

CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health &
Human Services (DHHS)
Centers for Medicare &
Medicaid Services (CMS)

Transmittal 108

Date: April 11, 2014

**SUBJECT: State Operations Manual (SOM) Exhibit 185 Revisions For
Intermediate Care Facilities For Individuals With Intellectual Disabilities (ICF/IID)**

I. SUMMARY OF CHANGES: The SOM Exhibit 185 has been revised to reflect the current ICF/IID nomenclature.

NEW/REVISED MATERIAL - EFFECTIVE DATE: April 11, 2014

IMPLEMENTATION DATE: April 11, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

**II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual not updated.)
(R = REVISED, N = NEW, D = DELETED) – (Only One Per Row.)**

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	Exhibit 185/Model Telegram-Notice of Termination to a Medicaid ICF/IID Following “Look Behind” Survey: Immediate and Serious Threat to Patient Health and Safety

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	Manual Instruction
	Confidential Requirements
	One-Time Notification
	One-Time Notification -Confidential
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

EXHIBIT 185

**MODEL TELEGRAM - NOTICE OF TERMINATION
TO A MEDICAID *ICF/IID* FOLLOWING “LOOK BEHIND” SURVEY:**

IMMEDIATE AND SERIOUS THREAT TO PATIENT HEALTH AND SAFETY

(Date)

Provider Name

Address

City, State, ZIP Code

Dear **(Provider Name)**:

RE: Provider Number **(Provider Number)**

On **(date)** representatives of the Centers for Medicare & Medicaid Services conducted a survey of **(name of facility)**. At the conclusion of this survey, our findings were discussed with you or your representative **(name)** and **(you, he, she)** **(was, were)** informed that conditions within **(name of facility)** might pose an immediate and serious threat to the health and safety of clients. Specifically, the facility does not meet the requirements of Section 1905(d) of the Social Security Act and the Conditions of Participation for *ICF/IID*. This letter is to inform you that we have determined that the conditions found do, in fact, pose an immediate and serious threat to the health and safety of clients.

If you have not corrected this situation by **(insert date 5 working days after date of telegram)**, the Centers for Medicare & Medicaid Services will terminate your participation in the Medicaid program. Termination will be effective **(same date as above)**. Should we not hear from you, we will assume that the situation has not been corrected.

If you have removed the threat or achieved compliance, please advise us immediately. If you notify us by **(date)** that corrections have been made, representatives of the Centers for Medicare & Medicaid Services will revisit the facility within 2 working days to verify necessary corrections. If the Centers for Medicare & Medicaid Services determines that the reasons for termination remain, the effective date of the termination remains **(date)**, and you will be so informed in writing. If corrections have been made to remove the threat and if total compliance has been achieved, the termination procedures will be halted, and you will be notified in writing. If the threat has been removed, but compliance with all the conditions of participation has not been achieved, additional time may be granted for correction. However, if compliance is not achieved by **(termination date)**, termination will occur.

(Name)

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(Date)

If you wish to appeal this determination, a written request for a hearing before an administrative law judge must be filed no later than 60 days from the date of receipt of this notice. However, the hearing will be afforded after the effective date of the termination based on immediate and serious threat deficiencies. You may file it with this office or any other office of the Department of Health and Human Services, to be forwarded to the Regional Chief Administrative Law Judge of the Office of Hearings and Appeals. Your request should state why the decision is considered incorrect, and should be accompanied by any evidence and arguments you may wish to bring to the attention of the Department of Health and Human Services.

Sincerely yours,

Associate Regional Administrator
(or its equivalent)