



Iowa Department of Human Services

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July 25, 2014

GENERAL LETTER NO. 8-K-19

ISSUED BY: Bureau of Financial, Health and Work Supports
Division of Adult, Children and Family Services

SUBJECT: Employees' Manual, Title 8, Chapter K, **PSYCHIATRIC INSTITUTIONS**, Title page, revised; and pages 5, 6, 12, 22, 24, and 27, revised.

Summary

Chapter 8-K is revised to:

- ◆ Update information on who determines level of care for children in psychiatric institutions.
- ◆ Update the chapter to indicate that the Centralized Facility Eligibility Unit (CFEU) will process all PMIC applications except for those children who are admitted to Cherokee MHI or Independence MHI.
- ◆ Correct grammatical errors.
- ◆ Remove references to form 470-0371, *Facility Notice of Client Participation*. Providers can access a member's client participation information through the Iowa Medicaid Provider Access (IMPA) system.
- ◆ Correct the review form used for SSI-related Medicaid reviews.

Effective Date

Removal of form 470-0371, *Facility Notice of Client Participation*, is effective November 19, 2013.

All other revisions are effective upon release.

Material Superseded

This material replaces the following pages from Employees' Manual, Title 8, Chapter K:

<u>Page</u>	<u>Date</u>
Title page	December 5, 2008
5	August 27, 2010
6, 12, 22, 24, 27	December 5, 2008

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

Revised July 25, 2014

Employees' Manual
Title 8
Chapter K

PSYCHIATRIC INSTITUTIONS



Iowa Department
of Human Services

The person must also meet the eligibility requirements for payment for care in a medical institution. A person must:

- ◆ Need the level of care provided by the medical institution.
- ◆ Be certified for care by an independent team. (For PMICs providing substance abuse treatment services, this requirement is satisfied by the Iowa Plan's authorization process. No additional documentation is required.)
- ◆ Have lived in an institution for 30 days if the person's eligibility will be determined under the 300 percent eligibility group.
- ◆ If married, meet specific income and resource guidelines for married couples.

See [8-1, Eligibility](#), for more information about these requirements.

The PMIC or MHI must obtain authorization for admission and continued stay for Medicaid applicants or members. The Iowa Medicaid Enterprise (IME) Medical Services Unit, Medicare, or the Iowa Plan managed care contractor authorizes the level of-care, depending on the payment source. (The Iowa Plan is the Medicaid managed care contract for mental health and substance abuse services.)

- ◆ For adults in MHIs:
 - The Iowa Plan makes the determination for a Medicaid enrollee who is voluntarily admitted.
 - Medicare makes the determination when Medicare is covering the stay. The provider will report this on the case activity report.
- ◆ For children in PMICs and MHIs:
 - The IME Medical Services Unit makes the determination for children **not** currently enrolled in Medicaid and the Iowa Plan.
 - The Iowa Plan makes the determination for children who are currently enrolled in Medicaid and the Iowa Plan.

Application Processing

Legal reference: 441 IAC 76.1(249A); 76.2(2)

The income maintenance (IM) worker for an MHI accepts and processes applications for MHI payment for people who live or who have lived in that facility. The MHI worker handles the ongoing case for the person entering and residing in the MHI.

| The Centralized Facility Eligibility Unit (CFEU) accepts and processes applications for PMIC payment for people who live or have lived in the PMIC. The worker assigned to the facility processes eligibility for the child in the PMIC and enters system information.

When a person enters a PMIC, an NF/MI, or an MHI, the IM worker handling the facility case should check to see if the person is already a Medicaid member.

See [Children in Foster Care or Subsidized Adoption in PMICs](#) when processing an application for foster children in a PMIC. See [Voluntary Placement in PMICs](#) for all other children.

Application After Discharge

| If a member is admitted and discharged before a Medicaid determination is made, determine eligibility according to the policies earlier in this chapter. Send form 470-3924, *Request for ISIS Changes*, to DHS, ISIS-Facilities. Include on the form:

- | ♦ Member's name, State ID,
- ♦ Aid type
- ♦ Date of entry
- ♦ Date of discharge
- ♦ Facility national provider identifier (NPI) number
- ♦ Client participation amounts and dates. If there are different amounts for different dates, specify all.

Submit form 470-0397, *Request for Special Update*, to Quality Assurance to authorize Medicaid eligibility for specific months.

Medical Necessity

Legal reference: 42 CFR 45, 441 IAC 78.3(249A), 81.3(249A), 81.7(249A), 85.6(1)"f", 85.24(1)"f," 85.45(1)

Payment will be made to a psychiatric medical institution only if the care provided is determined to be reasonable, necessary and appropriate. This determination must be done before ABC entries are made to allow facility payments.

A determination of the medical necessity for the level of care provided is required when a person:

- ◆ Enters a psychiatric medical facility.
- ◆ Moves to a bed that is certified for a different level of care.
- ◆ Returns to the psychiatric medical facility after leave beyond reserve bed days.
- ◆ Moves to a different medical facility, even if at the same level of care.

The IME Medical Services Unit makes the determination for people who are **not** currently enrolled in Medicaid and the Iowa Plan. For children entering PMIC substance abuse treatment and people who are currently enrolled in Medicaid and the Iowa Plan, the Iowa Plan contractor determines medical necessity. The IME Medical Services Unit also screens all persons to determine if they are mentally ill or mentally retarded or have a related condition.

When a child in foster care is a candidate for PMIC placement, the social worker contacts the facility so the facility can request a level-of-care determination from the IME Medical Services Unit or the Iowa Plan. The IME Medical Services Unit or the Iowa Plan usually calls the facility with a determination within one working day.

The day the determination is made, the facility sends the IM worker form 470-0042, *Case Activity Report*. Review this form to verify approval for the level of care that the person is seeking. If the person meets all other eligibility requirements and the level of care is medically necessary, complete ABC system entries for an eligibility determination. See [14-B\(9\)](#) for system instructions.

Contact the facility if the effective date on the *Case Activity Report*, form 470-0042, does not match the date the person wants Medicaid payment to begin or if you do not receive a *Case Activity Report*.

If an applicant has requested retroactive eligibility to cover the cost of medical institution care, check to see if the IME Medical Services Unit or the Iowa Plan has made a retroactive determination. A person may have needed institutional care in the retroactive period even if such care is not medically necessary now.

Mrs. A pays \$300 monthly for health insurance coverage for her family. One of Mrs. A's children, Betty, is approved for Medicaid and PMIC facility payments effective May 1. Betty is covered under the family's health insurance. Betty receives \$530 social security. She is allowed a deduction of \$300 unmet medical needs in computing her client participation.

Collecting Client Participation in PMICs

Legal reference: 441 IAC 85.4(249A)

The consideration of unearned income in the PMIC client participation calculation is not different from other medical facilities. However, how that client participation is collected may be different, depending on whether or not the income has been assigned to the Department.

The IM worker is responsible for the calculation of the client participation, sending the notice, and making the system entries. The PMIC is responsible for collecting the client participation.

Facilities are notified of the amount of client participation through Iowa Medicaid Provider Access (IMPA). The facility makes arrangements directly with the member for collection of client participation.

Ted's father admitted him to a PMIC. Ted's mother receives child support of \$300 monthly for Ted and his sister. The IM worker sends Ted's father a notice explaining that Ted owes client participation. Ted's mother refuses to pay the client participation. The IM worker is not responsible for resolving this issue. Ted's father may want to seek legal counsel about the situation.

The "governmental income" of foster children who enter PMICs is assigned to the Department. The assignment continues while the child is in foster care. This assigned income cannot be considered for client participation to be paid to the facility. It is used to credit the Medicaid payment to the facility.

When a foster child in a PMIC has income such as Social Security, SSI, Veterans, Railroad Retirement, etc., the income is assigned to or collected by the Department. If the child has been in a foster care setting before entering the PMIC, this assignment will likely already be done. If not, the child's service worker should initiate this assignment and inform you when completed.

Sam, a foster child, enters a PMIC on November 18. Sam's Social Security benefit of \$500 has already been assigned to the Department. For November 1 through November 17, Sam was responsible for paying \$200 towards his foster care costs. For the month of November, the amount paid for foster care is not counted for client participation.

The IM worker sends a notice explaining that Sam owes client participation and that the Department will collect this from the Social Security income the Department was already receiving. The worker enters \$0 client participation on the system. When the PMIC bills the Department, the client participation is not subtracted from the PMIC's payment. The Department sends Sam his personal needs allowance and credits the remaining income to the Medicaid program.

Child support income is assigned to the Department for a child receiving foster care cash assistance. The assigned child support paid by the noncustodial parent to CSRU is not sent to the child or the custodial parent but is instead paid to the foster care program.

When a foster care child enters a PMIC, the service worker completes entries into the FACS system. FACS communicates to CSRU that the child has entered a PMIC. The communication results in CSRU terminating the assignment of the child support to the state.

The IM worker is not responsible for billing and collection of the client participation. The PMIC is responsible for collecting any client participation. Facilities are notified of the amount of client participation through Iowa Medicaid Provider Access (IMPA). If the facility asks for assistance in collecting child support from the noncustodial parent, tell the facility to use any collection method they would normally use to collect any other debt.

Any child support that is paid to CSRU by the noncustodial parent (other than medical support) will be sent to the child or the child's representative.

While the child support is assigned, list it on the notice as income for determining client participation, because the child support that should be paid will go to the parent upon the termination of assignment.

When determining client participation for current and future months, project the amount of child support that will be received. Project future child support payments using the child support payment history screen on Iowa Collection and Reporting System (ICAR) as a tool.

Reviews and Redeterminations

Legal reference: 441 IAC 76.14(2)

Review eligibility according to the policies for the coverage group under which the member is eligible. The following chart shows by coverage group when reviews are required. For any coverage group, when there is a change in the person's circumstances that might affect eligibility, complete a desk review to determine the effect of the change.

Medicaid Coverage Group	Review Due	Review Form
SSI-related	Annually	<i>Medicaid Review</i> , form 470-3118 and 470-3118(S)
FMAP-related, including MAC	Annually	<i>Review/Recertification Eligibility Document</i> , form 470-2881
Foster care children Subsidized adoption children State-only medical assistance Unaccompanied refugee minors	Annually	<i>Foster Care and Subsidized Adoption Medicaid Review</i> , form 470-2914

Send the applicable review form to the person who signed the application. For children in foster care, use form 470-2914, *Foster Care and Subsidized Adoption Medicaid Review*. When the review form is returned, complete the review and request needed verification.

If the necessary review form is not returned or the requested information is not provided, contact the service worker or juvenile court officer for assistance.

If this person does not know the financial circumstances of the family, and the family income and resources must be considered or eligibility cannot be determined, cancel Medicaid eligibility and reopen the case as state-only with a FUND code of "4." However, continue to request this information from the service worker or juvenile court officer.

See [8-G](#), ADDITIONAL FMAP-RELATED CASE MAINTENANCE: Eligibility Reviews and ADDITIONAL SSI-RELATED CASE MAINTENANCE: Eligibility Review.