

SECTION
ELIGIBILITY FOR SERVICES

SUBJECT
Termination of Services / Adverse Actions

The Department will provide written notice to applicants and individuals at least ten working days before the date of an adverse action. (Refer to SDMI HCBS 205)

The Case Management Team (CMT) issues a Letter of Notification, form DPHHS-AMDD-144, (Refer to SDMI HCBS 899-18) to provide notification of adverse action for all reasons except terminations and denials based on level of care for which the Mountain-Pacific Quality Health completes the DPHHS- AMDD - 61 (Refer to SDMI HCBS 599-1). The Office of Human Services will issue adverse actions resulting from Medicaid financial ineligibility. However, individuals receiving Medically Needy Medicaid may not receive notice for up to 90 days, so a DPHHS-AMDD - 144 is required. The DPHHS-AMDD-144 and DPHHS-AMDD-61 tell the individual how to request a fair hearing. The CMT must mail the notice at least ten working days before the date of the action.

CIRCUMSTANCES THAT REQUIRE AN DPHHS-AMDD-144 WITH ADVANCED WRITTEN NOTICE

The CMT must send advance written notice of adverse action when Home and Community Based Services (HCBS) are denied or terminated for any of the following reasons:

1. Discharge of a medically needy individual from HCBS;
2. Termination due to lack of HCBS program funds. The Department will provide at least 30 day notice before any termination of services due to insufficient program funds;
3. The plan of care costs exceed the maximum limit; or
4. Termination of HCBS for other reasons. In this instance, the CMT completes the DPHHS-AMDD-144 with concurrence from the CPO and indicates reasons for termination.

EXCEPTIONS FROM ADVANCE NOTICE

Terminations for the reasons listed below do not require advance notice, but still require the AMDD-144:

1. The individual is admitted to a nursing facility, hospital, intermediate care facility for the mentally retarded (ICF/MR), or institution for mental disease (IMD); or
2. The individual requests in writing that services be terminated or refuses to sign the Person-Centered Recovery Plan.
3. Discharge of a medically needy individual from HCBS because of failure to pay incurment.

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DO NOT COMPLETE AN AMDD-144 WHEN THE INDIVIDUAL DIES. The effective date of HCBS discharge is the date of death.

ADMISSION TO A NURSING FACILITY, TRANSITIONAL CARE UNIT (TCU), ICF-MR, OR IMD

If the individual is admitted to a nursing facility, transitional care unit, ICF-MR or IMD, the individual must be discharged from the Home and Community Based Services (HCBS) program effective the day of admission to the facility. If the individual is an inpatient in a hospital prior to the nursing facility admission, the effective date of HCBS discharge is the first day of hospitalization.

A CMT may elect to hold the slot open and re-enroll the individual at a later date. The Department considers the decision to leave the slot vacant to be an internal decision on the part of the CMT. No Medicaid payment for HCBS is allowed for those days. (Refer to re-enrollment process in this section on page 3.)

ADMISSION TO A HOSPITAL

If an individual is admitted to a hospital, no payment for HCBS can be made during the individual's hospitalization period however, it is permissible for the team to bill for case management and other services provided on the day of hospital admission and the day of hospital discharge **if** the individual returns to HCBS. If the individual remains in the hospital for more than 30 days, the CMT must discharge the individual from HCBS. The discharge date should be the date of admission to the hospital.

Services (e.g., homemaker) that need to be provided to assist the individual to return home can be arranged and completed prior to the individual's discharge from the hospital, but must not be billed until the individual returns home. CMS has determined the discharge date to be the date services become available to the individual.

When the individual is unable to return to his/her residence (e.g., death or alternate placement), payment for services provided prior to hospital discharge can be reimbursed by Medicaid. However, the CMT must have completed a Person-Centered Recovery Plan form (DPHHS-AMDD-135) or Person-Centered Recovery Plan Short form (DPHHS-AMDD-135B) prior to the commencement of such services for reimbursement to be approved.

TEMPORARY ABSENCES

The individual can be temporarily absent from home for up to 30 days for vacations, visits, and to receive outpatient medical care and continue to receive HCBS. In order for the CMT to bill during a period of temporary absence, the following conditions must be met:

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1. There must be a plan for the individual to return home; and
2. The record must document that case management continued to be provided during the individual's absence (e.g., telephone contacts to check on the individual's progress, etc.).

If the individual does not return within 30 days, the individual must be discharged from SDMI HCBS on day 31.

EXTENDED ABSENCE

Occasionally an individual may require an absence of more than 30 days but still plans to return to HCBS. The CMT may elect to hold the slot open and re-enroll the individual upon return. The department considers the decision to leave the slot vacant to be an internal decision on the part of the CMT. No Medicaid payment for HCBS is allowed in these instances.

DISCHARGE PROCEDURE

The CMT must do discharge planning for individuals who will be terminated from services and complete the Discharge Sheet, refer to HCBS 899-13 (form DPHHS-AMDD-137). A discharge notification must be sent to all appropriate individuals involved in the case including the health care professional, and service providers. The CMT must send a DPHHS-DD/SLTC/AMDD-55 form to the Office of Human Services Eligibility Staff (Refer to SDMI HCBS 899-6).

RE-ENROLLMENT

If an individual has been discharged from HCBS due to a short term admission to a hospital, nursing facility, ICF-MR or IMD or an extended absence and the CMT is holding the individual's slot open, or if there has been a significant change in the individual's condition, the CMT is required to complete a new Person-Centered Recovery Plan with a new service plan date span. An Intake Sheet (DPHHS AMDD-33-001) must be faxed to the Mountain Pacific Quality Health, a DPHHS-DD/SLTC/AMDD-55 form sent to the Office of Public Assistance. A Request for Level of Care form (DPHHS-AMDD-85) must be submitted to the MPQH if the previous level of care screening is over a year old or there has been a significant change in the individual's condition.

