



C A L I F O R N I A D E P A R T M E N T O F

Mental Health

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February 1, 2010

DMH LETTER: 10-02

TO: LOCAL MENTAL HEALTH DIRECTORS
LOCAL MENTAL HEALTH PROGRAM CHIEFS
LOCAL MENTAL HEALTH ADMINISTRATORS
COUNTY ADMINISTRATIVE OFFICERS
CHAIRPERSONS, LOCAL MENTAL HEALTH BOARDS

SUBJECT: MEDI-CAL COVERAGE AND CLAIMING FOR BENEFICIARIES IN
INSTITUTIONS FOR MENTAL DISEASES

REFERENCE: DMH LETTER NO.: 98-03, DMH LETTER NO.: 02-06, and
DMH LETTER NO.: 06-04

This Department of Mental Health (DMH) letter updates prior DMH communications related to the requirement that no State General Funds (SGF) nor Federal Financial Participation (FFP) be expended for services and treatment to Medi-Cal beneficiaries who are residents of institutions for mental diseases (IMDs) and who are 21 years of age and older and under 65 years of age (known as the "IMD exclusion"). This letter also reiterates that Welfare and Institutions (W&I) Code section 14053.3, in conjunction with section 14053(b)(3), requires DMH to recover SGF and FFP paid for ancillary services provided at the time that a Medi-Cal beneficiary is a resident of an IMD and subject to the IMD exclusion, in accordance with applicable state and federal statutes and regulations, as referenced below. In order to prevent claiming of SGF and FFP for Medi-Cal beneficiaries residing in an IMD per the IMD exclusion, the Department of Health Care Services (DHCS) has directed Medi-Cal providers to bill the county of responsibility for the beneficiary, as reflected in the Medi-Cal Eligibility Data System (MEDS). Attachment 1 is the Provider Bulletin titled Medical Ancillary Services Billing Procedures Update, which was sent by DHCS to all Medi-Cal providers on June 30, 2009.

Inappropriate Claiming of FFP for Services Provided in IMDs

In accordance with Title 42 United States Code section 1396d(a)(28)(B), Title 42, Code of Federal Regulations, sections 435.1009, 435.1010, 441.13 and 436.1005; W&I Code sections 14053(b)(3) and 14053.3, California Code of Regulations (CCR), title 22, section 50273, and CCR, title 9, sections 1840.210 and 1840.312, neither SGF nor FFP reimbursement is available for services for adults (individuals who are 21 years of age or older, and under 65 years of age) residing in IMDs. See Attachment 2 for the text of the cited statutes and regulations.

As guidance on this matter, the Federal Centers for Medicare and Medicaid Services (CMS) issued sections 4390 and 4390.1 of the State Medicaid Manual (Attachment 3). Each Mental Health Plan (MHP) should carefully review the applicable federal and state laws, regulations and guidelines and implement and enforce effective policies and procedures to prevent inappropriate claiming of SGF and FFP for services to Medi-Cal beneficiaries residing in IMDs

subject to the IMD exclusion. IMDs in California generally include facilities in the following licensing categories, if the facility has more than 16 beds: acute psychiatric hospitals; psychiatric health facilities (PHFs); skilled nursing facilities (SNFs) with a certified special treatment program for the mentally disordered (STPs); and mental health rehabilitation centers (MHRCs).

MHPs must not submit claims to the State for specialty mental health services or other services provided to Medi-Cal beneficiaries subject to the IMD exclusion. Providers outside the MHPs must not submit claims for other mental health, medical or ancillary services provided to Medi-Cal beneficiaries subject to the IMD exclusion. Inappropriate claiming of SGF or FFP must not occur, whether through the Short-Doyle/Medi-Cal (SD/MC) claiming system or through the Medi-Cal fiscal intermediary (FI) claims processing system. Improper claiming and/or failure to establish adequate procedures to prevent inappropriate claiming of SGF or FFP will result in disallowances and/or compliance actions and other oversight activities, reviews, actions and proceedings available to the State (including but not limited to CCR, title 9, sections 1810.380 and 1810.385) and to the federal government.

MHP Obligations for Client and Services Information (CSI) Reporting When Clients Enter and Exit IMDs

MHPs must submit updated Client, Service, and Periodic record information through the CSI System to DMH for clients in IMDs when the MHP pays the room and board. DMH Letter No. 06-04 issued on May 18, 2006, eliminated the New Institutions for Mental Disease (NIM) reporting system and informed MHPs to report through CSI. DMH Letter No. 98-03 issued on April 29, 1998, provided MHPs with the directive to submit a Client record at first contact with the county and a Service record as services are provided. Periodic records, which contain data elements that change, such as living arrangements, must be submitted at the time of admission to an IMD, at discharge from an IMD, and at the time of the annual client plan update.

If you have any questions, please contact your County Programs Technical Assistance contact person identified on the following internet site:
http://www.dmh.ca.gov/Services_and_Programs/Local_Program_Support/County_Technical_Assistance.asp

Sincerely,

Original Signed by

STEPHEN W. MAYBERG, Ph.D.
Director

Enclosures

cc: California Mental Health Planning Council
California Mental Health Directors Association

ATTACHMENT 1

Medical Ancillary Services Billing Procedure Update

Effective immediately, Medi-Cal should not be billed for any health care (medical ancillary) services such as laboratory, X-ray or other medical services performed off-site for persons residing as inpatients in Institutions for Mental Diseases (IMDs) when they receive services in an acute care hospital for a medical condition.

Medi-Cal does not cover medical ancillary services for individuals (21 through 64 years of age) residing as inpatients in IMDs. Health care providers who perform medical ancillary services must directly bill the county of responsibility as identified on the Medi-Cal Eligibility Data System (MEDS).

In accordance with the *Code of Federal Regulations*, Title 42, Sections 435.1010(b)(2), 441.13 and 435.1009, *California Welfare and Institutions Code*, Section 14053.3, and *California Code of Regulations* (CCR), Title 22, Sections 50273, 1840.210 and 1840312, Federal Financial Participation (FFP) reimbursement is not allowed for medical ancillary services provided to persons residing in IMDs. Counties are financially responsible for the medical ancillary services performed off-site for persons residing in IMDs when they receive services in an acute care hospital for a medical condition.

Providers must take necessary steps to immediately comply with the above information, including informing all off-site health care providers of this billing requirement.

If providers have any questions about this notice, they should contact the Benefits Analysis Section of the Medi-Cal Benefits, Waiver Analysis and Rates Division at (916) 552-9400.

[Hardcopy version only]

This information is reflected on manual replacement pages [Part 1] elig rstrict 2 (Part 1) and [IP, 13th] inp ment 13 (Part 2).

DCN/IDCN 10660

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[Editor's Note: With this DCN/IDCN, this article will added to the Newsroom area on the Medi-Cal Web site for a period of 30 days. The following title will link to the article:]

Medical Ancillary Services Billing Procedure Update

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Policy Originator: Janice Spitzer, Chief, Benefits Analysis Section, Medi-Cal Benefits, Waiver Analysis and Rates Division, 552-9633

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EDS Contact: Monica Sellers

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SELECTED STATE & FEDERAL STATUTES & REGULATIONS RELATED TO IMDs

Title 42, United States Code, Section 1396d(a)(28)(B), Definitions.

(Note: the text of this statute is too lengthy to reproduce here, but is available on the U.S. Code website search web page at <http://uscode.house.gov/search/criteria.shtml>.)

Title 42, CFR, § 435.1009, Institutionalized individuals.

“(a) FFP is not available in expenditures for services provided to –

- (1) Individuals who are inmates of a public institution as defined in Sec. 435.1010.
- (2) Individuals under age 65 who are patients in an institution for mental diseases unless they are under age 22 and are receiving inpatient psychiatric services under Sec. 440.160 of this subchapter.

b) The exclusion of FFP described in paragraph (a) of this section does not apply during that part of the month in which the individual is not an inmate of a public institution or a patient in an institution for tuberculosis or mental diseases.

(c) An individual on conditional release or convalescent leave from an institution for mental diseases is not considered to be a patient in that institution. However, such an individual who is under age 22 and has been receiving inpatient psychiatric services under Sec. 440.160 of this subchapter is considered to be a patient in the institution until he is unconditionally released or, if earlier, the date he reaches age 22.”

Title 42, Code of Federal Regulations (CFR), § 435.1010, Definitions relating to institutionalized status. (The following excerpts define Institution for Mental Disease [IMD], inmate of a public institution [referenced above in § 435.1009], institution and public institution:)

“*Institution for Mental Disease* means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.”

“*Inmate of a public institution* means a person who is living in a public institution.

An individual is not considered an inmate if—

- (a) He is in a public educational or vocational training institution for purposes of securing education or vocational training; or
- (b) He is in a public institution for a temporary period pending other arrangements appropriate to his needs.”

“*Institution* means an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.”

“*Public institution* means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. The term “public institution” does not include—

- (a) A medical institution as defined in this section;

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- (b) An intermediate care facility as defined in §§ 440.140 and 440.150 of this chapter;
- (c) A publicly operated community residence that serves no more than 16 residents, as defined in this section; or
- (d) A child-care institution as defined in this section with respect to—
 - (1) Children for whom foster care maintenance payments are made under title IV-E of the Act; and
 - (2) Children receiving AFDC—foster care under title IV-A of the Act.”

§ 441.13, Prohibitions on FFP: Institutionalized individuals.

- “(a) FFP is not available in expenditures for services for—
 - (1) Any individual who is in a public institution, as defined in § 435.1010 of this chapter; or
 - (2) Any individual who is under age 65 and is in an institution for mental diseases, except an individual who is under age 22 and receiving inpatient psychiatric services under subpart D of this part.
- (b) With the exception of active treatment services (as defined in § 483.440(a) of this chapter for residents of ICFs/MR and in § 441.154 for individuals under age 21 receiving inpatient psychiatric services), payments to institutions for the mentally retarded or persons with related conditions and to psychiatric facilities or programs providing inpatient psychiatric services to individuals under age 21 may not include reimbursement for formal educational services or for vocational services. Formal educational services relate to training in traditional academic subjects. Subject matter rather than setting, time of day, or class size determines whether a service is educational. Traditional academic subjects include, but are not limited to, science, history, literature, foreign languages, and mathematics. Vocational services relate to organized programs that are directly related to the preparation of individuals for paid or unpaid employment. An example of vocational services is time-limited vocational training provided as a part of a regularly scheduled class available to the general public.
- (c) FFP is not available in expenditures for services furnished by an organ procurement organization on or after April 1, 1988, that does not meet the requirements of part 486 subpart G of this chapter.”

Title 9, California Code of Regulations (CCR), § 1840.210. Non-Reimbursable Psychiatric Inpatient Hospital Services.

- “(a) The MHP may claim FFP for psychiatric inpatient hospital services in a psychiatric health facility that is larger than 16 beds and is certified by the State Department of Health Services as a Medi-Cal provider of inpatient hospital services or an acute psychiatric hospital that is larger than 16 beds only under the following conditions:
 - (1) The beneficiary is 65 years of age or older, or
 - (2) The beneficiary is under 21 years of age, or
 - (3) The beneficiary was receiving such services prior to his/her twenty-first birthday and the services are rendered without interruption until no longer required or his/her twenty-second birthday, whichever is earlier.
- (b) The restrictions in Subsection (a) regarding claiming FFP for services in acute psychiatric hospitals and psychiatric health facilities shall cease to have effect if federal law changes or a federal waiver is obtained and reimbursement is subsequently approved.

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(c) The MHP may not claim FFP for psychiatric inpatient hospital services until the beneficiary has met the beneficiary's share of cost obligations under Title 22, Sections 50657 through 50659.”

Title 9, CCR, § 1840.312. Non-Reimbursable Services -General. (Excerpt related to the IMD exclusion:)

“The following services are not eligible for FFP:

(g) Specialty mental health services covered by this Article provided during the time a beneficiary 21 years of age through 64 years of age resides in any institution for mental diseases, unless:

(1) The beneficiary was receiving, prior to his/her twenty-first birthday, services in an institution for mental diseases and the services are rendered without interruption until no longer required or his/her twenty-second birthday, whichever is earlier; and

(2) The facility has been accredited in accordance with Title 42, Code of Federal Regulations, Section 440.160, and complies with Title 42, Code of Federal Regulations, 441.150 through 441.156. Facilities at which FFP may be available include but are not limited to acute psychiatric hospitals and psychiatric health facilities certified by the State Department of Health Services as a Medi-Cal provider of inpatient hospital services.”

Title 22, CCR, § 50273, Medi-Cal Ineligibility Due to Institutional Status.

(a) Individuals who are inmates of public institutions are not eligible for Medi-Cal: The following individuals are considered inmates of a public institution:

(1) An individual in a prison, or a county, city, or tribal jail.

(2) An individual in a prison or jail: Prior to arraignment, prior to conviction, or prior to sentencing.

(3) An individual who is incarcerated, but can leave prison or jail on work release or work furlough and must return at specific intervals.

(4) Individuals released from prison or jail due to a medical emergency who would otherwise be incarcerated but for the medical emergency. Institutional status of such persons is not affected by transfer to a public or private medical facility.

(5) A minor in a juvenile detention center prior to disposition (judgement) due to criminal activity of the minor.

(6) A minor, after disposition, placed in a detention or correctional facility, including a youth ranch, forestry camp, or home which is part of the criminal justice system.

(7) A minor placed on probation by a juvenile court on juvenile intensive probation with specific conditions of release, including residence in a juvenile detention center.

(8) A minor placed on probation by a juvenile court on juvenile intensive probation to a secure treatment facility contracted with the juvenile detention center if the secure treatment facility is part of the criminal justice system.

(9) Individuals between the ages of 21-65 who are in an institution for mental diseases shall be considered inmates of a public institution until they are unconditionally released.

(b) Ineligibility for individuals classified as inmates in (a) begins on the day institutional status commences and ends on the day institutional status ends.

(c) The following individuals are not considered inmates of a public institution and shall be eligible for Medi-Cal provided that all other requirements for eligibility set out in this chapter are satisfied:

(1) An individual released from prison or jail on permanent release, bail, own recognizance (OR), probation, or parole with a condition of:

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- (A) Home arrest;
 - (B) Work release;
 - (C) Community service;
 - (D) Outpatient treatment;
 - (E) Inpatient treatment.
- (2) An individual who, after arrest but before booking, is escorted by police to a hospital for medical treatment and held under guard.
- (3) An individual in prison or jail who transfers temporarily to a halfway house or residential treatment facility prior to a formal probation release order.
- (4) An individual released from prison or jail under a court probation order due to a medical emergency.
- (5) A minor in a juvenile detention center prior to disposition (judgment) due to care, protection or in the best interest of the child (e.g., Child Protective Services) if there is a specific plan for that person that makes the stay at the detention center temporary. This would include those juveniles awaiting placement but still physically present in juvenile hall.
- (6) A minor placed on probation by a juvenile court on juvenile intensive probation with home arrest restrictions.
- (7) A minor placed on probation by a juvenile court on juvenile intensive probation to a secure treatment facility contracted with the juvenile detention center if the secure treatment facility is not part of the criminal justice system.
- (8) A minor placed on probation by a juvenile court on juvenile intensive probation with treatment as a condition of probation:
- (A) In a psychiatric hospital;
 - (B) In a residential treatment center;
 - (C) As an outpatient.
- (9) Individuals released from an institution for mental diseases or transferred from such an institution to a public or private medical facility.
- (10) Individuals on conditional release or convalescent leave from an institution for mental diseases.
- (11) Individuals under age 22 who are patients in an institution for mental diseases, were institutionalized prior to their 21st birthday, and continue to receive inpatient psychiatric care.

Welfare and Institutions Code (WIC), Division 5, Part 5, Section 5900 (added by Chapter 89, Statutes of 1991):

“This part is intended to organize and finance mental health services in skilled nursing facilities designated as institutions for mental disease, in a way that will promote the well-being of the residents. It is furthermore intended to effectively utilize existing resources in the delivery of mental health services to severely and persistently mentally disabled persons; to ensure continued receipt of federal funds; to minimize the fiscal exposure of counties; to maintain state responsibility for licensing and certification; to maintain services to individual county consumers at the 1990 -91 fiscal year levels; and to provide a mechanism for the orderly transition of programmatic and fiscal responsibility from the state to the counties, in a way that will maintain the stability and viability of the industry.”

WIC, Section 5902(c)(1).

“By October 1, 1991, the department, in consultation with the California Conference of Local Mental Health Directors and the California Association of Health Facilities, shall develop and

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publish a county-specific allocation of institutions for mental disease funds which will take effect on July 1, 1992.”

WIC, Section 5902(c)(3) (Excerpt related to contracts for realigned IMD services:)

“By April 1, 1992, counties shall have entered into contracts for basic institutions for mental disease services...”

WIC Section 14053.

“(a) The term "health care services" means the benefits set forth in Article 4 (commencing with Section 14131) of this chapter and in Section 14021. The term includes inpatient hospital services for any individual under 21 years of age in an institution for mental diseases. Any individual under 21 years of age receiving inpatient psychiatric hospital services immediately preceding the date on which he or she attains age 21 may continue to receive these services until he or she attains age 22. The term also includes early and periodic screening, diagnosis, and treatment for any individual under 21 years of age.

(b) The term "health care services" does not include, except to the extent permitted by federal law, any of the following:

(1) Care or services for any individual who is an inmate of an institution (except as a patient in a medical institution).

(2) Care or services for any individual who has not attained 65 years of age and who is a patient in an institution for tuberculosis.

(3) Care or services for any individual who is 21 years of age or over, except as provided in the first paragraph of this section, and has not attained 65 years of age and who is a patient in an institution for mental disease.

(4) Inpatient services provided to individuals 21 to 64 years of age, inclusive, in an institution for mental diseases operating under a consolidated license with a general acute care hospital pursuant to Section 1250.8 of the Health and Safety Code, unless federal financial participation is available for such inpatient services.”

WIC Section 14053.3.

“As federal financial participation reimbursement is not allowed for ancillary services provided to persons residing in facilities that have been found to be institutions for mental disease (IMD), and since, consistent with Part 2 (commencing with Section 5600) of Division 5 and Chapter 6 (commencing with Section 17600) of Part 5, counties are financially responsible for mental health services and related ancillary services provided to persons through county mental health programs when Medi-Cal reimbursement is not available, when it is determined that Medi-Cal reimbursement has been paid for ancillary services for residents of IMDs, both the federal financial participation reimbursement and any state funds paid for the ancillary services provided to residents of IMDs shall be recovered from counties by the State Department of Mental Health in accordance with applicable state and federal statutes and regulations.”

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03-94

REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

4390

4390. INSTITUTIONS FOR MENTAL DISEASES

A. Statutory and Regulatory Provisions.--The statutory provisions relating to institutions for mental diseases (IMDs) include two categories of covered services and a broad payment exclusion that can preclude payment for services provided to certain individuals in both participating and non-participating facilities.

1. IMD Coverage.--The original Medicaid legislation (P.L. 89-97) included a benefit for individuals 65 years of age or older who are in hospitals or nursing facilities that are IMDs. This provision is in §1905(a)(14) of the Act and regulations relating to this benefit are in Subpart C of 42 CFR 441.

In 1972, the Medicaid program was expanded (P.L. 92-603) to include inpatient psychiatric hospital services for individuals under age 21, or, in certain circumstances, under age 22. This provision is in §1905(a)(16) of the Act. Authority for using additional settings was enacted in P.L. 101-508. This benefit is currently being provided in a wide variety of psychiatric facilities. Regulations for this benefit are in Subpart D of 42 CFR 441.

Both IMD benefits are optional, except that inpatient psychiatric services for individuals under age 21 must be provided in any State as early and periodic screening, diagnosis and treatment (EPSDT) services if they are determined to be medically necessary.

2. IMD Exclusion.--The IMD exclusion is in §1905(a) of the Act in paragraph (B) following the list of Medicaid services. This paragraph states that FFP is not available for any medical assistance under title XIX for services provided to any individual who is under age 65 and who is a patient in an IMD unless the payment is for inpatient psychiatric services for individuals under age 21. This exclusion was designed to assure that States, rather than the Federal government, continue to have principal responsibility for funding inpatient psychiatric services. Under this broad exclusion, no Medicaid payment can be made for services provided either in or outside the facility for IMD patients in this age group.

3. IMD Definition.--In 1988, P.L. 100-360 defined an institution for mental diseases as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. This definition is in §1905(i) of the Act and in 42 CFR 435.1009. The regulations also indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.

Facilities with fewer than 17 beds that specialize in treating persons with mental disorders can provide the types of services discussed in item 1 if they meet the regulatory requirements to provide these institutional benefits, but these facilities are not technically IMDs. Because IMDs are defined to be institutions with more than 16 beds, the IMD exclusion applies only to institutions with at least 17 beds.

B. Guidelines for Determining What Constitutes an Institution.--When it is necessary to determine whether an institution is an IMD, the IMD criteria listed in subsection C must be applied to the appropriate entity. In most cases, there is no difficulty in determining what entity to apply the criteria to. But in cases in which multiple components are involved, it may be necessary for the HCFA regional office (RO) to apply the following guidelines

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to identify the institution to be assessed. Components that are certified as different types of providers, such as NFs and hospitals, are considered independent from each other.

1. Are all components controlled by one owner or one governing body?
2. Is one chief medical officer responsible for the medical staff activities in all components?
3. Does one chief executive officer control all administrative activities in all components?
4. Are any of the components separately licensed?
5. Are the components so organizationally and geographically separate that it is not feasible to operate as a single entity?
6. If two or more of the components are participating under the same provider category (such as NFs), can each component meet the conditions of participation independently?

The RO may also use other guidelines that it finds relevant in a specific situation. If the answer to items 1, 2, or 3 is "no," or the answer to items 4, 5, or 6 is "yes," for example, there may be a separate facility/component. If it is determined that a component is independent, the IMD criteria in subsection C are applied to that component unless the component has 16 or fewer beds.

C. Guidelines for Determining Whether Institution Is an IMD.--HCFA uses the following guidelines to evaluate whether the overall character of a facility is that of an IMD. If any of these criteria are met, a thorough IMD assessment must be made. Other relevant factors may also be considered. For example, if a NF is being reviewed, reviewers may wish to consider whether the average age of the patients in the NF is significantly lower than that of a typical NF. A final determination of a facility's IMD status depends on whether an evaluation of the information pertaining to the facility establishes that its overall character is that of a facility established and/or maintained primarily for the care and treatment of individuals with mental diseases.

1. The facility is licensed as a psychiatric facility;
2. The facility is accredited as a psychiatric facility;
3. The facility is under the jurisdiction of the State's mental health authority. (This criterion does not apply to facilities under mental health authority that are not providing services to mentally ill persons.);
4. The facility specializes in providing psychiatric/psychological care and treatment. This may be ascertained through review of patients' records. It may also be indicated by the fact that an unusually large proportion of the staff has specialized psychiatric/psychological training or that a large proportion of the patients are receiving psychopharmacological drugs; and
5. The current need for institutionalization for more than 50 percent of all the patients in the facility results from mental diseases.

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REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

4390 (Cont.)

D. Assessing Patient Population.--The review team applying the guidelines must include at least one physician or other skilled medical professional who is familiar with the care of mentally ill individuals. No team member may be employed by or have a significant financial interest in the facility under review.

In applying the 50 percent guideline (see §4390.C.2), determine whether each patient's current need for institutionalization results from a mental disease. It is not necessary to determine whether any mental health care is being provided in applying this guideline.

For purposes of determining whether a facility is subject to the IMD exclusion, the term "mental disease" includes diseases listed as mental disorders in the International Classification of Diseases, 9th Edition, modified for clinical applications (ICD-9-CM), with the exception of mental retardation, senility, and organic brain syndrome. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a subspecification of the mental disorder chapter of the ICD and may also be used to determine whether a disorder is a mental disease.

If it is not possible to make the determination solely on the basis of an individual's current diagnosis, classify the patient according to the diagnosis at the time of admission if the patient was admitted within the past year. Do not include a patient in the mentally ill category when no clear cut distinction is possible.

To classify private patients when review of their records is not possible, rely on other factors such as the surveyor's professional observation, discussion with staff of the overall character and nature of the patient's problems, and the specialty of the attending physician.

When the 50 percent guideline is being applied in a NF, the guideline is met if more than 50 percent of the NF residents require specialized services for treatment of serious mental illnesses, as defined in 42 CFR 483.102(b). Facilities providing non-intensive care for chronically ill individuals may also be IMDs. All NFs must provide mental health services which are of a lesser intensity than specialized services to all residents who need such services. Therefore, in applying the 50 percent guidelines, it is important to focus on the basis of the patient's current need for NF care, rather than the nature of the services being provided.

E. Chemical Dependency Treatment Facilities.--The ICD-9-CM system classifies alcoholism and other chemical dependency syndromes as mental disorders.

There is a continuum of care for chemical dependency. At one end of the spectrum of care, treatment follows a psychiatric model and is performed by medically trained and licensed personnel. If services are psychological in nature, the services are considered medical treatment of a mental disease. Chemically dependent patients admitted for such treatment are counted as mentally ill under the 50 percent guideline. Facilities with more than 16 beds that are providing this type of treatment to the majority of their patients are IMDs.

At the other end of the spectrum of care are facilities that are limited to services based on the Alcoholics Anonymous model, i.e., they rely on peer counseling and meetings to promote group support and encouragement, and they primarily use lay persons as counselors. Lay counseling does not constitute medical or remedial treatment. (See 42 CFR 440.2(b).) Do not count patients

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REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

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admitted to a facility only for lay counseling or services based on the Alcoholics Anonymous model as mentally ill under the 50 percent guideline. If psychosocial support provided by peers or staff without specialized training is the primary care being provided in the facility, the facility is not an IMD. The major factor differentiating these facilities from other chemical dependency treatment facilities is the primary reliance on lay staff.

Federal matching funds may not be claimed for institutional services when lay/social treatment is the primary reason for the inpatient stay. Facilities may not claim Medicaid payment for providing covered medical or remedial services in a nursing facility or hospital to patients admitted for treatment of chemical dependency and simultaneously claim that they are providing only lay or social services to those same patients when the 50 percent guideline is being applied. Facilities also may not avoid having their chemically dependent patients counted as mentally ill under the 50 percent guideline by withholding appropriate treatment from those patients. Facilities failing to provide appropriate treatment to patients risk termination from the program.

In determining whether a facility has fewer than 17 beds, it is not necessary to include beds used solely to accommodate the children of the individuals who are being treated. Children in beds that are not certified or used as treatment beds are not considered to be patients in the IMD and therefore are not subject to the IMD exclusion if they receive covered services while outside the facility.

4390.1 Periods of Absence From IMDs.--42 CFR 435.1008(c) states that an individual on conditional release or convalescent leave from an IMD is not considered to be a patient in that institution. These periods of absence relate to the course of treatment of the individual's mental disorder. If a patient is sent home for a trial visit, this is convalescent leave. If a patient is released from the institution on the condition that the patient receive outpatient treatment or on other comparable conditions, the patient is on conditional release.

If an emergency or other need to obtain medical treatment arises during the course of convalescent leave or conditional release, these services may be covered under Medicaid because the individual is not considered to be an IMD patient during these periods. If a patient is temporarily transferred from an IMD for the purpose of obtaining medical treatment, however, this is not considered a conditional release, and the patient is still considered an IMD patient.

The regulations contain a separate provision for individuals under age 22 who have been receiving the inpatient psychiatric services benefit defined in 42 CFR 440.160. This category of patient is considered to remain a patient in the institution until he/she is unconditionally released or, if earlier, the date he/she reaches age 22.