N/A and sign.

Item 26: Date signed by the physician
Enter the date the physician signs the form.

Item 27: Physician's Licensure Number
Enter the attending or admitting physician's license number.

Item 28: Physician's Telephone Number
Enter the attending or admitting physician's telephone number including area code.

Section C - Evaluation of Nursing Care Needed (Check Appropriate boxes only)

This section may be completed by the Katie Beckett child's Primary Care Physician or a registered nurse who is well aware of the child's condition.

Items 29--38: Check **each appropriate box.**

Item 39: Other Therapy Visits
If applicable, check the appropriate box for the number of treatment or therapy sessions per week the applicant receives or needs. Enter N/A, if not applicable.

Item 40: Remarks
Enter additional remarks if needed or "None".

Item 41: Pre-admission Certification Number
Leave this item blank.

Item 42: Date Signed
Enter the date this section of the form is completed.

Item 43: **Print Name of MD or RN/Signature of MD or RN**
The individual completing Section C should print their name legibly and sign the DMA-6 (A).
This must be an original signature; signature stamps are not acceptable.

Do Not Write Below This Line
Items 44 through 52 are completed by Contractor staff only.

TEFRA/Katie Beckett Medical Necessity/Level of Care Statement

Member Name:_____ DOB: _____ SS#_____
Diagnosis: _____
_____

Recommended level of Care:
☐ Nursing facility level of care ☐ Hospital level of care
☐ Level of care required in an Intermediate Care Facility for MR (ICF-MR)

Medical History: (May attach hospital discharge summary or provide narrative):
_____
_____
_____

Current Needs

	None	Description of Skilled Nursing Needs
Cardiovascular:	____	_____
Neurological:	____	_____
Respiratory:	____	_____
Nutrition:	____	_____
Integumentary:	____	_____
Urogenital:	____	_____
Bowel:	____	_____
Endocrine :	____	_____
Immune:	____	_____
Skeletal:	____	_____
Other:	____	_____

Therapy: Speech sessions/wk ____ PT sessions/wk ____ OT sessions/wk ____
(Attach current notes)

Hospitalizations within last 12 months: (Attach most recent hospital discharge summary)
Date: _____ Reason: _____ Duration: _____
Comments: _____
_____

Child in school: _____ Hrs per day _____ Days per wk ___ N/A ____ IEP/IFSP __
Nurse in attendance during school day: _____ N/A ____(Attach most recent month's nursing notes)

Skilled Nursing hours received: Hrs/day _____ N/A _____
I attest that the above information is accurate and this member meets Pediatric Level of Care Criteria and requires the skilled care that is ordinarily provided in a nursing facility, hospital or facililty whose primary purpose is to furnish health and rehabilitative services to persons with mental retardation or related conditions.

Physician's Signature: _____ Date: _____
Primary Caregiver Signature: _____ Date: _____
**** Foster Care Applicants must have the signature of the DFCS representative.**

TEFRA/KATIE BECKETT MEDICAL NECCESSITY/LEVEL OF CARE STATEMENT INSTRUCTIONS FOR COMPLETION

This document provides detailed instructions for completion of the TEFRA/Katie Beckett Medical Necessity/Level of Care Statement. It may be completed by physician and the primary caregiver.

Member (Applicant) Information

Enter the Member's Name, DOB and SS#.

Diagnosis

Enter the Member's primary, secondary, and any third diagnoses relevant to the member's condition.

Level of Care

Check the correct box for the recommended level of care.

Medical History

Provide narrative of member's medical history or attach documents (i.e., hospital discharge summary, etc.)

Current Needs

Check member's current needs and provide description of skilled nursing needs.

Therapy

Include frequency per week of therapies and attach current notes.

Hospitalizations

Attach most recent hospital discharge summary and document date, reason and duration.

School

Enter a check for member's appropriate school attendance and IFSP or IEP plan

Signature

The primary care physician or physician of record must sign and date. The caregiver (parent or guardian) must sign and date. Foster Care members must have the signature of the DFCS representative.

TEFRA/KATIE BECKETT
Cost-Effectiveness Form
(Child's Physician Must Complete Form)

The following information is requested to determine your patient's eligibility for Medicaid:

Patient's Name _____ Medicaid #:_____

Diagnosis: _____

Prognosis: _____

Please provide the estimated **monthly** costs of Medicaid services your patient will need or is seeking from Medicaid for in-home care:

- Physician's services $_____
- Durable medical equipment $_____
- Drugs $_____
- Therapy(s) $_____
- Skilled nursing services $_____
- Other(s)_____ $_____

TOTAL: $_____

Will home care be as good as or better than institutional care? _____Yes _____No

Comments: _____

_____

_____

_____

Physician's Signature: _____

Date: _____

Date

Parent's Name
Address
City, State, Zip

RE: Member Name (SS#«SSN»)

☐ Initial Application ☐ Continued Stay Application

INITIAL DENIAL OF ADMISSION OR CONTINUED SERVICES

Dear Parent/Legal Guardian of Member Name:

To receive TEFRA/Katie Beckett coverage under the Georgia Medicaid program, the child's medical condition must require the level of care provided in a nursing facility or hospital, or if the child is mentally retarded, he/she must meet criteria for placement in an intermediate care facility ("ICFMR"). *See* 42 CFR § 409.33, 435.1010, 440.10 and 440.150.

The Georgia Health Partnership (GHP), agent for the Department of Community Health (DCH), makes the level of care determination based on the information submitted. Member Name does not meet criteria for the TEFRA/Katie Beckett because:

_____ Member Name does not require daily skilled/professional nursing services because his/her condition is not so inherently complex that care cannot be safely and effectively performed by unskilled healthcare personnel as evidenced by documentation submitted which states:

-
-

_____ The child's condition does not meet hospital inpatient-qualifying criteria that necessitates:

_____ nursing interventions every 4-8 hours,
_____ post-critical care or weaning monitoring,
_____ procedures/interventions that require hospitalization/interventions or
_____ IV medications that require hospitalization.

_____ Services for this child are not required 24 hours per day nor are they required to be ordinarily furnished on an inpatient basis which is a requirement of 42 CFR 409.31-409.34 as evidenced by previous documentation.

_____ Rehabilitative services are not required five (5) days per week per documentation Submitted. (This is a requirement of 42 CFR 409.31- 409.34.)

_____ Your child has a diagnosis of mental retardation, cerebral palsy, epilepsy, or a

condition that is closely related to mental retardation, but health and rehabilitative services are not required 24 hours per day nor are they required to be ordinarily furnished on an inpatient basis. (This is a requirement of 42 CFR 440.150, 435.1009 and 483.440(a).)

_____ Other: _____

In accordance with the 42 CFR δ 435.225, your request for long-term care services under the Georgia Medicaid program will be denied unless additional medical information can justify the need for institutional care. Attached is a copy of the Level of Care Criteria used for this determination for your review.

You may obtain a review of this decision by sending additional current detailed clinical information from your child's physician within thirty (30) days from the date of this letter. Please contact the Right From the Start Katie Beckett Team, attending physician, or your original referring agency if you need help with your request. All information must be submitted to the following address:

Georgia Medical Care Foundation
Attention: "TEFRA/Katie Beckett Review Nurse"
P.O. Box 105406
Atlanta, Georgia 30348 (4-digit extension)
Fax number: 678-527-3001

Once the Department has received the additional information, it will be reviewed and a Final Determination Letter will be issued regarding your child's level of care determination.

Sincerely,

_____, BSN, RN
Katie Beckett Review Nurse

cc: _____, Medicaid Specialist
RSM Katie Beckett Team

«Date»

«Parents_Name»
«Address_Line_1»
«City_State_Zip»

RE: «Member_Name» (SS#«SSN»)

FINAL DENIAL OF ADMISSION OR CONTINUED STAY

Dear Parent or Legal Guardian of «Member_Name»:

To receive TEFRA/Katie Beckett coverage care under the Georgia Medicaid program, the child's medical condition must require the level of care provided in a nursing facility or a hospital, or if the child is mentally retarded, he/she must meet criteria for placement in an intermediate care facility ("ICFMR"). *See* 42 CFR § 409.33, 435.1010, 440.10 and 440.150.

The Georgia Medical Care Foundation (GMCF), on behalf of the Georgia Department of Community Health (DCH), Division of Medicaid, has:

- reviewed the **new supplementary medical information submitted by you** or
- not received any additional medical information from you.

This letter is to notify you that based on our **re-evaluation,** the initial decision is being upheld for «Member_Name» because:

_____ The child does not require daily skilled/professional nursing services because his/her condition is not so inherently complex that care cannot be safely and effectively performed by unskilled health care personnel as evidenced by:

_____
_____
_____
_____

_____ The child's condition does not meet hospital inpatient-qualifying criteria which necessitates:

_____ nursing interventions every 4-8 hours,
_____ post critical care or weaning monitoring,
_____ procedures/interventions that require hospitalization/interventions or
_____ IV medications that require hospitalization

_____ Services for this child are not required 24 hours per day nor are they required to be ordinarily furnished on an inpatient basis as evidenced by documentation submitted. (This is a requirement of 42 CFR 409.31-409.34.)

_____ Rehabilitative services are not required five (5) days per week per documentation Submitted. (This is a requirement of 42 CFR 409.31-409.34.)

_____ Your child has a diagnosis of mental retardation, cerebral palsy, epilepsy, or a condition that is closely related to mental retardation, but health and rehabilitative services are not required 24 hours per day nor are they required to be ordinarily furnished on an inpatient basis which is a requirement of 42 CFR 440.150, 435.1009 and 483.440(a).

_____ Other: _____

In accordance with 42 CFR δ 435.225, your request for long-term services under the Georgia Medicaid program is denied. If you disagree with this denial, you may request a fair hearing. To have a hearing, you must ask for one in writing within thirty (30) days of the date of this letter. An explanation of your hearing rights is attached.

If you are currently receiving services, you may also request that the Department maintain your services at the current level pending the outcome of your hearing. If the Administrative Law Judge rules in favor of the Department, the Department will seek reimbursement for services rendered during the appeal period.

If you are challenging the Department's "level of care" determination, please send your written request for hearing to:

Georgia Department of Community Health
Legal Services
2 Peachtree Street, NW 40th Floor
Atlanta, GA 30303-3159

If you want a hearing for any reason other than for the level of care determination, please send your written request to your local KB Team..

Please attach this letter to your request for a hearing.

Finally, if your child's condition changes significantly (i.e., major surgery occurrence, progression/relapse of disease, etc.), you may reapply.

Sincerely,

_____, BSN, RN
Katie Beckett Review Nurse

cc: _____ Medicaid Specialist
«RSM Katie Beckett TeamCounty»

Date

Parents Names
Address
City, State, Zip

RE: Applicant's Name (SS#)

☐ Initial Application ☐ Continued Stay Application

INITIAL TECHNICAL DENIAL OF SERVICES

Dear Parent/Legal Guardian of Applicant's Name:

To receive TEFRA/Katie Beckett coverage under the Georgia Medicaid program, the child's medical condition must require the level of care provided in a nursing facility or hospital or if the child is mentally retarded, he/she must meet criteria for placement in an intermediate care facility ("ICFMR"). *See* 42 CFR § 409.33, 435.1010, 440.10 and 440.150.

The Georgia Medical Care Foundation (GMCF), agent for the Department of Community Health, makes the level of care determination based on the information submitted. Member Name does not meet criteria for the TEFRA/Katie Beckett because**:**

☑ **The physician failed to certify that Member Name requires the level of care provided by a nursing facility, ICF/MR facility, or hospital (see Item 25 of DMA 6(A) form); therefore, Member Name does not meet TEFRA/Katie Beckett criteria; or,**

☑ **You failed to submit all the required documents for review.**
The following documents are missing from the packet:

-

In accordance with the 42 C.F.R. §435.225, your request for long-term care services under the Georgia Medicaid program will be denied unless additional medical information can justify the need for institutional care. For your review, please find attached a copy of the Level of Care Criteria used for this determination.

You may obtain a review of this decision by sending **the required documentation/certification, within thirty (30) days from the date of this letter. Failure to submit the required documentation/certification will result in denial of the application.** Should you need assistance with compiling the required documentation/certification, please contact the Right From the Start Katie Beckett Team, attending physician, or your original referring agency. All information must be submitted to the following address:

Georgia Medical Care Foundation
Attention: "TEFRA/Katie Beckett Review Nurse"
P.O. Box 105406
Suite 750
Atlanta, Georgia 30348 (4-digit extension)
Fax number: 678-527-3001

Once the documentation is received, the Department will review the additional information and issue a Final Determination letter regarding your child's level of care determination.

Sincerely,

_____, BSN, RN
Katie Beckett Review Nurse

cc: _____, Medicaid Specialist
RSM Katie Beckett Team

Date

Parents' Names
Address
City, State Zip

RE: Member name (SS#)

FINAL TECHNICAL DENIAL OF SERVICES

Dear Mr. and Mrs.:

To receive TEFRA/Katie Beckett coverage care under the Georgia Medicaid program, the child's medical condition must require the level of care provided in a nursing facility or a hospital, or if the child is mentally retarded, he/she must meet criteria for placement in an intermediate care facility ("ICFMR"). *See* 42 C.F.R. §§409.33, 435.1010, 440.10 and 440.150.

The Georgia Medical Care Foundation (GMCF) on behalf of the Georgia Department of Community Health (DCH), Division of Medicaid, has **not** received any additional medical information from you. The purpose of this letter is to notify you that, based on our **re-evaluation,** the initial decision denying services for child's name is upheld **because:**

☑ **The physician failed to certify that name requires the level of care provided by a nursing facility, ICF/MR facility, or hospital, therefore, name does not meet TEFRA/Katie Beckett criteria; and,**

☑ **You failed to return the required documentation (a complete packet) within the designated thirty (30)- day time frame as outlined in the previous certified letter sent to you.**

In accordance with 42 C.F.R. §435.225 your request for long-term services under the Georgia Medicaid program is denied. Additionally, as noted in Part I Policies and Procedures (Manual § 508(C)), "…if the parent fails to submit additional documentation, the initial decision will become final on the 30th day after the date of the initial decision." Therefore, this letter is your notice of the Department's final decision.

If you want a hearing for any reason other than for the level of care determination, please send your written request to the Right From the Start Katie Beckett Team.

Sincerely,

_____, BSN, RN
Katie Beckett Review Nurse

cc: _____, Medicaid Specialist
RSM Katie Beckett Team

Date

Parents' Name
Parents' Address
City/State

RE: Child's Name (SS # _____)

☐ Initial Application ☐ Continued Stay Application

INITIAL DETERMINATION APPROVAL LETTER

Dear Mr. and Mrs. _____:

To receive TEFRA/Katie Beckett coverage care under the Georgia Medicaid program, the child's medical condition must require the level of care provided in a nursing facility or a hospital, or if the child is mentally retarded, he/she must meet criteria for placement in an intermediate care facility ("ICFMR"). *See* 42 CFR § 409.33, 435.1010, 440.10 and 440.150.

This letter is to notify you that based on our evaluation, Child's name "level of care" is being **approved** for the TEFRA/Katie Beckett Waiver for one year, effective _____.

Thank you for submitting the additional information so a final determination could be made.

Sincerely,

_____, BSN, RN
Katie Beckett Review Nurse

cc: _____, Medicaid Specialist
RSM Katie Beckett Team

Georgia Medical Care Foundation
P. O. Box 105406
Atlanta, GA 30348Date

Date

Parents' Names
Address
City/State

RE: Child's Name (SS#)

☐ Initial Application ☐ Continued Stay Application

FINAL DETERMINATION APPROVAL LETTER

Dear Mr. and Mrs._____:

To receive TEFRA/Katie Beckett coverage care under the Georgia Medicaid program, the child's medical condition must require the level of care provided in a nursing facility or a hospital, or if the child is mentally retarded, he/she must meet criteria for placement in an intermediate care facility ("ICFMR"). *See* 42 CFR § 409.33, 435.1010, 440.10 and 440.150.

This letter is to notify you that based on our evaluation of the additional information you submitted, child's name "level of care" is being **approved** for the TEFRA/Katie Beckett Waiver for one year, effective _____.

Thank you for submitting the additional information so a final determination could be made.

Sincerely,

_____, MD
Medical Director, Katie Beckett Wavier
Georgia Medical Care Foundation

_____, BSN, RN
Katie Beckett Review Nurse

cc: _____, Medicaid Specialist
RSM Katie Beckett Team

Level of care criteria are based on definitions and guidelines derived from the Federal regulations and are used to assist assessors in evaluating clinical information submitted. Level of care criteria are based on the overall medical condition of the individual and medically necessary services and is not diagnosis specific.

PEDIATRIC

NURSING FACILITY LEVEL OF CARE

Summary:

1. Nursing facility level of care is appropriate for individuals who do not require hospital care, but who, on a regular basis, require licensed nursing services, rehabilitation services, or other health-related services *ordinarily provided in an institution*. With respect to an individual who has a mental illness or mental retardation, nursing facility level of care services are usually inappropriate unless that individual's mental health needs are secondary to needs associated with a more acute physical disorder.
2. The criteria set forth herein encompass both "skilled" and "intermediate" levels of care services.
3. A nursing facility level of care is indicated if the conditions of Column A are satisfied in addition to the conditions of Column B being satisfied. Conditions are derived from 42 C.F.R.409.31– 409.34.
4. Some examples of those cases which may meet Nursing Facility Level of Care Criteria are as follows:
   a. Severely Medical Fragile Child as they may meet the criteria in Column A, 1, and I, 2, b and possibly others under 2 depending on the individual child plus Column B. Examples of children in this category include the child with Spina Bifida who has been hospitalized 3 or more times in the past year for shunt infection/malfunction or Urinary Tract Infections or a child with Poorly Controlled Type I Diabetes requiring hospitalization 3-4 times per year. These are ONLY examples and other cases may qualify in this category.
   b. Child with Cystic Fibrosis if they are receiving oxygen 5-7 days a week intermittently or continuously and/or the child has to be hospitalized 3-4 times per year for Cystic Fibrosis exacerbations which will meet the criteria in Column A, 1, and I, 2, b, j and Column B.
   c. Child with Osteogensis Imperfecta Type 2 and 3. A child with Type 2 has the most severe form which is frequently lethal and the child has numerous fractures with severe bone deformity. Type 3 has bones that fracture easily and possible respiratory problems. This child may meet the criteria in Column A, 1, and 2, b, k and II (possibly a-e) and Column B.
   d. Child who is medically unstable awaiting organ transplant and/or is in post-op period for one year post transplant. This child may meet the criteria in Column A, 1, and I, 2, b, and possibly others under 2 depending on the individual child plus Column B. This child may meet hospital level of care while in hospital for transplant. Once the child is stable post transplant he/she no longer meets nursing facility level of care criteria.
   e. Children born at 26 weeks or less gestation. These children are at high risk of complications due to prematurity and are in the NICU at the beginning of life. These children may meet hospital level of care criteria while hospitalized and nursing facility level of care once discharged. The child may meet multiple criteria in Column A and B depending on the medical needs of the child and may initially be approved for up to six months and then re-evaluated.
   f. Child with Hemophilia: who is receiving IV Factor 8 on a 2-3 times/month schedule; or who has documented antibodies to Factor 8 (high risk for bleeding); or who exhibits chronic joint syndrome or a head bleed which requires an aggressive rehabilitation program. The child may meet multiple criteria in Column A and B depending on the medical needs of the child.
   g. Child with Sickle Cell: who is receiving chronic transfusions of 1-2 per month; or is admitted to the hospital with acute chest syndrome 2 or more times per year; or who is in pain crisis requiring hospitalization 3 or more times per year; or who has had a stroke and is involved in an aggressive rehabilitation program. The child may meet multiple criteria in Column A and B depending on the medical needs of the child.
   h. Child with Spina Bifida: Any child born with meningomyelocele, the most severe form of Spina Bifida, for one year after birth. (All of these children will at least require some surgical correction on the spine, most will require shunting, and most of their complications such as shunt malfunctions will occur in that 1st year). After the first year, any child with myelomeningocele may meet criteria if they have a medically severe combination of impairments documented by their physician which includes at least 4 of the following: (1) shunted hydrocephalus; (2) neurogenic bladder/bowel; (3) requirements for integument (skin) system intervention for a stage 2 or > decubiti (bedsore) by licensed health care workers within last 6 months (4) substantial limitations in physical mobility with at minimum being wheelchair bound; (5) substantial limitations in adaptive functioning as evidenced by a score on a standardized adaptive functioning tool of 2 standard deviations below the norm in 3 or more of any of the following behavior domains: self-care skills, understanding and use of verbal and nonverbal language learning in communication with others, mobility, self-direction, and age-appropriate ability to live without extraordinary assistance; and/or (6) rehabilitation needs/therapeutic activities/exercises performed by licensed personnel 5 times per week. Or after the first year, 3 or more hospitalizations for Spina Bifida related problems (i.e. shunt malfunction, urosepsis, orthopedic surgeries, or urological surgeries) in the preceding year.

COLUMN A	COLUMN B
1. The individual requires service which is so inherently complex that it can be safely and effectively performed only by, or under the supervision of, technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, and speech pathologists or audiologists, **AND** In addition to the condition listed above, one of the following subparts of #2 must be met: **I.** 2. The service is one of the following or similar and is required seven days per week: a. Overall management and evaluation of a care plan for an individual who is totally dependent in all activities of daily living b. Observation and assessment of an individual's changing condition because the documented instability of his or her medical condition is likely to result in complications, or because the documented instability of his or her mental condition is likely to result in suicidal or hostile behavior c. Intravenous or intramuscular injections or intravenous feeding d. Enteral feeding that comprises at least 26 per cent of daily calorie requirements and provides at least 501 milliliters of fluid per day e. Nasopharyngeal or tracheostomy aspiration f. Insertion and sterile irrigation or replacement of uprapubic catheters g. Application of dressings involving prescription medications and aseptic techniques h. Treatment of extensive decubitis ulcers or other widespread skin disorder i.Heat treatments as part of active treatment which requires observation by nurses j.Initial phases of a regimen involving administration of medical gases k. Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment **II.** 3. The service is one of the following or similar and is required five days per week: a. Ongoing assessment of rehabilitation needs and potential: services concurrent with the management of a patient care plan b. Therapeutic exercises and activities performed by PT or OT c. Gait evaluation and training to restore function to a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality d. Range of motion exercises which are part of active treatment of a specific condition which has resulted in a loss of, or restriction of mobility e. Maintenance therapy when specialized knowledge and judgment is needed to design a program based on initial evaluation f. Ultrasound, short-wave, and microwave therapy treatment g. Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool treatment when the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, etc. and specialized knowledge and judgment is required h. Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing **OR** **III** 2. The service is one of the following only if an additional special medical complication requires that it be performed or supervised by technical or professional personnel: a. Administration of routine medications, eye drops, and ointments. b. General maintenance care of colostomy or ileostomy c. Routine services to maintain satisfactory functioning of indwelling bladder catheters d. Changes of dressings for non-infected postoperative or chronic conditions	1. The service needed has been ordered by a physician. 2. The service will be furnished either directly by, or under the supervision of, appropriately licensed personnel. 3. *The beneficiary must require skilled nursing or skilled rehabilitation services, or both, on a daily basis.*

OR	e. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems. f. Routine care of incontinent individuals, including use of diapers and protective sheets g. General maintenance care (e.g. in connections with a plaster cast) h. Use of heat as a palliative and comfort measure (e.g. whirlpool and hydrocollator) i. Routine administration of medical gases after a regimen of therapy has been established j. Assistance in dressing, eating, and toileting k. Periodic turning and positioning of patients. l. General supervision of exercises that were taught to the individual and can be safely performed by the individual including the actual carrying out of maintenance programs.	

INTERMEDIATE CARE FACILITY (ICF/MR) LEVEL OF CARE

Summary:

1. ICF/MR level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and rehabilitative services to persons with mental retardation or related conditions.
2. An ICF/MR level of care is generally indicated if one condition of Column A is satisfied in addition to the conditions Column B and Column C being satisfied. Conditions derived from 42 C.F.R. 440.150, 435.1009, and 483.440(a).
3. Column B refers to "an aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services." These active treatment services, as defined in 42 C.F.R. 483.440, provide aggressive, consistent monitoring, supervision and/or assistance as defined in the plan of care to address the specific medical conditions, developmental and behavioral needs, and/or functional limitations identified in the comprehensive functional assessment. This comprehensive functional assessment must be age appropriate.
4. The following conditions meet ICF/MR institutional level of care criteria, as these individuals would be institutionalized regardless of ability to participate in an aggressive program of specialized and generic training, treatment, health services, and related services as outlined in Column B:
   - Those children with an IQ of 50 or below (moderate to profound mental retardation) or
   - Those children who meet the criteria for Autism, Autism-Spectrum, Asperger's, Pervasive Developmental Disorder, Developmental Delay, Mental Retardation, Down's Syndrome, and any other Developmental Disability as evidenced by:
     i. a score on a standardized adaptive functioning tool of 2 standard deviations below the norm in three or more of any of the following behavior domains: self care skills, understanding and use of verbal and nonverbal language learning in communication with others, mobility, self-direction, and age-appropriate ability to live without extraordinary assistance or an overall standard score < 70, or
     ii. if their age equivalency composite score is less than 50% of their chronological age, and/or
     iii. the child has a Childhood Autism Rating Scale (CARS) score of above 37, a Gilliam Autism Rating Scale (GARS) of 121 or greater, or any other equivalent standardized assessment tool which indicate severe autism.

COLUMN A (Diagnosis)	**COLUMN B (Plan of Care)**	**COLUMN C (Functional Need)**
1. The individual has mental retardation. OR 2. The individual has a severe chronic disability attributable to cerebral palsy or epilepsy. OR 3. The individual has a condition, *other than mental illness*, (i.e. Autism, Autism-spectrum, Asperger's, Pervasive Developmental Disorder, Down's Syndrome or Developmental Delay) which is found to be closely related to mental retardation because it is likely to last indefinitely, and requires similar treatment and services.	On a continuous basis, the individual requires aggressive consistent implementation of a program of specialized and generic training, treatment, health services, and related services which is directed towards- a. The acquisition of the skills necessary for the individual to function with as much self-determination and independence as possible; and b. The prevention of further decline of the current functional status or loss of current optimal functional status. This is evidenced in the Plan of Care by the individual's participation (at least five (5) days a week) in interventions which are required to correct or ameliorate the conditions/diagnosis; and are compatible with acceptable professional practices in light of the condition(s) at the time of treatment.	1. The services have been ordered by a licensed physician. AND 2. The services will be furnished either directly by, or under the supervision of, appropriately qualified providers (see definitions): AND 3. The services, as a practical matter, would have ordinarily been provided in an ICF-MR, in the absence of community services.

COLUMN A (Diagnosis)	COLUMN B (Plan of Care)	COLUMN C (Functional Need)
AND 4. The impairment for those conditions outlined above constitutes an impairment of general intellectual functioning, and results in substantial limitations in three or more of the following functional limitations: • Self-care skills such as feeding, toileting, dressing and bathing; • Understanding and use of verbal and nonverbal language learning in communication with others; • Mobility; • Self-direction in managing one's social and personal life and the ability to make decisions necessary to protect one's self as per age-appropriate ability; and/or • Age-appropriate ability to live without extraordinary assistance.	Active treatment does not include: • interventions that address age-appropriate limitations; or • general supervision of children whose age is such that supervision is required by all children of the same age or • physical assistance for persons who are unable to physically perform tasks but who understand the process needed to do them	

Revised 3/3/06

HOSPITAL LEVEL OF CARE

Summary:

1. Hospital level of care is appropriate for individuals who continuously require the type of care ordinarily provided in an institution for the care and treatment of inpatients with disorders other than mental diseases.
2. A hospital level of care is indicated if the conditions of Column A, Column B, and Column C are satisfied. Conditions derived from 42 C.F.R 440.10.

COLUMN A	COLUMN B	COLUMN C
1. The individual has a condition for which room, board, and professional services furnished under the direction of a physician or dentist is expected to be medically necessary for a period of 48 hours or longer. 2. The professional services needed are something other than nursing facility and ICF/MR services.	The individual's condition meets inpatient level of care.	1. The service needed has been ordered by a physician or dentist. 2. The service will be furnished either directly by, or under the supervision of, a physician or dentist. 3. The service is ordinarily furnished, as a practical matter, in an appropriately licensed institution for the care and treatment of patients with disorders other than mental diseases.