TRANSMITTAL LETTER FOR MANUAL RELEASES

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BENEFICIARY SERVICES ADMINISTRATION
DIVISION OF ELIGIBILITY POLICY
201 WEST PRESTON STREET L-9
BALTIMORE, MARYLAND 21201

410-767-1463 or 1-800-492-5231 option 2 and request extension 1463

MANUAL: Model Waiver for Adults With Traumatic Brain Injury Eligibility Manual

EFFECTIVE DATE: February 2007

RELEASE NO: MR-02

ISSUED: January 2007

APPLICABILITY: TBI Waiver Applicants and Recipients

Item	Remove Pages	Insert Pages
DHMH/TBI 06 Notice of Ineligibility Form	DHMH/TBI 06 Form	DHMH/TBI 06 Form
DHMH/TBI 08 Notice of Closing Form	DHMH/TBI 08 Form	DHMH/TBI 08 Form

Place this transmittal letter in the front of your eligibility manual.

COMMENTS

The main purpose of this manual release is to replace all references to Delmarva in the notices and letters section in the TBI Eligibility Manual, with the term "utilization control agent." As of February 1st 2007 the Keystone Peer Review Organization (KePRO) is replacing Delmarva as the utilization control agent for the Maryland Department of Health and Mental Hygiene.

As of February 1, 2007, all documentation, copies, faxes and telephone inquires pertinent to the utilization control agent should be directed to:

KePRO
Executive Plaza II
11350 McCormick Road
Suite 102
Hunt Valley, MD 21031
Phone: 866-581-6773
Acute Care Fax: 866-581-6771
Long Term Care/Community Services Fax: 866-581-6769
E-mail: Maryland@KePRO.org
Website: http://dhmh.kepro.org/default.aspx

The latest appeal rights are also attached to the notices.

Division of Eligibility Waiver Services (DEWS)
Schaefer Tower
6 St. Paul Street, Suite 306
Baltimore, Maryland 21202

Date: _____
MA No._____

Participant
Participant Address
Participant City, State, Zip Code

Dear _____:

The Department of Health and Mental Hygiene has reviewed your application received on _____ and has determined that you **are not** eligible to receive Medical Assistance (Medicaid) services under the Waiver for Adults with Traumatic Brain Injury (TBI). This determination is based on the following reasons as determined by the Mental Hygiene Administration (MHA) and the Division of Eligibility Waiver Services (DEWS):

Medicaid Eligibility (financial and technical)

❑ 1. You do not meet the Medicaid eligibility requirements under:
- ❑ a. Medicaid eligibility rules at COMAR 10.09.24
- ❑ b. TBI eligibility rules at COMAR 10.09.46.02

See the attached notice for the reason(s):
- ❑ Notice of Ineligibility: Transfer Penalty (DHMH/ TBI 05)
- ❑ Notice of Ineligibility: Financial Reasons (DHMH/ TBI 07)

- ❑ Other reason(s):_____

❑ 2. You did not provide the information necessary to complete your Medicaid eligibility determination. The information required is:

_____
_____
_____

If you send in this information before _____, you will not have to file another application form. This agency will re-activate your original application and determine your Medicaid eligibility for the TBI Waiver.

Medical Eligibility

❑ 3. You are not medically eligible for the TBI Waiver because the Medicaid Program's utilization control agent found that you do not need nursing facility or special hospital level of care. (COMAR 10.09.46.03A)

Client Name on Page One _____

Technical Eligibility

❑ 4. You have not been diagnosed a qualified physician with a type of traumatic brain injury included under this waiver program. (COMAR 10.09.46.03B(2))

❑ 5. You are not between 22 and 64 years old at the time of initial admission to the waiver. (COMAR 10.09.46.03B(1))

❑ 6. You were younger than 22 years old when the initial traumatic brain injury occurred. (COMAR 10.09.46.03B(3))

❑ 7. At the time of application for the waiver, you were not receiving care in a:
a. State psychiatric hospital that is determined to be inappropriate because you do not need that level of care;
b. Traumatic brain injury community placement funded by the MHA with all-State funds; or
c. Nursing facility owned and operated by the State of Maryland or an out-of-State rehabilitation institution funded by Maryland Medical Assistance. (COMAR 10.09.46.03B(4))

❑ 8. You are not clinically appropriate to be served in the waiver. (COMAR 10.09.46.03B(6))
Comments: _____
_____

❑ 9. You are presently enrolled and choose to remain in:
- ❑ a. Another Medicaid 1915 (c) home and community-based services waiver
  Specify: _____
- ❑ b. Program of All-Inclusive Care for the Elderly (PACE) (COMAR 10.09.46.03B(5))

❑ 10. The Mental Hygiene Administration could not approve a waiver plan of care for the following reason(s):
a. The plan of care was not approved by all members of the multidisciplinary team.
   Explain: _____
b. The plan of care does not include any waiver services.
c. A plan of care cannot be developed to serve you safely in the community. (COMAR 10.09.46.03B(6))
   Explain: _____
d. Other: _____

❑ 11. Individual cost-neutrality cannot be met: It would cost more to provide waiver and other Medicaid services to you in the community than the alternative institutional placement. (COMAR 10.09.46.03B(8))

❑ 12. You or your authorized representative did not choose in the Freedom of Choice document to receive TBI Waiver services as an alternative to nursing facility or special hospital care. (COMAR 10.09.46.03B(7))

❑ 13. Your Medical Assistance application expired after 6 months. (COMAR 10.09.24.04)

❑ 14. Other reason(s)_____
Additional Comments:_____

Client Name on Page One _____

This decision is based on COMAR 10.09.24 and COMAR 10.09.46. Please be advised that this decision does not affect your current or potential eligibility for other Medical Assistance benefits. If you have questions concerning items 1 and 2 in this letter, contact your eligibility technician at the number below. If you have questions regarding items 3 through 14 in this letter, please call the Mental Hygiene Administration at (410) 402-8476. You may reapply at any time.

You or your authorized representative may appeal this decision to the Office of Administrative Hearings, pursuant to COMAR 10.01.04, within ninety (90) days of the date on this notice. Further details about the appeals process are attached. Mail your request for a hearing to the following address:

Department of Health and Mental Hygiene
Office of Health Services
Attention: Appeals
201 W. Preston Street, 1st Floor
Baltimore, Maryland 21201

Sincerely,

_____
Eligibility Technician
Division of Eligibility Waiver Services

_____
Telephone

cc: Authorized Representative
DHMH Mental Hygiene Administration
DHMH Division of Waiver Programs
DHMH Office of Access, Quality, and Program Integrity

See next page for information about Fair Hearings

Summary of Procedures for Fair Hearings

You have the right to appeal this decision within 90 days from the date of the notice. **Your request must be made in writing. Please include the specific reason(s) for your appeal and a copy of the denial letter that accompanies this notice. If you wish, someone may assist you in filing your appeal.**

Mail your request for a hearing to the following address:
Department of Health and Mental Hygiene
Office of Health Services
Attention: Appeals
201 W. Preston Street, 1st Floor
Baltimore, Maryland 21201

If you are presently receiving benefits, you must request a fair hearing within 10 days from the date of this notice of agency determination or by the effective date of the termination of benefits, whichever is later, to insure continuation of your services until the fair hearing decision is made. However, if the judge agrees with us and you lose your appeal, you may have to pay back benefits received while you waited for the hearing and judge's decision. This recovery might not be required if it is determined that your request for a hearing resulted from a bona fide belief that the Department's decision was in error.

The hearing will be scheduled at a time and place that are convenient for you. You will be expected to be present. If for any reason you cannot be present, you must notify the Office of Administrative Hearings to reschedule the hearing or you must identify the person who will attend in your place. You may represent yourself, or if you wish, you may be represented by legal counsel or by a relative, friend or other person. It is not necessary, however, that someone represent you. You may bring any witnesses or documents you desire to help you establish pertinent facts and to explain your circumstances. A reasonable number of persons from the general public may be admitted to the hearing if you desire.

Prior to the hearing, you may review the documents and records that the Department will use at the time of the hearing and you can ask for the names of the witnesses the Department intends to call.

During the time before the hearing, if you have new or additional information you wish the Department to know about, you may request a reconsideration of your case by calling your resource coordinator, service coordinator, case manager or waiver eligibility case worker**.**

Under some circumstances, the Department may pay for transportation and other costs if they are necessary for the proper conduct of the hearing.

All these procedures and a fuller explanation of the fair hearing process can be found in the Code of Maryland Regulations (COMAR), 10.01.04, 10.09.24.12, 10.09.24.13, and 10.09.24.15 and in the Code of Federal Regulations (C.F.R.), 42 C.F.R. § 431.200.

You may obtain free legal aid and help through various resources, such as the Legal Aid Bureau at 1-800-999-8904 or the Maryland Disability Law Center at 1-800-233-7201.

Division of Eligibility Waiver Services (DEWS)
Schaefer Tower
6 St. Paul Street, Suite 306
Baltimore, Maryland 21201

Date: _____
MA No: _____

Participant
Participant Address
Participant City, State, Zip code

Dear _____:

It has been determined that you are **no longer eligible** for the **Waiver for Adults with Traumatic Brain Injury** (TBI).

Your eligibility for TBI Waiver services ends as of _____.

Your eligibility for Medical Assistance (Medicaid):

- ❑ Ends as of _____
- ❑ Remains active.

This determination is based on the following reasons as determined by the Mental Hygiene Administration (MHA) and the Division of Eligibility Waiver Services (DEWS):

Medicaid Eligibility (financial and technical)

❑ 1. You no longer meet the Medicaid eligibility requirements under:
- ❑ a. Medicaid eligibility rules at COMAR 10.09.24
- ❑ b. TBI eligibility rules at COMAR 10.09.46.

- ❑ See the attached Notice of Closing: Financial Reasons (DHMH/TBI 09) for the reason(s).
- ❑ Other reason(s):_____

❑ 2. You failed to complete the redetermination process. Your eligibility will be considered and may be re-established without a gap in coverage if you file the redetermination package or a new application with your eligibility technician by _____.

❑ 3. You failed to provide the requested information needed to determine your continued Medicaid eligibility. The information required is:

_____
_____
_____

If you send in this information before _____, you will not have to file another redetermination application. This agency will re-activate your original redetermination application and determine your continued Medicaid eligibility for the TBI Waiver.

Client Name on Page One _____

Medical Eligibility

❑ 4. You are not medically eligible for the TBI Waiver because the Medicaid Program's utilization control agent found that you do not need nursing facility or special hospital level of care. (COMAR 10.09.46.03A).

Technical Waiver Eligibility

❑ 5. You have not been diagnosed with a required type of traumatic brain injury by a qualified physician. (COMAR 10.09.46.03B(2))

❑ 6. You have chosen to disenroll from the TBI Waiver to enroll in:
- ❑ a. Another Medicaid 1915 (c) home and community-based services waiver
  Specify: _____
- ❑ b. Program of All-Inclusive Care for the Elderly (PACE)

(COMAR 10.09.46.03B(5))
If you still wish to participate in the TBI Waiver, you or your authorized representative should contact the other program and the Mental Hygiene Administration.

❑ 7. You are not clinically appropriate to be served in the waiver.
(COMAR 10.09.46.03B(6))
Comments: _____

❑ 8. The Mental Hygiene Administration could not approve a waiver plan of care for the following reason(s):

a. The plan of care was not approved by all members of the multidisciplinary team.
Explain: _____

b. The plan of care does not include any waiver services.

b. A plan of care cannot be developed to serve you safely in the community.
(COMAR 10.09.46.03B(6))
Explain: _____

d. Other: _____

❑ 9. You or your authorized representative chose to stop receiving TBI Waiver services as an alternative to nursing facility or special hospital care. (COMAR 10.09.46.03B(7)).
- ❑ You or your authorized representative asked that you be disenrolled from the waiver.
- ❑ You have been admitted to a long-term care facility for a stay longer than 30 days, so you can no longer receive waiver services.

❑ 10. Individual cost-neutrality cannot be met: It would cost more to provide waiver and other Medicaid services to you in the community than the alternative institutional placement.
(COMAR 10.09.46.03B(8))

❑ 11. Other reason(s)_____

Additional Comments: _____

Client Name on Page One _____

This decision is based on COMAR 10.09.24 and COMAR 10.09.46. Please be advised that this decision does not affect your current or potential eligibility for other Medical Assistance benefits. If you have questions concerning items 1 through 3 in this letter, contact your eligibility technician at the number below. If you have questions regarding items 4 through 11 in this letter, please call the Mental Hygiene Administration at (410) 402-8476. You may reapply at any time.

You or your authorized representative may appeal this decision to the Office of Administrative Hearings, pursuant to COMAR 10.01.04, within ninety (90) days of the date on this notice. If you are presently receiving benefits, you must request a fair hearing within 10 days from the date of this notice of agency determination or by the effective date of the termination of benefits, whichever is later, to insure continuation of your services until the fair hearing decision is made. Further details about the appeals process are attached. Mail your request for a hearing to the following address:

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Attention: Appeals
201 W. Preston Street, 1st Floor
Baltimore, Maryland 21201

Sincerely,

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Eligibility Technician
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Prior to the hearing, you may review the documents and records that the Department will use at the time of the hearing and you can ask for the names of the witnesses the Department intends to call.

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