

Via USPS

[Date]

Georgia Department of Community Health  
Legal Services, Floor #18  
2 Martin Luther King Jr. Drive, SE  
Atlanta, Georgia 30334

**RE: [Child's Name]; MEDICAID ID: if applicable**  
**Request for fair hearing regarding denial of TEFRA/KATIE BECKETT**  
**eligibility**

I am parent and legal guardian of [child's name]. I disagree with the [date listed on denial letter] letter wherein the state determined [child's name] does not qualify for Medicaid coverage through Katie Beckett Medicaid eligibility criteria. Accordingly, we hereby request a fair hearing in this matter.

If you have any questions, please feel free to contact me at [your phone number] or [your email]. Thank you in advance.

Thank you,

[Your Name]  
Legal Guardian  
[Your address]



Date: 06/15/2025

Legal Guardian of BRETT YATES  
604 SHIPLEY AVE,  
GROVETOWN, GA 30813-4248

## TEFRA/KATIE BECKETT INITIAL DETERMINATION LETTER

Level of Care Denial (LOC)  Technical Denial

MEMBER NAME: BRETT YATES  
MEDICAID ID: 222119697459  
PA ID: 125050501578

Dear Parent/Legal Guardian:

To receive TEFRA/Katie Beckett coverage under the Georgia Medicaid Program, the child's medical condition must require the level of care (LOC) provided in a nursing facility, hospital, or if the child is intellectually disabled, he/she must meet criteria for placement in an intermediate care facility ("ICF/ID"). See 42 C.F.R. 9435.225(b)(1); 409.31-409.34; 440.150; 435.1010; 483.440(a) and 440.10.

Alliant Health Solutions, on behalf of the Department of Community Health (DCH), makes the level of care determination based on the documentation submitted. The child's name listed above does not meet criteria for the TEFRA/Katie Beckett Class of Eligibility for the following reasons:

Applicant does not meet the criteria of:

- o Nursing Facility LOC - 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.
- o ICF/ID LOC - ICF/ID 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 an intellectual disability or related conditions.
- o Hospital LOC - 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.

Rehabilitative services are not required five (5) days per week or skilled nursing services seven (7) days per week per the documentation submitted which is a requirement of 42 C.F.R. 409.31-409.34

This child has a diagnosis of intellectual disability, or a condition that is closely related to intellectual disability, but the psychological/developmental evaluation scores do not meet the Level of Care criteria. This is a requirement of 42 C.F.R. 440.150, 435.1010 and 483.440(a).

Reviewer Comments: Rehab therapies are not ordered or in place at least five times per week. The psychological evaluation scores submitted do not meet criteria for institutional level of care. Please see the level of care criteria attached for more information.

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 for the LOC denial can justify the need for institutional care. Attached is a copy of the Level of Care Criteria used for this determination of your review. Likewise, if the determination was a technical denial, all missing information must be submitted in order to make a level of care determination.

If you disagree with this initial determination, you may request a Reconsideration Review or request a hearing. You may obtain a Reconsideration Review by one of two ways:

1. An electronic request with new medical information can be submitted by navigating to <https://bit.ly/AHSReconsideration> and following these instructions:
  - a. Click on link Request for Reconsideration of Decision
  - b. Enter Prior Authorization Number found at the beginning of this letter
  - c. Enter contact information, message for reviewer, and click "submit"
  - d. After submitting a request, parent/legal guardian will be given the opportunity to upload an attachment by clicking on "choose file" and selecting appropriate file from device.
  - e. Once attachment is selected from device, click "attach file"
  - f. Parent/guardian will receive an email notification when the request has been received by Alliant Health Solutions (from [noreply@allianthealth.org](mailto:noreply@allianthealth.org)). It may go into a spam folder.
2. A written request with new medical information from your child's physician can be mailed within thirty (30) calendar days of the date of this letter to:

Alliant Health Solutions  
Attention: TEFRA/Katie Beckett Review Nurse  
PO Box 105406  
Atlanta, Georgia 30348  
Fax Number: 678-527-3001

Please contact the Right from the Start Katie Beckett Team, attending physician, or your original referring agency if you need help with your request. 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.

If additional medical information is not received within thirty (30) calendar days from the date of this letter, the decision will become FINAL. You do not lose your right to a fair hearing if you choose to have a Reconsideration Review completed. You have thirty (30) calendar days from the date of this letter to request a hearing in writing to the following address:

Legal Services, Floor #18  
2 Martin Luther King Jr. Drive, SE  
Atlanta, Georgia 30334

Sincerely,  
TEFRA/Katie Beckett Review Team

## PEDIATRIC NURSING FACILITY LEVEL OF CARE

Level of care criteria are based on definitions and guidelines derived from the Federal regulations in 42 C.F.R. 409.31-409.34, 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 the medically necessary services required. Level of care is not diagnosis specific.

### Summary:

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 intellectual disability, 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.

A nursing facility level of care is indicated if all of the following conditions are met. Services in an educational setting must meet these same conditions.

1. The service(s) has been order by a physician;
2. The service(s) will be furnished either directly by, or under the direct supervision of, appropriately licensed personnel;
3. The individual requires service(s) which are 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, occupational therapists, speech pathologists or audiologists; and autism service qualified health care providers; and
4. The individual requires either skilled nursing services seven days per week or skilled rehabilitation services at least five days per week.

## HOSPITAL LEVEL OF CARE

Level of care criteria are based on definition and guidelines derived from the Federal regulations 42 C.F.R. 440.10 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.

### Summary:

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.

A hospital level of care is indicated if the conditions are met:

1. The service needed has been ordered by a physician or dentist;
2. The service will be furnished either directly by, or under the direct supervision of, a physician or dentist;
3. The individual's condition meets inpatient level of care;
4. 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.

## INTERMEDIATE CARE FACILITY (ICF/ID) LEVEL OF CARE

Level of care criteria are based on definitions and guidelines derived from the Federal regulations, 42 C.F.R. 440.150, 435.1009, and 483.440(a) 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 the medically necessary service required and is not diagnosis specific.

### Summary:

ICF/ID 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 intellectual disabilities or related conditions.

An ICF/ID level of care is generally indicated if any of the following conditions are met:

1. The child has an IQ of 70 or below (moderate to profound intellectual disability); or
2. The child has a standard score of 70 or below in at least three of the five domains of function (cognitive, language, motor, social-emotional, and adaptive) on a standardized developmental assessment tool or an overall standard score of 70 or below; or
3. The child has a standard score of 70 or below in at least three domains of function on a standardized adaptive functioning assessment tool or an overall composite score of 70 or below; or
4. The child's Childhood Autism Rating Scale (CARS) score is 37 or greater, or the Gilliam Autism Rating Scale (GARS) is 101 or greater.

Note: An age appropriate, comprehensive functional assessment is required at least every three years. For children 0-5 years of age, a comprehensive developmental evaluation is required. For children 6-18 years of age, a comprehensive psychological evaluation is required.

## Favors Review

- A. Should the Division deny a provider's request for prior approval of a covered service that (as defined in the "Definitions" section of this Manual) is not medically necessary, the member or through their provider may request within thirty (30) days an administrative review of the initial decision (Providers see §505 of this Chapter). If the Division denies the provider's request for administrative review or if the provider fails to submit further medical evidence of medical necessity, the Division will send a final determination to the member and a copy to the provider. At this stage the provider cannot request a hearing on the denial.
- B. Members may request additional information related to a Favors review by calling 1-866-211-0950. Members may request a Favors review by mailing any supporting documentation to:

**Gainwell Technologies**  
P.O. Box 105200  
Tucker, Georgia 30085-5200  
Or Fax to 1-866-483-1045

Requests for Favors reviews must be in writing with a cover sheet that indicates that the request is a Favors review and includes the member's name, 12 digit Medicaid/PeachCare for Kids ID number, the reason for the request, a copy of the adverse action letter and any supporting documentation.

- C. If the Favors review does not result in approval, the Division will send a final determination notice to the member. The member may request a hearing pursuant to §506 of this Chapter.

## **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. Your request for hearing, along with a copy of the adverse action letter, must be received within **THIRTY (30) calendar days** of the date of the letter. Please mail your request for a hearing to:

Department of Community Health  
Legal Services, Floor #18  
2 Martin Luther King Jr. Drive, SE  
Atlanta, Georgia 30334

If you want to maintain your services pending the hearing decision, you must send a written request before the date your services change. **If this action is sustained 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)

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

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

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