DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

AUG 31 2004

TO: Wynethea Walker
Acting Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Audit of Medicaid Claims for Iowa's Rehabilitative Treatment Services Group Care Program (A-07-02-03026)

Attached is an advance copy of our final report on Iowa's Rehabilitative Treatment Services (RTS) Group Care program. We will issue this report to the Iowa Department of Human Services (the State) within 5 business days. We conducted this audit at the request of the Centers for Medicare & Medicaid Services (CMS), which was concerned about the State's procedures to safeguard against unnecessary or inappropriate use of Medicaid services and against excess payments. We suggest that you share this report with the Center for Medicaid and State Operations and any other CMS components involved with Medicaid program integrity and provider issues.

Our objective was to determine whether the amounts claimed by the State for the RTS Group Care program met Medicaid reimbursement requirements for Federal fiscal year (FFY) 2001.

Of the 100 claims sampled, 46 did not comply with Federal and State criteria. Sixteen of those claims contained more than one error. The errors occurred because the State lacked adequate internal controls over the Group Care program to ensure that services claimed for Medicaid reimbursement met applicable requirements. We estimate that $3,305,208 of the $14,389,908 in Federal funds that the State claimed for FFY 2001 was unallowable.

We recommend that the State:

- refund $3,305,208 to the Federal Government

- strengthen policies and procedures to ensure that services claimed for Medicaid reimbursement are directed exclusively to the rehabilitative treatment needs of the child, as defined in the Iowa State plan, and are in compliance with other State and Federal requirements

In response to our draft report, the State concurred, in part, with the findings on therapy and counseling services, documentation errors, and nonrehabilitative services. Additionally, the State requested that we revise the final report to allow certain claims that we had questioned.

After reviewing the State's additional documentation, we agreed that some of the disputed claims were allowable. We modified this report and the recovery recommendation accordingly.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or James P. Aasmundstad, Regional Inspector General for Audit Services, Region VII, at (816) 426-3591, extension 225. Please refer to report number A-07-02-03026 in all correspondence.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

SEP - 3 2004

Report Number: A-07-02-03026

Mr. Kevin W. Concannon
Director
Iowa Department of Human Services
1305 East Walnut
Hoover State Office Building, Fifth Floor
Des Moines, Iowa 50319-0114

Dear Mr. Concannon:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Audit of Medicaid Claims for Iowa's Rehabilitative Treatment Services Group Care Program." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), OIG reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-07-02-03026 in all correspondence.

Sincerely,

James P. Aasmundstad
Regional Inspector General
for Audit Services, Region VII

Enclosures

Direct Reply to HHS Action Official:

Mr. Joe Tilghman
Regional Administrator
Midwestern Consortium Administrator
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106-2808

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF MEDICAID CLAIMS FOR IOWA'S REHABILITATIVE TREATMENT SERVICES GROUP CARE PROGRAM

SEPTEMBER 2004
A-07-02-03026

Office of Inspector General

http://oig.hhs.gov

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Medicaid program, established by Title XIX of the Social Security Act, is jointly funded by the Federal and State Governments to provide medical assistance to qualified pregnant women; children; and needy individuals who are aged, blind, or disabled. In Iowa, the Department of Human Services (the State) is the State agency responsible for administering the Medicaid program.

The Iowa State plan describes rehabilitative treatment services (RTS) for Medicaid beneficiaries aged 20 or under. RTS programs include Family-Centered, Family Preservation, Family Foster Care, and Group Care.

The Centers for Medicare & Medicaid Services (CMS) requested that the Office of Inspector General (OIG) audit the Iowa RTS program.

OBJECTIVE

Our objective was to determine whether the amounts claimed by the State for the RTS Group Care program met Medicaid reimbursement requirements for Federal fiscal year (FFY) 2001.

SUMMARY OF FINDINGS

Of the 100 claims sampled, 46 did not comply with Federal and State criteria, including CMS's State Medicaid Manual, the Iowa State plan, and the Iowa Administrative Code. Sixteen of those claims contained more than one error. Specifically:

- Twenty-one claims did not meet the minimum time requirements for therapy and counseling services.
- Thirty-two claims lacked documentation to properly support billed services.
- Five claims were for nonrehabilitative services.

The errors occurred because the State lacked adequate internal controls over the Group Care program to ensure that services claimed for Medicaid reimbursement met applicable requirements.

We estimate that $3,305,208 of the $14,389,908 in Federal funds that the State claimed for FFY 2001 was unallowable.

RECOMMENDATIONS

We recommend that the State:

- refund $3,305,208 to the Federal Government

- strengthen policies and procedures to ensure that services claimed for Medicaid reimbursement are directed exclusively to the rehabilitative treatment needs of the child, as defined in the Iowa State plan, and are in compliance with other State and Federal requirements

AUDITEE'S COMMENTS

In response to our draft report, the State concurred, in part, with the findings on therapy and counseling services, documentation errors, and nonrehabilitative services. Additionally, the State requested that we revise the final report to allow certain claims that we had questioned.

OIG'S RESPONSE

After reviewing the State's additional documentation, we agreed that some of the disputed claims were allowable. We modified this report and the recovery recommendation accordingly.

We have also redacted the State's comments (included as Appendix C) that no longer apply to the final report.

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INTRODUCTION

BACKGROUND

Medicaid Program

The Medicaid program was established by Title XIX of the Act and is jointly funded by the Federal and State Governments to provide medical assistance to qualified pregnant women; children; and needy individuals who are aged, blind, or disabled. Within broad Federal guidelines, States design and administer the program under the general oversight of CMS. Federal funding is available to match expenditures under the Medicaid State plan. In Iowa, the Department of Human Services (the State) is the agency responsible for administering the Medicaid program. As the Medicaid State agency, the State is required to safeguard against unnecessary or inappropriate use of Medicaid services and against excess payments.

Rehabilitative Treatment Services

Title XIX of the Act allows optional coverage of rehabilitative services under the Medicaid program. Section 1905(a)(13) of the Act defines "rehabilitation services" as any medical or remedial services recommended by physicians or other licensed practitioners of the healing arts, within the scope of their practice under State law, and provided for the maximum reduction of physical or mental disability and the restoration of an individual to the best possible functional level.

RTS for Medicaid recipients age 20 or under are described in the Iowa State plan as Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT). RTS are composed of four distinct programs: Family-Centered, Family Preservation, Family Foster Care, and Group Care.

The State plan requires that all RTS be:

- directed toward treatment of the Medicaid-eligible child
- determined to be medically necessary and reasonable
- a specific and effective treatment for a child's medical or disabling condition that meets accepted standards of medical and psychological practice

RTS Group Care Program

The Iowa Administrative Code describes the Group Care program as a highly structured treatment service in a licensed group care setting having intensive staff supervision and programs for children or adolescents who may be emotionally disturbed, aggressive, or multihandicapped. The treatment program is behavioral, psychological, and psychosocial

in orientation. There are four levels of group care treatment,[1] differentiated by the intensity and frequency of services and the supervision required by a child who presents various levels of emotional or behavioral problems. Core services include therapy and counseling, social skill development, and restorative living skills. Additional therapy and counseling services are available on an as-needed basis.

CMS Review of Iowa RTS Program

In 1994, CMS initiated a review of the Iowa RTS program, based on a combination of factors including the nontraditional Medicaid services included in the program and the significant cost of the program. The State indicated that certain corrective actions would occur in response to the ensuing CMS report. Subsequently, CMS requested that OIG conduct an audit of the Iowa RTS program.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the amounts claimed by the State for the RTS Group Care program met Medicaid reimbursement requirements for FFY 2001.

Scope

Our audit period was October 1, 2000 through September 30, 2001 (FFY 2001). We did not review the State's overall internal control structure. Rather, our internal control review was limited to those controls pertaining directly to the RTS Group Care program. We performed audit fieldwork at the State offices in Des Moines, IA, and at RTS provider locations across Iowa, Nebraska, and Wisconsin.

Methodology

To accomplish our audit objectives:

- We selected a simple random sample of 100 claims from a population of 18,141 Group Care claims for FFY 2001. The 18,141 claims totaled $22,961,398 ($14,389,908 Federal share). The 100 random sample claims totaled $109,551 ($68,655 Federal share) and were from 21 RTS providers. (See Appendix B.)

- We reviewed Federal and State laws, regulations, and guidelines and the Iowa State plan pertaining to the Medicaid program and the RTS program.

- We held discussions with CMS regional office personnel; State officials; and contractors responsible for the authorization of RTS (Review Organization),

[1]The four levels of group care treatment are (D1) Community Residential, (D2) Comprehensive Residential, (D3) Enhanced Residential, and (D4) the Highly Structured Juvenile Program.

certification of RTS providers (Certification Team), and transmission of RTS claims data (Fiscal Agent).

- We obtained data files of all RTS claims for FFY 2001 and reconciled the claim amounts to the CMS-64 reports that were submitted to CMS to claim Federal funding for FFY 2001.

- We analyzed supporting documentation for the 100 sample claims from each of the 21 providers in our sample.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Of the 100 claims sampled, 46 contained errors and 16 of those had more than one error. However, the amount questioned never exceeded 100 percent of the amount paid for each claim. The 46 claims in error were not in compliance with Federal and State criteria, including CMS's State Medicaid Manual, the Iowa State plan, and the Iowa Administrative Code. The State lacked adequate internal controls over the Group Care program to ensure that services claimed for Medicaid reimbursement met applicable requirements. We estimate that $3,305,208 in Federal funds that the State claimed for FFY 2001 was unallowable.

The errors were summarized under the following categories: therapy and counseling services, documentation errors, and nonrehabilitative services. Appendix A details the errors for each claim.

THERAPY AND COUNSELING SERVICES

For 21 of the 100 sample claims, the minimum time requirements for therapy and counseling services as set forth by the Iowa Administrative Code were not met. For example, one claim had a deficiency of one-half hour per week of therapy and counseling where the required weekly average was 2 hours. Additionally, 2 of the 21 claims included billings for additional therapy and counseling services even though the core requirements were not met.

The Iowa Administrative Code, Section 441, Chapter 185.83, sets forth the core requirements for therapy and counseling services for each level of RTS Group Care services. The Code requires that the minimum amount of therapy and counseling services be provided before the claim is submitted for payment.

The billable unit for core services is 1 day, but the billing cycle is monthly. The computation to determine if the minimum time requirement for therapy and counseling services was met is based upon the number of days in a month that the client was in the

facility. Table 1 summarizes the core requirements for therapy and counseling services for each level (D1 through D4) of RTS Group Care treatment.

Table 1: Core Requirements

Level of Services	D1	D2	D3	D4
Therapy and Counseling Minimum Requirements	Average of 1 Hour Per Week	Average of 2 Hours Per Week	Average of 3 Hours Per Week	1 Hour Per Week

Group Care providers may also bill for additional therapy and counseling services that are provided in excess of the required core services. However, the Iowa Administrative Code, Section 441, Chapter 185.84, requires that RTS additional therapy and counseling services for a child in a group care facility may not be billed until the core therapy and counseling requirements have been met.

DOCUMENTATION ERRORS

For 32 of the 100 sample claims, the documentation failed to properly support billed services. Additionally, 11 of those claims had more than 1 documentation error. The Iowa Administrative Code, Section 441, Chapter 185.10, requires that documentation of billed services include the setting, amount of time, date, specific services rendered, relationship to the treatment plan, service provider, and updates describing the client's progress. Table 2 describes the documentation errors.

Table 2: Documentation Errors

	Number of Claims
Setting	15
No Documentation	14
Amount of Time	11
Specific Services Rendered	4
Relationship to the Treatment Plan	2
Service Provider	1

NONREHABILITATIVE SERVICES

For 5 of the 100 sample claims, the services did not meet the definition of rehabilitative services given in the State plan and the Iowa Administrative Code. These services included movies during therapy and counseling sessions and services directed toward family members' mental health and alcohol-related issues.

The CMS report on the Iowa RTS program stated that habilitative, social, educational, vocational, or leisure services delivered under RTS are not reimbursable under the Medicaid program. The Iowa State plan requires that services be primarily rehabilitative, not habilitative, in nature.

The Iowa Administrative Code, Section 441, Chapter 78, defines habilitative services as those designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills. Additionally, the Iowa Administrative Code, Section 441, Chapter 185.1, defines nonrehabilitative treatment needs as protective, supportive, or preventative and nonrehabilitative services as those directed toward a family member to help them meet the treatment, safety, or permanency needs of a child.

The Iowa State plan, under EPSDT, requires that "all RTS must be directed toward treatment of the Medicaid-eligible child, be determined medically necessary and reasonable, and be a specific and effective treatment for a child's medical or disabling condition." In addition, according to CMS's State Medicaid Manual, section 4385(B), a service that addresses an individual's basic life needs (adequate food, housing, and income) would not be covered under Medicaid because it is not directly and primarily concerned with the individual's health.

RECOMMENDATIONS

We recommend that the State:

- refund $3,305,208 to the Federal Government

- strengthen policies and procedures to ensure that services claimed for Medicaid reimbursement are directed exclusively to the rehabilitative treatment needs of the child, as defined in the Iowa State plan, and are in compliance with other State and Federal requirements

AUDITEE'S COMMENTS

The State did not concur with all of the findings and recommendations. The State's comments are summarized below and are included as Appendix C. The State contended in its comments on our draft report that some errors were unfounded and requested a revision of the findings and the recovery recommendation. The State also said that its policies and procedures were adequate to ensure that Medicaid payments were in accordance with State and Federal requirements.

Timing of the Audit and Impact of State Audits and Recoupment

The State asserted that the errors identified are routinely reviewed and recoupments made during the State's audit process. It indicated that State audits result in the recoupment of significant overpayments. Furthermore, it contended that the overlap of the State and Federal audit periods resulted in an overstatement of the error amounts, as the findings did not reflect amounts the State recouped. The State requested the adjustment of the error amounts to reflect Federal funding already returned to the Federal Government.

Therapy and Counseling Services

The State agreed with us on the majority of the claims identified as having a deficiency in the required amount of core therapy and counseling services. However, it did not concur with six of the claims.

Documentation Errors

The State cited the documentation requirements for billed services from the Iowa Administrative Code. It agreed with most of the claims and disagreed with three claims for missing documentation, two for setting, and four claims for specific services rendered.

Nonrehabilitative Services

The State disagreed with three claims found to have nonrehabilitative services. According to the State, the services were rehabilitative services directed toward the needs of the client. Additionally, the State asserted that the client does not need to be present during treatment services if the services are directed at the client's needs. It presented a portion of a letter to CMS in which the State contended that CMS said the State would be in compliance if the client were not in attendance during services, as long as the services were directed toward the treatment of the client.

OIG'S RESPONSE

After considering the State's comments and reviewing additional documentation, we removed certain findings from the final report. Therefore, the State's comments that are no longer applicable to the final report have been redacted, and the final report and the recovery recommendation have been modified accordingly.

Timing of the Audit and Impact of State Audits and Recoupment

Our review of the billing documentation did not indicate that the State made any recoveries for the 100 sample claims. Additionally, the State did not cite any specific claims for which recoupments were made. Consequently, the recovery recommendation is not overstated because of the State's recoupments.

A review of the State's billing audit worksheets indicated that State audits were limited to reviewing the documentation requirements for billed services stated in the Iowa Administrative Code and determining if the units billed for services were documented in the client's case files. The State audit process did not include reviewing for nonrehabilitative services or determining if the services provided for the treatment of the Medicaid-eligible client.

The State's recoupments for the RTS program for 2001 were only 0.38 percent of the total program cost. Therefore, the recoupments were not significant, even considering

the overlap of the State and Federal audit periods. Consequently, any overstatement of the findings due to the overlap was immaterial.

Therapy and Counseling Services

We reviewed documentation that the State provided and partially agreed with three of the six claims disputed and reduced the units of service questioned. However, the claims remained in error, as the minimum time requirements for therapy and counseling services were not fulfilled**.** Therefore, 3 of the 21 claims identified in this report remain in dispute.

Documentation Errors

After reviewing documentation that the State provided, we agreed with the State on some claims and disagreed on others. Only eight claims remain in dispute, as the documentation did not meet the requirements for billed services. The Iowa Administrative Code, section 441, chapter 185.10, requires that documentation of billed services include the date, amount of time, setting, service provider, specific services rendered, relationship to the treatment plan, and updates describing the client's progress.

Table 3 summarizes the documentation errors that are questioned in this report and those that remain in dispute.

Table 3: Documentation Errors in Dispute

Documentation Errors	Number of Claims	Claims Remaining in Dispute
Setting	15	1
No Documentation	14	3
Amount of Time	11	0
Specific Services Rendered	4	4
Relationship to the Treatment Plan	2	0
Service Provider	1	0

Nonrehabilitative Services

After reviewing documentation that the State provided, only one of the five claims counted in error remains in dispute. A review of the case note documentation for that claim did not indicate that the services were rehabilitative in nature. The services did not meet the requirements of the Iowa State plan, which stated, "all RTS must be directed toward treatment of the Medicaid-eligible child, be determined medically necessary and reasonable, and be a specific and effective treatment for a child's medical or disabling condition, which meets accepted standards of medical and psychological practice."

APPENDICES

SCHEDULE OF SAMPLE ITEMS

Error Conditions in Units of Service

						Documentation Errors						
Sample Order	Service Code	Claim $ Paid	Units Paid	Units in Error	Therapy and Counseling Services	Setting	Missing Documentation	Amount of Time	Specific Services Rendered	Relationship to the Treatment Plan	Service Provider	Nonrehabilitative Services
1	D2	$ 1,245	20	8			8					
2	D2	$ 1,935	31	31		31						
3	D6	$ 93	2	2								2
4	D6	$ 407	10	10								10
5	D3	$ 2,324	28	28		28						5
6	D1	$ 1,724	30	30	2	30		30				
7	D2	$ 1,969	31	0								
8	D6	$ 93	2	0								
9	D2	$ 1,153	18	0								
10	D5	$ 179	6	0								
11	D6	$ 342	9	3								3
12	D2	$ 640	10	0								
13	D5	$ 258	7	0								
14	D2	$ 1,083	30	30		30	9					
15	D3	$ 996	12	0								
16	D6	$ 263	6	0								
17	D5	$ 216	8	0								
18	D2	$ 1,345	21	3	3							
19	D5	$ 332	9	0								
20	D3	$ 2,623	31	12		12						
21	D5	$ 230	5	0								
22	D2	$ 1,985	31	7	7							
23	D5	$ 276	6	0								
24	D2	$ 2,096	30	2	2							
25	D1	$ 1,609	28	28		28		28				
26	D1	$ 1,790	31	3	3							
27	D1	$ 1,781	31	31	3	31		31	1			
28	D6	$ 77	2	0								
29	D1	$ 1,967	31	0								
30	D5	$ 427	10	0								
31	D5	$ 111	3	0								
32	D1	$ 1,609	28	28	7			28				
33	D5	$ 59	2	1	1							
34	D1	$ 1,777	28	0								
35	D6	$ 64	2	0								
36	D2	$ 1,872	30	30		30						
37	D1	$ 1,790	31	3	3							
38	D2	$ 1,935	31	31		31						
39	D5	$ 116	4	0								
40	D5	$ 74	2	0								
41	D1	$ 1,551	27	27	6			27				
42	D6	$ 76	2	0								
43	D1	$ 1,781	31	31	3		1	30				
44	D2	$ 2,739	31	1			1					
45	D3	$ 2,663	30	0								
46	D1	$ 632	11	11				11				
47	D1	$ 1,813	30	0								
48	D2	$ 384	6	0								
49	D5	$ 127	20	0								

Error Conditions in Units of Service

						Documentation Errors							
Sample Order	**Service Code**	**Claim $ Paid**	**Units Paid**	**Units in Error**	**Therapy and Counseling Services**	**Setting**	**Missing Documentation**	**Amount of Time**	**Specific Services Rendered**	**Relationship to the Treatment Plan**	**Service Provider**	**Nonrehabilitative Services**
50	D5	$ 368	8	0								
51	D5	$ 58	2	0								
52	D1	$ 1,781	31	31				31				
53	D2	$ 1,921	30	1	1							
54	D2	$ 1,685	27	0								
55	D5	$ 129	4	0								
56	D2	$ 635	10	0								
57	D2	$ 64	1	0								
58	D5	$ 207	7	0								
59	D5	$ 207	7	0								
60	D1	$ 1,191	28	0								
61	D1	$ 853	28	28	28		28				21	
62	D3	$ 2,779	31	0								
63	D3	$ 2,538	30	22		20	2					
64	D2	$ 872	14	3			3					
65	D1	$ 1,781	31	31	3	8	3	28				
66	D2	$ 2,651	30	13						13		
67	D6	$ 190	5	0								
68	D6	$ 170	4	2		2						
69	D2	$ 1,921	30	0								
70	D3	$ 533	6	1			1					
71	D5	$ 174	6	0								
72	D5	$ 177	6	0								
73	D1	$ 1,334	30	30	2		7		23	23		
74	D2	$ 811	31	6	6							
75	D1	$ 1,318	31	0								
76	D3	$ 2,623	31	0								
77	D3	$ 2,752	31	0								
78	D1	$ 1,649	30	0								
79	D2	$ 2,350	31	31		31	4		27			
80	D3	$ 1,154	13	1								1
81	D5	$ 276	6	0								
82	D1	$ 1,724	30	30	2			30				
83	D5	$ 203	7	2	2							
84	D2	$ 1,119	31	1			1					
85	D6	$ 154	4	2			2					
86	D3	$ 2,369	28	19	5	19						
87	D5	$ 354	12	0								
88	D6	$ 152	4	0								
89	D1	$ 1,732	30	0								
90	D3	$ 2,664	30	0								
91	D2	$ 896	14	0								
92	D2	$ 1,921	30	5	5							
93	D1	$ 1,781	31	31	3	31		31				
94	D5	$ 59	2	0								
95	D4	$ 336	5	1			1					
96	D5	$ 148	4	0								
97	D5	$ 118	4	0								
98	D2	$ 1,969	31	1					1			
99	D2	$ 1,921	30	0								
100	D5	$ 148	4	0								
Totals*		$ 109,551	1,816	683	97	362	71	305	52	36	21	21
Total Claims with Error				46	21	15	14	11	4	2	1	5

**Units disallowed were based upon a percentage of dollars disallowed due to the nature of the bundled services for the Group Care program.*

SAMPLE METHODOLOGY

POPULATION

The RTS Group Care program sample population consisted of claims made by the State of Iowa for Title XIX Federal reimbursement during Federal fiscal year 2001 for payments made to providers. The Group Care claims totaled 18,141 for $22,961,398 ($14,389,908 Federal share).

SAMPLE UNIT

The sample unit consisted of a claim for one type of Group Care service received by an individual client for the month of service. Service codes included those beginning with D1, D2, D3, D4, D5, D6, and D7, but excluded any maintenance service codes.

SAMPLE DESIGN

We used a simple random sample to determine the results.

SAMPLE SIZE

We used a sample size of 100 units.

ESTIMATION METHODOLOGY

We used the OIG, Office of Audit Services Statistical Software Variable Unrestricted Appraisal program to project the amount of the unallowable claims based on the dollar value of sample units determined to be in error. The estimate of unallowable claims was reported using the "difference estimator" at the lower limit of the 90-percent two-sided confidence interval.

SAMPLE RESULTS

The results of our review are as follows:

Sample Size	Value of Sample	Number of Nonzero Errors	Value of Errors
100	$109,551	46	$40,590

VARIABLE PROJECTIONS

	Claim Dollars	**Federal Dollars**
Point Estimate	$7,363,373	$4,614,626
90% Confidence Interval		
Lower Limit	$5,273,987	$3,305,208
Upper Limit	$9,452,759	$5,924,044

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

AUG 2 6 2003

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

James P. Aasmundstad, Regional Inspector General for Audit Services
HHS/OIG/OAS, Region VII
Room 284A
601 East 12th Street
Kansas City, MO 64106

RE: TITLE XIX FEDERAL FINANCIAL PARTICIPATION CLAIMED FOR REHABILITATIVE TREATMENT SERVICES GROUP CARE – AUDIT REPORT CIN: A-07-02-03026

Dear Mr. Aasmundstad:

This is in response to a draft report dated July 25, 2003, concerning the Office of Inspector General's (OIG) audit of Iowa's claim for federal financial participation (FFP) under title XIX for rehabilitative treatment group care services for federal fiscal year 2001. The Iowa Department of Human Services (DHS) is the state Medicaid agency.

In conducting the audit, OIG randomly selected for review 100 claims from a total of 18,141 group care claims for federal fiscal year 2001. The report indicates that OIG found errors in 87 of the 100 claims sampled with 68 of these having multiple errors. OIG summarized the errors it found into six categories. OIG extrapolated its findings from the 100 claims sampled to all group care claims during the audit period resulting in a recommended disallowance of $10,184,243 of the FFP claimed for these services for that period. The draft report also identifies five additional areas of concern that were not independently counted as errors.

The attached response addresses each finding and other concerns individually, indicating whether DHS agrees or disagrees with the finding or concern, as well as providing some general comments about the audit and draft report. DHS appreciates the effort of OIG in conducting this audit and the opportunity to provide comments that will be incorporated into the final report.

Questions about the attached response can be addressed to:

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Sincerely,

Kevin W. Concannon by sfr

Kevin W. Concannon
Director

AUDIT OF TITLE XIX FEDERAL FINANCIAL PARTICIPATION CLAIMED BY IOWA FOR REHABILITATIVE TREATMENT SERVICES – GROUP CARE
AUDIT REPORT CIN: A-07-02-03026
Comments from Iowa Department of Human Services (August 25, 2003)

GENERAL COMMENTS

Data redacted by OIG Auditors.

Timing of the Audit - Impact of DHS Audits and Recoupment:

In selecting federal fiscal year 2001 as the audit period, OIG sampled Group Care claims prior to the DHS routine audit on these claims. With respect to error findings other than staff qualifications and staff ratios, DHS wants to clarify and emphasize that these types of errors are routinely identified during DHS audits of RTS providers. If necessary, corrective actions are taken, including claiming adjustments and recoupment of claims paid in error. DHS, through its standard auditing practice, conducted over 30 audits of Group Care services including hundreds of claims, provided in whole, or in part, in federal fiscal year (FFY) 2001. Significant overpayments are recouped and claiming adjustments made as the result of these audits.

Due to the coinciding of the OIG and DHS audit periods, adjustments to claims that would normally result from DHS audits did not occur until after OIG selected its audit universe and conducted its audit. Consequently, the OIG audit error amounts are overstated as they do not reflect adjustments resulting from DHS audits conducted during the OIG audit period. In addition, DHS is requesting that the error amounts be adjusted to take into account federal financial participation (FFP) already returned by DHS for FFY 2001 claims as the result of DHS audits, and the amount of any extrapolated disallowance recalculated, so DHS is not required to repay the same FFP twice.

Other General Comments:

The draft report makes references to non-specified federal and state requirements which are relied upon to support the report's findings. To the extent the draft report relies on requirements or criteria outside of the federal Medicaid statutes, federal Medicaid regulations, or the Iowa State Plan for Medical Assistance, DHS requests that the final report specify how any failure to meet such requirements or criteria violates an identified requirement for federal financial participation in the federal Medicaid statutes, federal Medicaid regulations, or the State Plan.

While DHS is familiar with federal requirements for Medicaid as well as state laws and rules governing RTS, statutes and regulations can often be complex with otherwise apparently similar provisions having subtle, yet important differences. To ensure our response corresponds to the specific regulatory requirements referenced in the draft report, DHS has requested that OIG provide the applicable legal cites for each finding. DHS also requests that these cites be included in the final report. For example, rather than stating "The Iowa Administrative Code required ...," the report should specify the rule(s) imposing the requirement.

In preparing this response to the draft report, DHS has also requested that OIG provide a more complete explanation describing how the results of the sample are extrapolated in calculating the recommended disallowance. DHS requests that this detailed explanation be included in the final report as well.

FINDINGS

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Therapy and Counseling Sessions

OIG Finding:

We determined that 24 of the 100 sample claims had not met their therapy and counseling core requirements at the time that services were billed. Additional therapy and counseling services may not be billed until the core therapy and counseling requirements have been met.

DHS Response:

Out of the 24 claims (138 units) identified as deficient by OIG for this reason, DHS takes exception to the findings in 6 claims (19.05 units). In 2 claims, we found the provider to be in full compliance. In 4 claims, we found that the provider had a deficiency, but not of the magnitude identified by OIG.

Attachment A of this response identifies the six claims and the basis for contesting the finding of error in each case. DHS requests that the final report be revised to reflect the correct status of these six claims and corresponding units and amount found to be in error for this reason, and that any recommended disallowance be adjusted accordingly.

As previously noted, DHS routinely identifies this type of error during its own auditing process and takes appropriate corrective action, including claims adjustment and recoupment, which are not reflected in the OIG findings. DHS is requesting that the error amounts be adjusted to take into account federal financial participation (FFP) already returned by DHS for FFY 2001 claims as the result of DHS audits, and the amount of any extrapolated disallowance recalculated, so DHS is not required to repay the same FFP twice.

Non-Rehabilitative Services

OIG Finding:

We identified 7 of the 100 sample claims with services not considered rehabilitative treatment of the client. The CMS report stated that habilitative, social, educational, vocational, and/or leisure services delivered under the RTS program were not reimbursable under the Medicaid program. To be eligible for Medicaid reimbursement, services provided must be directed exclusively to the effective medical or remedial treatment of the Medicaid-eligible and not toward the treatment and education of family members.

DHS Response:

DHS agrees that, under CMS rules for the Rehabilitative Treatment and Supportive Services program, rehabilitative treatment services must be directed toward the client, who is the child. However, the child need not be present during service delivery as long as the service is directed toward the identified needs of the child. This position has been supported by the regional Centers for Medicare and Medicaid Services (CMS) office as evidenced by documentation found in Attachment B of this response of a conversation between DHS and the regional CMS office held January 18, 2002. Attachment B consists of an excerpt from a letter dated February 5, 2002, from DHS to the regional CMS office, summarizing the agreement between DHS and the regional CMS on the issue of whether the child must be physically present during the delivery of RTS services. As indicated, the regional CMS had determined that, "pending further CMS clarification on this issue, DHS would not be out of compliance if the child was not present when services are provided, so long as the documentation indicated that the service was directed toward the treatment of the eligible child."

Out of the 7 claims (25 units) identified as deficient by OIG for this reason, DHS takes exception to the findings in 3 claims (5 units). In those three claims, DHS staff concluded that the service was either therapy and counseling or skill development and that the service was directed toward the rehabilitative need of the child.

Attachment A of this response identifies the three claims and the basis for contesting the finding of error in each case. DHS requests that the final report be revised to reflect the correct status of these three claims and corresponding units and amount found to be in error for this reason, and that any recommended disallowance be adjusted accordingly.

As previously noted, DHS routinely identifies this type of error during its own auditing process and takes appropriate corrective action, including claims adjustment and recoupment, which are not reflected in the OIG findings. DHS is requesting that the error amounts be adjusted to take into account federal financial participation (FFP) already returned by DHS for FFY 2001 claims as the result of DHS audits, and the amount of any extrapolated disallowance recalculated, so DHS is not required to repay the same FFP twice.

Documentation Errors

OIG Finding:

We identified several claims with incomplete or inadequate documentation for the billed services. The Iowa Administrative Code required that documentation of billed services must include the date and amount of time services were delivered; who rendered the services; the setting in which services were rendered; the specific services rendered; the relationship of the service to the treatment plan and updates describing client's progress. The types and number of documentation errors that we found are summarized in the following schedule.

DOCUMENTATION ERRORS	NUMBER OF CLAIMS
Missing documentation	14
Time of service unknown	11
Service provider unknown	1
Place of service unknown	16
Specific services rendered unknown	8
Relationship of services to treatment plan unknown	15

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DHS Response:

The administrative rule establishing documentation requirements for RTS (441 IAC—185.10(6)b) states the following:

b. Documentation of billed services. Documentation shall include:

- the date and amount of time services were delivered except when delivering restorative living and social skill development services in a group care setting only the date and shift hours shall be identified,
- who rendered the services,
- the setting in which the services were rendered,
- the specific services rendered and
- the relationship of the services to the services described in the treatment plan, and
- updates describing the client's progress. For the family preservation program this documentation shall be provided every ten days on Form 470-2413, Family Preservation Service Report.

DHS reviewed each of the claims identified as having documentation errors and found the following:

DOCUMENTATION ERRORS	NUMBER OF CLAIMS	DHS FINDINGS
Missing documentation	14	Out of the 14 claims (75 units) identified as deficient by OIG, DHS takes exception to the findings in 3 claims (4 units).
Time of service unknown	11	The Department takes no exception to the findings (11 claims/325 units).
Service provider unknown	1	The Department takes no exception to the findings (1 claim, 21 units).
Place of service unknown	16	Out of the 16 claims (363 units) identified as deficient by OIG, DHS takes exception to the findings in 2 claims (5 units). DHS staff found documentation of setting in those

DOCUMENTATION ERRORS	NUMBER OF CLAIMS	DHS FINDINGS
		disputed instances.
Specific services rendered unknown	8	Out of the 8 claims (143 units) identified as deficient by OIG, DHS disagrees with the findings in 4 claims (91 units). DHS staff found that the specific services rendered were identified.
Relationship of services to treatment plan unknown	15	Out of the 15 claims (399 units) identified as deficient by OIG, DHS takes exception to the findings in 14 claims (382 units). In all 14 claims, the service provided is a service identified in the treatment plan. In all 14 claims, the documentation reflected the relationship of the service provided to the needs, goals or objectives identified in the treatment plan. There is no requirement in the RTS administrative rules, manual, or contract that the provider document, in each case note, the goal and objective toward which the intervention is directed.
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Attachment A of this response identifies the claims included in the table above and the basis for contesting the finding of error in each case. DHS requests that the final report be revised to reflect the correct status of these claims and corresponding units and amount found to be in error for this reason, and that any recommended disallowance be adjusted accordingly.

In addition to contesting the specific findings above, DHS also found that there were several instances in which the project managers found inconsistencies in how OIG determined non-compliance. For 2 similar if not identical entries in the record, one may have been found deficient and the other not, for no apparent reason. These inconsistencies were noted by several project managers with respect to several providers.

As previously noted, DHS routinely identifies this type of error during its own auditing process and takes appropriate corrective action, including claims adjustment and recoupment, which are not reflected in the OIG findings. DHS is requesting that the error amounts be adjusted to take into account federal financial participation (FFP) already returned by DHS for FFY 2001 claims

as the result of DHS audits, and the amount of any extrapolated disallowance recalculated, so DHS is not required to repay the same FFP twice.

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RECOMMENDATIONS

OIG Recommendations:

We recommend that the State:

- Refund $10,184,243 of the Medicaid FFP claimed for the Group Care program for FFY 2001.

- Strengthen policies and procedures to ensure that Medicaid payments are based on services directed exclusively to the rehabilitative treatment needs of the child as defined in the State plan and are provided in compliance with State and Federal regulations.

DHS Response:

DHS contends that it has sufficiently demonstrated that a substantial number of errors identified in the draft report are unfounded, warranting a significant revision of the report's findings as well as any recommended disallowance. DHS is prepared to work with OIG to re-examine the errors in question and resolve any discrepancies between OIG's findings and DHS's review.

DHS contends that as described throughout this response, its current policies and procedures are adequate to ensure Medicaid payments for RTS services are made in accordance with the State Plan and comply with state and federal regulations.

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ATTACHMENT A

During the week of August 4, 2003, DHS project managers conducted a "look behind" review of the 100 Group Care claims reviewed by OIG with respect to error findings concerning documentation, including documentation for therapy and counseling services and non-rehabilitative services. The findings of the project manager review are summarized below.

The comments only relate to the specific areas for which project managers reviewed for compliance with documentation requirements. If, for a specific claim, there were multiple OIG findings of non-compliance (deficiency), DHS initially reviewed for the requirement for which the highest number of deficiencies were found by OIG. If DHS agreed with OIG, we did not, in most instances, review the remaining areas for which deficiencies were found. We took this approach because of time constraints and the need to focus on the number of units for which we would take exception to OIG's recommendation for repayment.

In those instances where we did not review for all OIG findings, our absence of comments does not imply that we would agree with those findings. This does not have an impact on the number of units in dispute. We identified the unduplicated number of units that were deficient for either a single or multiple reasons and the associated dollar amount.

Out of 57 claims (1,008 units) in the amount of $60,855.53 that were identified as deficient in the OIG findings under C, D & E, DHS disputes the finding for 25 claims (333 units) in the amount of $20,782.88.

The results of the DHS review for specific claims are included in the following spreadsheet.

ATTACHMENT A
Schedule of Sample Items

Error Conditions in Units of Service:

				OIG Documentation Errors									IDHS DOCUMENTATION FINDINGS			
Sample Order		Mo/Yr Svc	Full Service Code	Therapy and Counseling Services	Non-Rehabilitative Services	Missing	Time of Service Unknown	Service Provider Unknown	Place of Service Unknown	Specific Services Rendered Unknown	Treatment Plan Relationship Unknown		max doc err	doc overpay	Agree	# Disputed	$ Disputed	Comments
1		08/2000	D261			10							10	$623	8	2	$ 124.54	Disagree. Documentation was present for 2 days.
	Data Redacted by OIG/ OAS Auditors											Data Redacted by OIG/ OAS Auditors						Setting: None of the therapy notes designated the setting although the agency name was at the top. Specific Service: Disagree. Service was apparent in all documentation. Treatment plan relationship: Disagree. The service provided was a service called for in treatment plan and services were directed towards goals and
2		03/2001	D260						31	2	31		31	$1,935	31		$ -	objectives in plan.
3		09/2000	D610		2								2	$93	2		$ -	Agree.
4		11/2000	D610		10								10	$407	10		$ -	Agree.
5		10/2000	D360		5				28				28	$2,324	28		$ -	Agree that none of the T&C notes had setting
6		04/2001	D161	2			30		30		29		30	$1,724	30		$ -	Agree there was no documentation of the shift on which skill development was provided.
9		12/2000	D261	7									7	$448		7	$ 448.21	We found T&C documentation for 512 minutes which is well in excess of required minimum for 18 days.
11		07/2001	D610		3								3	$114	3		$ -	Agree.
14		05/2001	D261			9			30				30	$1,083	30		$ -	Agree. SD inadequate or not documented for 9 days. Documentation did not state where service was provided.
18		07/2001	D261	6									6	$384	3	3	$ 192.09	We found T&C documentation for 307 minutes which is a deficiency of 3.09 days.
20		10/2000	D361						13				13	$1,100	10	3	$ 253.83	Found 9 hours T&C with setting and 5.42 hrs without setting. When Overpayment worksheet used this is a 10 day not a 13 day overpayment.
22		05/2001	D261	13							27		27	$1,729	13	14	$ 896.42	Agree re: T&C deficiency. Treatment Plan relationship disagree. All services were services in treatment plan.
24		04/2001	D261	4									4	$279	4		$ -	Agree. Insufficient T&C documented.
25		12/2000	D161				28		28				28	$1,609	28		$ -	No documentation of shift on which skill development was provided.
26		12/2000	D160	3									3	$173	3		$ -	Agree.
27		12/2000	D161	3			31		31	1			31	$1,781	31		$ -	No documentation of shift on which skill development was provided: Same as our recent audit findings.
29		10/2000	D160							31			31	$1,967		31	$ 1,967.26	Top of page states Forest Ridge Weekly Skill development form and middle of form states "skill development service- provided daily"–seems clear as to what service was documented. Therapy forms says Individual therapy. While YSI stated that the therapy is done in group setting, it is clear that therapy was provided and all therapy is countable.
32		02/2001	D161	7			28				27		28	$1,609	28		$ -	Agree that no documentation of shift on which skill development was provided.
33		04/2001	D510	1									1	$30		1	$ 29.60	Two units of D510 service were provided in a one hour, i.e., 2 unit session. The service was well documented.
34		02/2001	D160							28			28	$1,777		28	$ 1,776.88	Top of page states Forest Ridge Weekly Skill development form and middle of form states "skill development service- provided daily"–seems clear as to what service was documented. Therapy forms says Individual therapy. While YSI stated that the therapy is done in group setting, it is clear that therapy was provided and all therapy is countable.

ATTACHMENT A
Schedule of Sample Items

Error Conditions in Units of Service:

Sample Order		Mo/Yr Svc	Full Service Code	OIG Documentation Errors: Therapy and Counseling Services	Non-Rehabilitative Services	Missing	Time of Service Unknown	Service Provider Unknown	Place of Service Unknown	Specific Services Rendered Unknown	Treatment Plan Relationship Unknown		max doc err	doc overpay	IDHS DOCUMENTATION FINDINGS: Agree	# Disputed	$ Disputed	Comments
	Data Redacted by OIG/ OAS Auditors.											Data Redacted by OIG/ OAS Auditors.						
36		06/2001	D260						30		30		30	$1,872	30		$ -	Setting: Agree. None of the therapy notes designated the setting although the agency name was at the top. Treatment plan relationship: Disagree. All services documented (T&C and SD) were services identified in treatment plan. All services were directed towards goals/objectives in the treatment plan. Some SD stated which goals/objectives were being worked on.
37		03/2001	D160	3									3	$173	3		$ -	Agree.
38		01/2001	D260						31		31		31	$1,935	31		$ -	Setting: Agree. None of the therapy notes designated the setting although the agency name was at the top. Treatment plan relationship: Disagree for 29 agree for 2 days. Except for 2 SD days, all services documented (T&C and SD) were services identified in treatment plan. All services were directed towards goals/objectives in the treatment plan.
41		06/2001	D161	6			27						27	$1,551	27		$ -	Agree no documentation of shift on which skill development was provided.
42		07/2001	D610		1								1	$38		1	$ 38.02	The provider documented 75 minutes of D61 service. One 60 minutes session was rehab activity. The 15 minute session was not rehab and was not billed.
43		07/2001	D161	3		1	30						30	$1,724	30		$ -	No documentation of shift on which skill development was provided.
44		08/2001	D260			1							1	$88		1.0	$ 88.36	We found daily SD documentation and adequate T&C documentation.
46		03/2001	D161				11						11	$632	11		$ -	No documentation of shift on which skill development was provided.
47		06/2000	D160							30	30		30	$1,813		30	$ 1,813.20	Specific services rendered: Disagree. Top of page states Forest Ridge Weekly Skill development form and middle of form states "skill development service- provided daily"--seems clear as to what service was documented. Therapy forms says Individual therapy. While YSI stated that the therapy is done in group setting, it is clear that therapy was provided and all therapy is countable. Relationship to treatment plan: Disagree. It is clear that the service defined in treatment plan was provided. While documentation did not refer to a goal or objective of the treatment plan, the service provided was clearly directed towards treatment plan goals.
52		10/2000	D161				31						31	$1,781	31		$ -	No documentation of shift on which skill development was provided: Same as our recent audit findings.
53		11/2000	D261	2									2	$128	1	1	$ 64.03	Disagree. We found T&C documentation for 500 minutes which is a deficiency of .89 of a day.
54		11/2000	D260								27		27	$1,685		27	$ 1,685.07	Disagree. All services provided were services in the treatment plan. One of SD units stated specific goal/objective being worked on. All services were directed towards identified needs in the treatment plan.
61		10/2000	D161	28		28		21			21		28	$853	28		$ -	Agree on therapy and counseling and mising documentation.
63		03/2001	D361	1		2			20				20	$1,692	20		$ -	Agree with setting unknown.
64		06/2001	D261			4							4	$249	3	1	$ 62.27	Documentation was present for other 1 day.

ATTACHMENT A
Schedule of Sample Items

Error Conditions in Units of Service:

Sample Order		Mo/Yr Svc	Full Service Code	OIG Documentation Errors: Therapy and Counseling Services	Non-Rehabilitative Services	Missing	Time of Service Unknown	Service Provider Unknown	Place of Service Unknown	Specific Services Rendered Unknown	Treatment Plan Relationship Unknown		max doc err	doc overpay	IDHS DOCUMENTATION FINDINGS: Agree	# Disputed	$ Disputed	Comments
65	Data Redacted by OIG/ OAS Auditors.	08/2001	D161	3		3	28		8			Data Redacted by OIG/ OAS Auditors.	28	$1,609	28		$ -	Agree. No documentation of shift on which skill development was provided.
66		06/2001	D260								30		30	$2,651	12.5	17.5	$ 1,546.30	T&C and SD provided as per treatment plan in most instances. SD documentation had detailed and frequent connections with treat plan goals. Therapy was not provided in all instances--found 12.5 day should be disallowed.
67		12/2000	D610		1								1	$38		1	$ 38.02	Disagree. The provider documented one 90 minute session and one 60 minute session. Both sessions, for 5 units, were rehab. Moreover, it is not clear what the basis for allowing part of a session and not allowing the remainder of that session? It seems that either 0, 2 or 3 units should have been disallowed.
68		10/2000	D611						2				2	$85	2		$ -	Setting was not listed on one day for 2 units.
69		06/2001	D261								30		30	$1,921		30	$ 1,920.90	Disagree. T&C and SD provided as per treatment plan. The T&C and SD that was provided related to goals and objectives in the treatment plan.
70		02/2001	D360			1							1	$89	1		$ -	No documentation of SD on day of placement.
73		09/2000	D160	2		7				23	23		23	$1,023	23		$ -	Agree with missing documentation and that activity provided was not a service in the treatment plan. Progress was addressed in the Quarterly Progress Reports.
74		03/2001	D261	11									31	$811	11	20	$ 523.20	Agree that T&C minimum not met. Disagree re Progress as this was discussed in the Quarterly report of 4/4/1
76		05/2001	D361						2				31	$2,623		31	$ 2,622.91	Disagree. While there was a 1-hour session on 5/22 which did not show setting, there were 13.75 hours of T&C session notes which did show setting (as did all SD documentation) and which, by themselves, met the T&C requirement for this month. The Quarterly report 6/7/1 had progress statements
79		03/2001	D260			4			31	27			31	$2,350	31		$ -	Agree that place of service and specific service is unknown.
80		10/2000	D360		3								3	$266		3	$ 266.34	Disagree. Service was SD. SD related to rehab needs identified in treatment plan.
82		07/2001	D161	2			30						30	$1,724	30		$ -	No documentation of shift on which skill development was provided.
83		07/2001	D511	2							3		5	$145	2	3	$ 86.82	Agree with 2 units of D5 being used to meet D26 requirements. Disagree with with relationship to treatment plan. T&C was provided and the T&C provided related to treatment plan.
84		07/2000	D261			1					30		30	$1,083	1	29	$ 1,046.61	One day of SD not provided as client sick. Child placed on 6/19, treatment plan developed appropriately on 7/13. Services provided were services in treatment plan. Services provided related to the plan. Quarterly Progress report was completed on 9/17 and outlined progress made by child.
85		11/2000	D617			2							2	$77	2		$ -	Agree.
86		02/2001	D361	14					17				28	$2,369	17	11	$ 930.71	Agree with setting and T&C finding. Question the progress finding. Quarterly report 3/12/01 has statements related to progress.

ATTACHMENT A
Schedule of Sample Items

Error Conditions in Units of Service:

Sample Order	Data Redacted by OIG/ OAS Auditors.	Mo/Yr Svc	Full Service Code	OIG Documentation Errors: Therapy and Counseling Services	Non-Rehabilitative Services	Missing	Time of Service Unknown	Service Provider Unknown	Place of Service Unknown	Specific Services Rendered Unknown	Treatment Plan Relationship Unknown	Data Redacted by OIG/ OAS Auditors	max doc err	doc overpay	IDHS DOCUMENTATION FINDINGS: Agree	# Disputed	$ Disputed	Comments
89		06/2001	D160	2									2	$115	0.25	1.75	$ 101.03	Disagree. Found 4.25 hours of T&C. On overpayment worksheet this is a .25 of a day overpayment.
92		10/2000	D261	10									10	$640	4.7	5.3	$ 339.36	Disagree. We found T&C documentation for 434 minutes which is a deficiency of 4.68 days.
93		05/2001	D161	3			31		31				31	$1,781	31		$ -	No documentation of shift on which skill development was provided.
95		04/2001	D460			1							1	$67	1		$ -	Agree.
98		01/2001	D260							1			1	$64	1		$ -	Agree.
99		06/2001	D261								30		30	$1,921		30	$ 1,920.90	T&C and SD provided as per treatment plan. The T&C and SD that was provided related to goals and objectives in the treatment plan.
Totals				138	25	74	305	21	363	143	399		1008	$60,855.53	675	333	$20,782.88	
Total Claims with Error				24	7	14	11	1	16	8	15		0.0					
													55.51%	55.55%				

													0.67	0.33
	subtotal of units	138	25	74	305	21	363	143	399	143	1008			
	sub count of cases	24	7	14	11	1	16	8	15	5	57			

65.85%	% OF $ IN DOCUMENTATION ERRORS	
37.19%	% OF TOTAL Units IN SAMPLE in error	
36.58%	% OF TOTAL $ IN SAMPLE in error	

Out of 24 cases/138 units	Agree/NR 18 cases/110 units(118.95)	Disagree 2(6) cases/8 units(19.05)
Out of 7 cases/25 units	Agree 4 cases/20 units	Disagree 3 cases/5 units
Out of 14 cases/75 units	Agree 11/cases/59 units (70)	Disagree 1 (3) case(s)/1 unit(s) (4)
Out of 11 cases/325 units	Agree 11 cases/325 units	Disagree 0 cases/0 units
Out of 1 case/21 units	Agree/NC 1 case/21 units	Disagree 0 cases/0 units
Out of 16 cases/363 units	Agree/NC 14 cases/348 units (358)	Disagree 1 (2) case(s) /2 units (5)
Out of 8 cases/143 units	Agree 4 cases/52 units	Disagree 4 cases/91 units
Out of 15 cases/399 units	Agree 1 case/17 units	Disagree 14 cases/382 units

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Comments from Iowa Department of Human Services (August 25, 2003)

ATTACHMENT B

Excerpt from DHS letter to Region VII CMS dated February 5, 2002.

Child Present

Background. CMS policy provides that, "Under the rehabilitation option, meeting, counseling, etc. with the client, family, legal guardian and/or significant other may be covered provided that the services are directed exclusively to the effective treatment of the recipient. Consultation with, and training others, can be a necessary part of planning and providing care to patients in need of psychiatric services ... State plan amendments must make clear that services are only provided to, or directed exclusively toward, the treatment of Medicaid eligible persons."

Iowa administrative rules for RTS services are consistent with this policy and require that RTS services be either provided directly to the child, or that services "be directed toward the needs of the child." CMS, however, has consistently expressed concerns that RTS services are being provided to "ineligible persons" – i.e., that services are being provided to treat the parent rather than to treat the child. We have requested technical assistance from CMS staff regarding how to address CMS's concerns.

In a March 21, 2001 letter to Thomas Lenz, we indicated that we had decided to begin taking steps to revise our current policy and practice to require that the child always be present in order for a service to be billable to Medicaid. At a subsequent meeting, CMS staff reiterated that such a policy change may not be necessary to address their concern, and indicated that new policy guidance from CMS was forthcoming.

Summary of Friday's call. During our call, we reviewed the history of our discussions on this issue, as well as the ambiguity of the CMS policy governing this issue. We advised that we had reconsidered our March 21, 2001 decision and were no longer moving forward to require that the child always be present in order for a service to be billable to Medicaid.

What we agreed on. You indicated that, pending CMS clarification of this policy, you would not find us out of compliance if the child was not present when services were provided, so long as the documentation indicated that the service was directed towards the treatment of the eligible child.

Follow-up. You indicated that you would follow-up with Baltimore on the status of the forthcoming policy guidance regarding this issue.

Note: The Region VII CMS office has not subsequently contradicted the summary above, nor provided further guidance on this issue.