DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Offices of Audit Services

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

July 6, 2004

Report Number: A-07-02-03023

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

Dear Mr. Concannon:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General final report entitled *"Title XIX Federal Financial Participation Claimed for Rehabilitative Treatment Services Family-Centered Services."* 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), Office of Inspector General 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 which the Department chooses to exercise (see 45 CFR Part 5).

If you have any questions or comments about this report, please do not hesitate to call me or Gregory Tambke, Audit Manager at (573) 893-8338, ext. 30 or through e-mail at gtambke@oig.hhs.gov. To facilitate identification, please refer to report number A-07-02-03023 in all correspondence.

Sincerely,

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

Enclosures – as stated

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF MEDICAID CLAIMS FOR IOWA REHABILITATION TREATMENT SERVICES FAMILY-CENTERED PROGRAM

JULY 2004
A-07-02-03023

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 information contained therein 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 awarding agency will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Medicaid program was established by Title XIX of the Social Security 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. In Iowa, the Department of Human Services is the State agency responsible for administering the Medicaid program.

Rehabilitative Treatment Services for Medicaid recipients age 20 or under are described in the Iowa State plan. Rehabilitative Treatment Services are comprised of four distinct programs, which are Family-Centered Services, Family Preservation, Family Foster Care, and Group Care.

The Centers for Medicare & Medicaid Services (CMS) requested that the Office of Inspector General (OIG) conduct an audit of the Iowa Rehabilitative Treatment Services to ensure that the State had procedures to safeguard against unnecessary or inappropriate use of Medicaid services and against excess payments.

OBJECTIVE

Our objective was to determine whether the amounts claimed by the State of Iowa for the Rehabilitative Treatment Services Family-Centered Program met Medicaid reimbursement requirements in Federal fiscal year (FFY) 2001.

SUMMARY OF FINDINGS

Criteria

Criteria applicable to the Rehabilitative Treatment Services Family-Centered Program is included in the Iowa State plan and the Iowa Administrative Code.

Condition

Fifty-one of the 100 claims in our statistically valid sample were unallowable because they were not in compliance with applicable criteria. Of the 51 unallowable claims, 26 contained more than 1 deficiency. The unallowable claims are summarized as follows**:**

- 31 claims were non-rehabilitative in nature
- 25 claims were for clients that did not receive direct patient care
- 10 claims lacked documentation to properly support billed services
- 13 claims had day treatment services

Cause

The State lacked adequate internal controls over the Family-Centered Program to ensure proper delivery of services for Medicaid reimbursement.

Effect

FFP totaling $2,536,187 of the $7,956,706 claimed by the State for FFY 2001 did not meet the required criteria for Medicaid reimbursement, and, therefore, was unallowable.

Recommendations

We recommend that the State:

- Refund $2,536,187 to the Federal Government.

- 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.

AUDITEE'S COMMENTS

In response to our draft report, the State concurred in part with the findings for non-rehabilitative services, lack of direct patient care, and documentation errors. The State disagreed with the day treatment and staff qualifications findings in their entirety. Additionally, it requested we revise the report and recovery request to the extent of the claims disputed.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We do not agree with the State in regard to all the claims disputed for non-rehabilitative services, lack of direct patient care, documentation errors, and day treatment services. We still view the staff qualification finding as a significant issue, and while we did not include it as an error for purposes of calculating the overpayment, we included it under the "Other Matters" section of the report.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicaid

The Medicaid program was established by Title XIX of the Social Security 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. FFP is available to match expenditures under the State plan. In Iowa, the Department of Human Services is the State agency responsible for administering the Medicaid program. The Medicaid State agency is required to safeguard against unnecessary or inappropriate use of Medicaid services and against excess payments.

Rehabilitative Treatment Services

Federal regulations define rehabilitation services as any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level. Rehabilitative Treatment Services for Medicaid recipients age 20 or under are described in the Iowa State plan under the Early and Periodic Screening, Diagnosis and Treatment Services. Rehabilitative Treatment Services are comprised of four distinct programs, which are Family-Centered, Family Preservation, Family Foster Care, and Group Care.

The Medicaid State plan requires that all Rehabilitative Treatment Services must:

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

Rehabilitative Treatment Services Family-Centered Program

The Iowa Administrative Code describes the Rehabilitative Treatment Services Family-Centered Program as providing assistance to children and families to prevent and alleviate child abuse, neglect, delinquency, and out-of-home placements. Three core sets of services are provided and include (1) Therapy and Counseling Services, (2) Skill Development Services, and (3) Psychosocial Evaluation. The Iowa Administrative Code also states these core services may include family members and can be provided in whatever locations are appropriate, except not while operating a motor vehicle.

CMS Review of Iowa Rehabilitative Treatment Services Program

In 1994, CMS initiated a review of the Iowa Rehabilitative Treatment Services program, based on a combination of factors including the non-traditional Medicaid services included in the program and the significant cost of the program. In response to the CMS report, the State indicated that certain corrective actions would be taken. Subsequently, CMS requested that the OIG conduct an audit of the Iowa Rehabilitative Treatment Services to ensure that the State had procedures to safeguard against unnecessary or inappropriate use of Medicaid services and against excess payments.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The overall objectives of the Rehabilitative Treatment Services reviews were to determine (1) whether Rehabilitative Treatment Services amounts claimed by the State for FFY 2001 met Medicaid Title XIX and Title XXI reimbursement requirements for FFP and (2) whether the State's Rehabilitative Treatment Services Program met eligibility requirements for Medicaid FFP. Each of the Rehabilitative Treatment Services programs was addressed in a separate report, as well as the Rehabilitative Treatment Services claims for the enhanced Title XXI FFP. Additionally, the second objective required a separate report to address issues that pertained to the Rehabilitative Treatment Services programs as a whole.

The objective for this review was to determine whether the amounts claimed by the State for the Family-Centered Program met Medicaid reimbursement requirements for FFY 2001.

Scope

Our audit period was October 1, 2000 through September 30, 2001 (FFY 2001). Audit fieldwork was performed at the State offices in Des Moines, Iowa and at Rehabilitative Treatment Services provider locations across Iowa and Illinois. The audit did not involve a review of the overall internal control structure of the State.

Methodology

To accomplish our audit objectives, we:

- Selected a simple random sample of 100 claims from a population of 45,895 claims from the Family-Centered Program for FFY 2001. The 45,895 Family-Centered Program claims totaled $12,696,196 ($7,956,706 FFP). The 100 random sample claims totaled $28,099 ($17,610 FFP) and were from 32 Rehabilitative Treatment Services providers. See Appendix B.

- Reviewed Federal and State laws, regulations, and guidelines pertaining to the Medicaid program and Rehabilitative Treatment Services.

- Held discussions with CMS regional office personnel; State officials; and contractors responsible for the authorization of Rehabilitative Treatment Services (Review Organization), certification of Rehabilitative Treatment Services providers (Certification Team), and transmission of Rehabilitative Treatment Services claims data (Fiscal Agent).

- Obtained data files of all Rehabilitative Treatment Services claims for FFY 2001, and reconciled the claim amounts to the CMS-64 reports that were submitted to CMS to claim FFP for FFY 2001.

- Obtained and analyzed supporting documentation from each of the 32 providers in our sample.

Our review was conducted in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Fifty-one of the 100 claims in our sample were unallowable because they were not in compliance with applicable criteria, including the Iowa State plan and the Iowa Administrative Code. Of the 51 unallowable claims, 26 contained more than 1 deficiency. The unallowable claims occurred because the State lacked adequate internal controls over the Family-Centered Program to ensure proper delivery of services for Medicaid reimbursement. As a result, during FFY 2001, we estimate that the State claimed unallowable Federal Medicaid funding totaling $2,536,187.

The unallowable claims are summarized under the following categories (1) Non-Rehabilitative Services, (2) Lack of Direct Patient Care, (3) Documentation Errors, and (4) Day Treatment. Appendix A details the errors for each claim.

NON-REHABILITATIVE SERVICES

Criteria

The CMS report stated that habilitative, social, educational, vocational, and/or leisure services delivered under Rehabilitative Treatment Services are not reimbursable under the Medicaid Program. The Iowa Administrative Code, section 441, chapter 185.1 defined "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. Additionally, the Iowa State plan, under Early and Periodic Screening, Diagnosis and Treatment Services required 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."

Condition

The services were non-rehabilitative in 31 of the 100 sample claims. There were services monitoring and/or teaching parents about general age-appropriate discipline, chore charts,

cleaning, and safety. In addition, services focused on the parent's issues such as marriage, finances, housing, and the parent's mental health and substance abuse issues.

Cause

The State lacked adequate internal controls to ensure the services provided were rehabilitative in nature.

Effect

The 31 claims are not allowable for Medicaid reimbursement, as the services provided did not meet the definition of rehabilitative services defined by the State plan and the Iowa Administrative Code.

LACK OF DIRECT PATIENT CARE

Criteria

The Iowa State plan under Early and Periodic Screening, Diagnosis and Treatment Services required all Rehabilitative Treatment Services to be directed toward the treatment of the Medicaid-eligible child and be a specific and effective treatment for the child's condition. Additionally, the CMS report stated that Medicaid services must involve direct patient care, and be directed exclusively to the effective treatment of the Medicaid-eligible individual in order to qualify for Medicaid reimbursement.

Condition

The services provided did not involve direct patient care in 25 of 100 sample claims. For each of the claims, the client was not present or involved in the treatment service, and the services were not directed at the effective treatment of the client. The services were provided to family members and dealt with issues that did not pertain to the client's treatment. Documents indicated that the State planned to implement a new policy to require the client's presence during Rehabilitative Treatment Services, but this policy was never implemented.

Cause

There was a lack of direct patient care provided to Rehabilitative Treatment Services clients, as the State did not maintain adequate internal controls over the Family-Centered Program.

Effect

The 25 claims are not allowable for Medicaid reimbursement, as the services provided did not involve direct patient care as defined by the Iowa State plan and the CMS report.

DOCUMENTATION ERRORS

Criteria

The Iowa Administrative Code, section 441, chapter 185.10 required that documentation of billed services must include the date, amount of time, setting, service provider, the specific services rendered, the relationship to the treatment plan, and updates describing the client's progress.

Condition

The documentation failed to properly support billed services in 10 of the 100 sample claims. The documentation errors were identified as follows:

Documentation Errors	Number of Claims
Missing Documentation	7
Missing Treatment Plan	3
Identical Case Notes Billed	1

Cause

The State lacked adequate internal controls to ensure proper documentation of billed services.

Effect

The 10 claims are not allowable for Medicaid reimbursement, as the documentation requirements for billed services set forth by the Iowa Administrative Code were not met.

DAY TREATMENT

Criteria

The Iowa State plan, Limitations on Service, section 4.b required, "*Under EPSDT authority, day treatment services for persons aged 20 or under shall be provided by hospitals with outpatient programs, psychiatric medical institutions for children, and community mental health centers.*" Additionally, The Rehabilitative Treatment and Supportive Services (RTSS) Provider Handbook stated, "*Rehabilitative or nonrehabilitative treatment services cannot be paid for when a child or youth is in a psychiatric medical institution for children* (*PMIC*), *or other medical program, such as partial hospitalization or day treatment*."

Condition

The services provided were in conjunction with day treatment programs in 13 of the 100 sample claims. There were 9 of the 13 claims in which Family-Centered group services were provided in a day treatment program. The other four claims were found to have individualized Family-Centered services provided when the client was attending a day treatment program. The provider's facilities were not of the type authorized to provide day treatment services under the

State plan. Additionally, the RTSS Provider Handbook does not allow for the billing of rehabilitative services when the client is attending day treatment.

Cause

The State lacked sufficient internal controls to prevent providers from delivering day treatment services.

Effect

The 13 claims are not allowable for Medicaid reimbursement, as the services were provided in conjunction with day treatment programs. The services did not meet the requirements set forth in the State plan and The Rehabilitative Treatment and Supportive Services Handbook.

RECOMMENDATIONS

We recommend that the State:

- Refund $2,536,187 to the Federal Government.

- 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 Iowa State plan and are provided in compliance with State and Federal regulations.

OTHER MATTERS

The following issues were considered significant, but were not counted as errors in the review of the 100 sample claims.

Staff Qualifications

The Iowa Administrative Code, section 441, chapter 79.9 required that services covered by Medicaid should be within the scope of the licensure of the provider. The Iowa Code section 154C.1 "Practice of Social Work" identified three categories of social work licensure (1) Bachelor social workers, (2) Master social workers, and (3) Independent social workers. Only Licensed Master Social Workers and Licensed Independent Social Workers are listed as qualified to provide evaluation of symptoms and behaviors; strengths and weaknesses; diagnosis and treatment; psychosocial therapy with individuals, couples, families, and groups; establishment of treatment goals; and monitoring progress, etc. According to the Iowa Board of Social Work Examiners, Bachelor level social workers may not provide therapy "*. . . in any setting . . . .*"

Staff that appeared to lack the qualifications to develop treatment goals or provide therapy provided services in 47 of the 100 sample claims. Therapy and counseling is one of three core services for the Family-Centered Program, and development of treatment goals is a required part of therapy and counseling services. At a minimum, individuals providing therapy and

developing treatment goals should be Licensed Master Social Workers, Licensed Independent Social Workers, or the equivalent.

Provider Criminal and Child Abuse Background Checks

The Iowa Code and the Iowa Administrative Code do not have any laws or regulations requiring criminal or child abuse background checks for the Family-Centered Program providers. Additionally, there are no licensure requirements for providers of Family-Centered services. Only providers of Rehabilitative Treatment Services Family Foster Care and Group Care are required to be licensed and perform staff background checks. This screening is especially important given that Family-Centered services are frequently provided to clients in their homes, and providers often transport clients.

The State may want to consider requiring Family-Centered services providers to (1) be licensed or held to standards similar to those for Family Foster Care providers, since both offer similar services, and (2) obtain background investigations on all employees.

Public Places of Service and Sensitive Topics

Services were provided in public settings where client confidentiality could be at risk in 15 of the 100 sample claims. Additionally, many of these sessions dealt with sensitive topics, such as sexual abuse and children's fears and problems.

The Social Security Act guarantees that a State plan must provide safeguards to restrict disclosure of information concerning recipients. The Iowa State plan indicates Rehabilitative Treatment Services for Medicaid recipients age 20 or under may be provided in various settings, including the recipient's home, school, or workplace, as well as provider facilities; yet also requires that rehabilitative services must be a specific and effective treatment for a client's medical or disabling condition. The effectiveness of treatment services delivered in public settings where the general public may be observing and overhearing the entire treatment session may be questionable, and could pose considerable risk of violating the clients' confidentiality.

AUDITEE'S COMMENTS

The State did not concur with all of the findings and recommendations. The State's comments are summarized below and included in their entirety as Appendix C. However, after consideration of the State's comments to our draft report, certain findings have been removed from this final report. Therefore, the State's comments that are no longer applicable to this final report have been redacted. Additionally, the final report and recovery request were modified to reflect the claims in which we agreed with the State's position.

1) Timing of the Audit-Impact of Department of Human Services Audits and Recoupment

The State asserted the errors identified, with the exception of Staff Qualifications and Day Treatment, are routinely reviewed and recoupments made during the State audit process. It indicated significant overpayments are recouped as a result of State audits. 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 recouped by the State. The State requested the error amounts be adjusted to reflect FFP already returned to the Federal Government.

2) Non-Rehabilitative Services

The State disagreed with 17 of the 35 sample claims. It stated the services were rehabilitative services directed toward the needs of the client.

3) Lack of Direct Patient Care

The State contested 16 of the 31 sample claims for services that did not provide direct patient care. It 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 they 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.

4) Documentation Errors

The State cited the documentation requirements for billed services from the Iowa Administrative Code and contested the following two claims for missing documentation, two claims for missing treatment plans, and two claims for duplicated documentation.

5) Day Treatment Services

The State disagreed with the finding that day treatment services were provided to Rehabilitative Treatment Services clients. It indicated these services were the standard core services provided in the Family-Centered Program and did not fall under Early and Periodic Services, and Diagnosis Treatment authority for day treatment services as stated in the Iowa State plan. Additionally, the State asserted it should have no responsibility if some providers used "colloquial terminology" to document Rehabilitative Treatment Services as day treatment.

6) Staff Qualifications

The State did not concur with the 48 claims found to be in error for staff qualifications. It contended that the finding was a result of our misinterpretation of the terminology "therapy and counseling," which is used to depict services provided under the Family-Centered Program. Additionally, the State asserted that we incorrectly applied the State Social Work Board requirements for therapy, development of treatment goals (a component of therapy and counseling services), and psychosocial evaluation services to Family-Centered services. It indicated State statutes and regulations, which did not require those providing therapy and counseling services to be Licensed Master or Independent Social Workers, supported its position.

OIG'S RESPONSE

1) Timing of the Audit-Impact of DHS Audits and Recoupment

The State's billing audit worksheets indicated its 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 non-rehabilitative services or determining if services were directed toward the treatment of the Medicaid-eligible client.

Our review of the billing documentation did not indicate the State made any recoveries for the 100 sample claims. Additionally, the State did not cite any specific claims for which recoupments were made.

The State's recoupments for the Rehabilitative Treatment Services 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**.**

2) Non-Rehabilitative Services

We agree with the State's position for 4 of the 17 claims contested. However, we do not concur with the other 13 claims questioned. A review of documentation provided by the State did not indicate the services were rehabilitative in nature. These 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."

3) Lack of Direct Patient Care

We acknowledge the State's position that treatment services can be provided and directed toward the client's needs in their absence. Therefore, we agree with 6 of the 16 claims disputed. However, we did not find that the other 10 claims had services in which the client's needs were addressed.

4) Documentation Errors

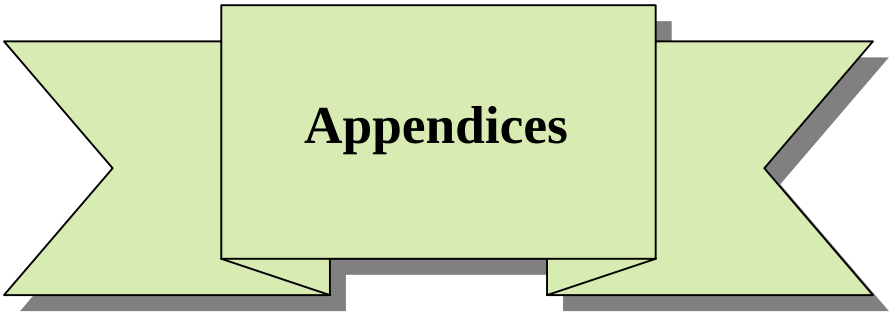
The Iowa Administrative Code stated the requirements for documentation of billed services. There was not any documentation of billed services for the two claims contested by the State at the time of the review of the case files. Requests were made to the provider, but the documentation was not received. Additionally, the Iowa Administrative Code required the client's treatment plan to be included in the case file. For the two claims questioned by the State, there was not a treatment plan in the case file at the time of the review or was one received from the provider upon request.

5) Day Treatment Services

The Iowa State plan required day treatment services to be provided by hospitals with outpatient programs, psychiatric institutions for children, or community mental health centers. The Rehabilitative Treatment Services providers that delivered the services were not the type of facilities required by the State plan. Documentation from the provider's case notes stated the services were day treatment. Additionally, there were instances where the Referral of Client for Rehabilitative and Supportive Services (Form 3055) was addressed to day treatment programs, and in the written portion of the authorization referred to clients beginning day treatment services at these facilities. This indicated the State was aware the providers considered the services to be day treatment. Therefore, these services were not the standard core Family-Centered services and did fall under Early and Periodic Services, Diagnosis Treatment authority requirements as stated in the Iowa State plan.

6) Staff Qualifications

We modified the report and recovery request to reflect the removal of staff qualifications as an independent error. However, we still consider this a significant issue and have reported it under the "Other Matters" section.


Appendices

Appendix A
Schedule of Sample Items

Error Conditions in Units of Service and Claim Dollars:

Sample Order	Units Paid	Claim $ Paid	Units Disallowed	Claim $ Disallowed	Non-Rehabilitative Services		Lack of Direct Care		Documentation		Day Treatment	
					Units	Claim $	Units	Claim $	Units	Claim $	Units	Claim $
1	24	$ 185	24	$ 185							24	$185
2	6	$ 266	0	$ -								
3	1	$ 33	0	$ -								
4	2	$ 71	0	$ -								
5	11	$ 491	2	$ 89	2	$89						
6	2	$ 76	0	$ -								
7	6	$ 182	0	$ -								
8	8	$ 268	6	$ 201	6	201	6	$201				
9	1	$ 38	0	$ -								
10	10	$ 412	0	$ -								
11	3	$ 131	0	$ -								
12	2	$ 75	2	$ 75	2	75	2	75				
13	16	$ 603	0	$ -								
14	8	$ 304	5	$ 190							5	190
15	6	$ 246	0	$ -								
16	14	$ 650	4	$ 186	4	186	3	139				
17	6	$ 66	3	$ 33	3	33						
18	18	$ 742	2	$ 82	2	82						
19	2	$ 82	0	$ -								
20	14	$ 534	0	$ -								
21	4	$ 150	4	$ 150					4	$150		
22	3	$ 141	3	$ 141					3	141		
23	5	$ 167	3	$ 100	3	100	2	67				
24	9	$ 377	9	$ 377							9	377
25	9	$ 424	0	$ -								
26	6	$ 233	0	$ -								
27	2	$ 83	0	$ -								
28	1	$ 42	1	$ 42	1	42	1	42				
29	2	$ 73	0	$ -								
30	3	$ 124	1	$ 41	1	41						
31	4	$ 164	4	$ 164	4	164	4	164				
32	17	$ 576	0	$ -								
33	10	$ 300	10	$ 300					10	300		
34	1	$ 38	0	$ -								
35	2	$ 84	0	$ -								
36	15	$ 665	6	$ 266	6	266	6	266				
37	3	$ 115	0	$ -								
38	7	$ 237	0	$ -								
39	2	$ 79	0	$ -								
40	17	$ 593	17	$ 593	17	593	13	454				
41	6	$ 261	6	$ 261					6	261		
42	54	$ 668	54	$ 668							54	668
43	4	$ 39	4	$ 39							4	39
44	10	$ 419	10	$ 419							10	419
45	3	$ 134	0	$ -								
46	60	$ 371	30	$ 371							30	371
47	2	$ 84	0	$ -								
48	3	$ 101	3	$ 101	3	101	3	101				
49	7	$ 271	3	$ 116	3	116	3	116				
50	8	$ 305	7	$ 267	7	267	4	153				
51	10	$ 447	0	$ -								
52	2	$ 94	0	$ -								

Appendix A
Schedule of Sample Items

Error Conditions in Units of Service and Claim Dollars:

Sample Order	Units Paid	Claim $ Paid	Units Disallowed	Claim $ Disallowed	Non-Rehabilitative Services Units	Non-Rehabilitative Services Claim $	Lack of Direct Care Units	Lack of Direct Care Claim $	Documentation Units	Documentation Claim $	Day Treatment Units	Day Treatment Claim $
53	3	$ 110	0	$ -								
54	8	$ 311	0	$ -								
55	16	$ 597	0	$ -								
56	10	$ 381	0	$ -								
57	10	$ 411	3	$ 123	3	$123	3	$123				
58	2	$ 81	0	$ -								
59	2	$ 79	2	$ 79	2	79	2	79				
60	14	$ 625	0	$ -								
61	5	$ 223	0	$ -								
62	6	$ 182	0	$ -								
63	11	$ 432	4	$ 157					4	$157		
64	2	$ 82	0	$ -								
65	12	$ 93	12	$ 93							12	$93
66	4	$ 134	2	$ 67	2	67	2	67				
67	2	$ 82	0	$ -								
68	40	$ 500	40	$ 500							40	500
69	8	$ 375	0	$ -								
70	3	$ 133	0	$ -								
71	6	$ 226	4	$ 151	2	75	2	75	2	75		
72	72	$ 561	72	$ 561					4	31	72	561
73	10	$ 393	10	$ 393	10	393	10	393				
74	4	$ 165	0	$ -								
75	6	$ 225	1	$ 37	1	37	1	37				
76	6	$ 252	6	$ 252	6	252						
77	3	$ 31	0	$ -								
78	14	$ 577	10	$ 412					10	412		
79	9	$ 314	9	$ 314	9	314	9	314				
80	11	$ 415	6	$ 226	6	226						
81	12	$ 402	0	$ -								
82	49	$ 606	49	$ 606							49	606
83	2	$ 83	2	$ 83	2	83	2	83				
84	7	$ 264	5	$ 189	5	189	5	189				
85	44	$ 1,414	44	$ 1,414							44	1,414
86	2	$ 95	0	$ -								
87	8	$ 302	0	$ -								
88	3	$ 115	3	$ 115	2	76	2	76	1	38		
89	8	$ 302	0	$ -								
90	4	$ 174	1	$ 44	1	44	1	44				
91	5	$ 191	4	$ 153	4	153	4	153				
92	8	$ 305	0	$ -								
93	21	$ 949	0	$ -								
94	5	$ 189	5	$ 189	5	189	3	113				
95	5	$ 161	0	$ -								
96	8	$ 299	0	$ -								
97	6	$ 178	6	$ 178	6	178	6	178				
98	8	$ 335	8	$ 335							8	335
99	8	$ 302	0	$ -								
100	3	$ 131	2	$ 87					2	87		
Totals	966	$ 28,099	533	$ 12,216	130	$4,836	99	$3,701	46	$1,654	361	$5,758
Total Claims with Error			51		31		25		10		13	

NOTE: Amounts and totals vary slightly from actual paid claim dollars due to immaterial rounding differences

SAMPLE METHODOLOGY

Population

The Rehabilitative Treatment Services Family-Centered Program sampling population consisted of claims made by the State of Iowa for Title XIX FFP reimbursement during FFY 2001 for payments made to providers. The Family-Centered claims totaled 45,895 for $12,696,196 with FFP equal to $7,956,706.

Sample Unit

The sample unit consisted of a claim for one type of Family-Centered service received by an individual client for the month of service. Service codes included those beginning with A1, A2, and A3, but excluded any supportive service codes.

Sample Design

A simple random sample was used to determine the results.

Sample Size

A sample size of 100 units was used.

Estimation Methodology

We used the Department of Health and Human Services, 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 Non-Zero Errors	Value of Errors
100	$28,099	51	$12,216

Variable Projections

	Claim Dollars	FFP Dollars
Point Estimate	$5,606,602	$3,513,657
90% Confidence Interval		
Lower Limit	$4,046,892	$2,536,187
Upper Limit	$7,166,312	$4,491,128

Fields of Opportunities

STATE OF IOWA

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

SEP - 3 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 FAMILY-CENTERED SERVICES – AUDIT REPORT CIN: A-07-02-03023

Dear Mr. Aasmundstad:

This is in response to a draft report dated August 1, 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 Family-Centered 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 45,895 Family-Centered claims for federal fiscal year 2001. The report indicates that OIG found errors in 83 of the 100 claims sampled with 51 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 Family-Centered claims during the audit period resulting in a recommended disallowance of $5,320,514 of the FFP claimed for these services for that period. The draft report also identifies two 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:

Bob Krebs
Iowa Department of Human Services, Division of Fiscal Management
Hoover State Office Building, 1st Floor
Des Moines, IA 50319
Phone: (515) 281-6028 Fax: (515) 281-6237 e-mail: rkrebs@dhs.state.ia.us

Sincerely,

Kevin W Concannon

Kevin W. Concannon
Director

AUDIT OF TITLE XIX FEDERAL FINANCIAL PARTICIPATION CLAIMED BY IOWA FOR REHABILITATIVE TREATMENT SERVICES FAMILY-CENTERED SERVICES AUDIT REPORT CIN: A-07-02-03023
Comments from Iowa Department of Human Services (September 2, 2003)

GENERAL COMMENTS

Revision of Draft Report:

Subsequent to issuing the draft report, OIG notified DHS in writing of revisions to the report. These revisions concerned the identification of one additional claim found to be in error and the details corresponding to that claim; i.e., the error reason(s), the number of units and amount in error, and the effect on the recommended disallowed amount. All figures and amounts in this response reflect these revisions.

OIG Interpretation of State Requirements:

It is the position of the Iowa Department of Human Services that OIG misinterpreted state law and administrative rule requirements pertaining to staff qualifications. This misinterpretation alone, resulted in the only "finding of error" in 24% of the sampled claims having an error. It is important to note that the staff qualification errors are the result of OIG's interpretation of **state** rather than federal requirements. This same interpretation resulted in OIG's determination that an error existed for each claim identified under this category. As described in more detail below, DHS is contesting OIG's interpretation of the state requirements associated with staff qualifications and requesting that all errors under this category be eliminated, the total number of units and dollar amount in error adjusted accordingly and the amount of any extrapolated disallowance recalculated after taking into account any other revisions necessary based on DHS's responses to the remaining findings.

Although the errors found by OIG in the sample of Family-Centered claims reviewed are summarized under six categories, this category (staff qualifications) is of particular concern due to its frequency and the methodology used by OIG in determining that errors existed. OIG found that 83 of the 100 claims sampled were in error for failure to meet staff qualifications. While this finding is specifically addressed under the **FINDINGS** section of this response, DHS wants to emphasize that this finding taken individually, has a substantial impact on the overall findings of the sampled claims and the recommended disallowance. Excluding all staff qualification errors could potentially reduce the overall unduplicated number of sampled units found in error by over 115, nearly 15% of the total of 783 sampled units found in error. Further, excluding all staff qualification errors would eliminate 20 sampled claims (24% of all sampled claims having an error) from having any errors, and reduce the amount of sampled claims in error by over 15%.

Providers' Terminology – Erroneous Use of the Phrase "Day Treatment"

DHS maintains that no error occurred for this reason under any of the sampled claims. Several audited providers erroneously used the phrase "day treatment" when referring to RTS Family-Centered services resulting in 13 of the 100 sample claims being found in error for this reason. Although a small percentage of Family-Centered service providers may have mistakenly used the term "day treatment" in documenting services provided, the services themselves were in fact

eligible Family-Centered services. DHS is contesting OIG's finding and requesting that all errors under this category be eliminated, the total number of units and dollar amount in error adjusted accordingly and the amount of any extrapolated disallowance recalculated after taking into account any other revisions necessary based on DHS's responses to the remaining findings.

While this error type is found less frequently (13 out of 100 sampled claims) than the staff qualifications error discussed above, it is also of special concern due to the number of units and corresponding amounts found in error for this reason as a proportion of all errors found. Five (5) claims were found to be in error for this reason only; however, these five claims represent nearly 28% of the total number of units found in error and almost 16% of the amount found in error.

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

In selecting federal fiscal year 2001 as the audit period, OIG sampled Family-Centered claims prior to the DHS routine audit on these claims. With respect to error findings other than staff qualifications and day treatment, 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 30 audits of Family-Centered 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. DHS requests that the applicable legal cites

for each finding 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.

FINDINGS

Staff Qualifications

OIG Finding:

We found that 47 of the 100 sample Family-Centered Services claims had staff that lacked the qualifications to provide therapy or develop treatment goals, both of which are required as part of the Therapy and Counseling Services. At a minimum, individuals providing therapy or developing treatment goals should be Licensed Master Social Workers, Licensed Independent Social Workers, or the equivalent. In 47 of the 100 sample claims, staff that did not have these minimum qualifications provided treatment.

The Iowa Administrative Code required that services covered by Medicaid should be within the scope of the licensure of the provider. The Iowa Code 154C.1 "Practice of Social Work" identified three categories of social work licensure: (1) Bachelor social workers (LBSW), (2) Master social workers (LMSW), and (3) Independent social workers (LISW). Only Licensed Master Social Workers and Licensed Independent Social Workers are listed as qualified to provide evaluation of symptoms and behaviors, strengths, and weaknesses; diagnosis, and treatment; psychosocial therapy with individuals, couples, families, and groups; establishment of treatment goals and monitoring progress etc. According to the Iowa Board of Social Work Examiners, Bachelor level social workers may not provide therapy, "*...in any setting....*"

Note: Subsequent to issuing the draft report, OIG reported to DHS that one additional claim had been found to be in error for this reason, bringing the total number of claims found to be in error due to staff qualifications to 48.

DHS Response:

This finding is based on OIG's misunderstandings of the "therapy and counseling" provided under the RTS program as well as the state social work licensure requirements regarding "therapy." "Therapy" is not a service provided under the RTS program. As stated in the background section of the draft report, the relevant RTS service is "therapy and counseling." In contrast, state social work licensing requirements provide that the practice of social work at the master social worker or independent social worker level includes "psychosocial therapy" that is part of "psychosocial assessment, diagnosis, and treatment." Iowa Code § 154C.1(3)(b)-(c).

"Therapy and counseling" under the RTS program is not "psychosocial therapy" that is part of "psychosocial assessment, diagnosis, and treatment" within the meaning of the state social work

licensing requirements. Therefore, the draft reports statement that "[a]t a minimum, individuals providing therapy . . . should be Licensed Master Social Workers, Licensed Independent Social Workers, or the equivalent" is incorrect. Regarding the development of treatment goals, state social work licensing requirements provide that the practice of social work at the Master Social Worker or Independent Social Worker level includes "differential treatment planning" that is part of "psychosocial assessment, diagnosis, and treatment." Iowa Code § 154C.1(3)(b)-(c). The development of treatment goals for "therapy and counseling" under the RTS program does not constitute "differential treatment planning" as part of "psychosocial assessment, diagnosis, and treatment." Therefore, OIG's statement in the draft report that "[a]t the minimum, individuals . . . developing treatment goals should be Licensed Master Social Workers, Licensed Independent Social Workers, or the equivalent" is also incorrect.

DHS's position on these matters is supported by the applicable state statutes and rules, past practice in the State, and 2001 state legislation directing DHS to further relax the staff qualifications for therapy and counseling services under the RTS program (which already did not require that those providing therapy and counseling or developing treatment goals for therapy and counseling must be Licensed Master Social Workers, Licensed Independent Social Workers, or the equivalent). *See* Iowa Code ch. 154C; 441 Iowa Admin. Code ch. 185; 645 Iowa Admin. Code ch. 282 (as amended August 11, 2003, to be published in the Iowa Administrative Bulletin on September 3, 2003); Iowa Acts 2001, ch. 135, sec. 23(1).

Non-Rehabilitative Services

OIG Finding:

We identified 35 of the 100 sample claims with services not considered rehabilitative treatment of the client. We found services monitoring and/or teaching parents about general age-appropriate discipline, chore charts, cleaning, and safety. In addition, services focused on the parent's issues such as marriage, finances, housing, and the parent's mental health and substance abuse issues.

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. The Iowa Administrative Code defined "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. CMS also reported that services aimed at teaching or enhancing parenting skills and general age-appropriate training were not covered rehabilitation services, regardless of how the specific needs of the child are documented in the case files.

DHS Response:

Out of 35 claims (166 units) identified as deficient by OIG, DHS takes exception to the findings in 17 claims (90 units). Refer to Attachment A for details. DHS requests that the final report be

revised to reflect the correct status of these 17 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.

Lack of Direct Patient Care

OIG Finding:

We concluded there was a lack of direct patient care in 31 of the 100 sample claims. The CMS report stated that Medicaid services must involve *direct* patient care, and be directed exclusively to the effective treatment of the Medicaid-eligible individual in order to qualify for Medicaid reimbursement. The CMS report further stated that nothing in the Medicaid statute or regulations would permit allowing FFP for services provided to treat family members. In each of these 31 claims, the client was not present or not involved in the treatment service.

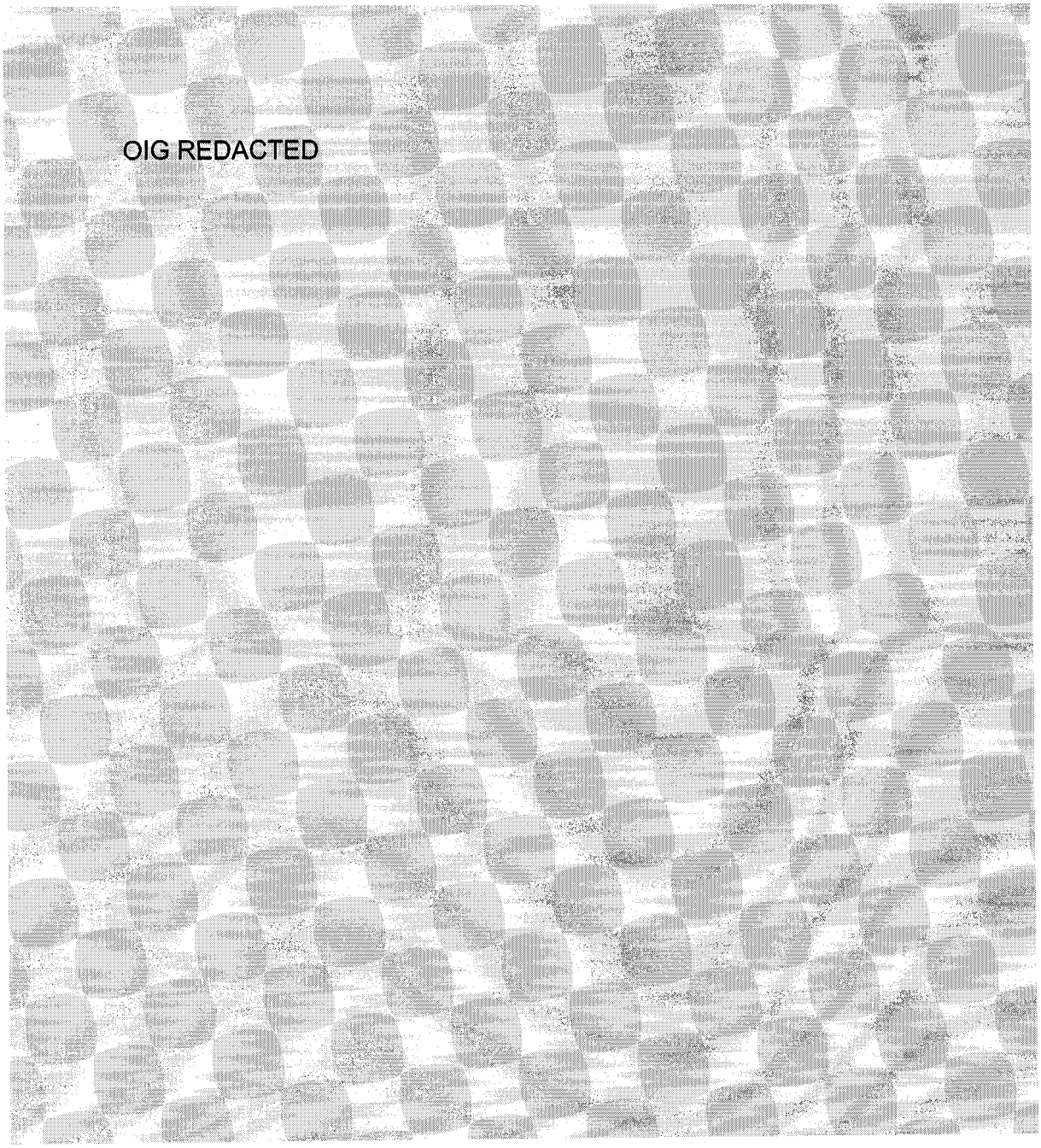
During our review we found documentation indicating that the State planned to implement a new policy to require the client's presence during RTS, but this policy was never implemented.

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 31 claims (126 units) identified as deficient by OIG, DHS takes exception to the findings in 16 claims (65 units). Refer to Attachment A for details. DHS requests that the final report be revised to reflect the correct status of these 16 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.



OIG REDACTED

Documentation REDACTED **Errors**

OIG Finding:

We found 17 of the 100 sample claims did not properly support the billed services. The Iowa Administrative Code required that documentation of billed services must include the date, amount of time, setting, service provider, the specific services rendered, the relationship of the service to the treatment plan, and updates describing client's progress.

OIG REDACTED

We identified the following documentation and authorization errors.

DOCUMENTATION AND AUTHORIZATION ERRORS	NUMBER OF CLAIMS
Missing documentation	7
Duplicated documentation of services	3
Missing treatment plan	3
OIG REDACTED	REDACTED

DHS Response (Documentation):

OIG REDACTED

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.

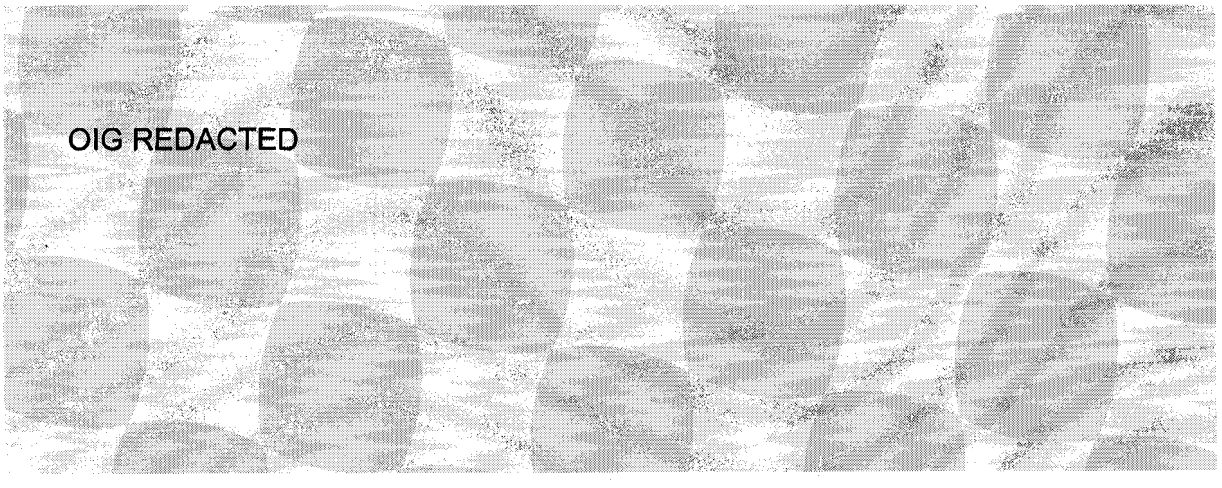
DHS reviewed each of the claims identified as having documentation errors and found the following:

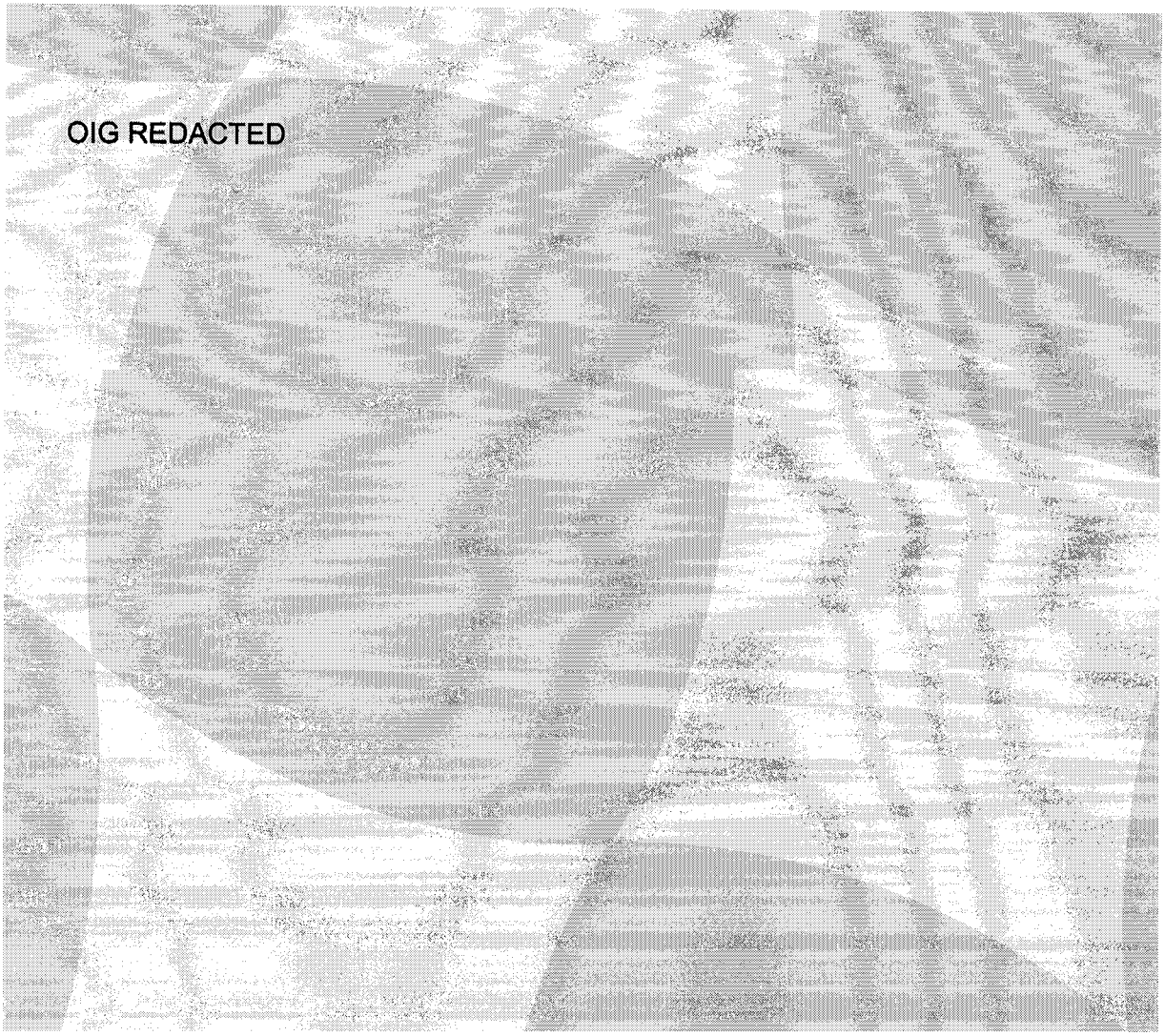
DOCUMENTATION ERRORS	NUMBER OF CLAIMS	DHS FINDINGS
Missing documentation	7	Out of the 7 claims (32 units) identified by OIG as deficient, DHS takes exception to the findings in 2 claims (7 units)
Duplicated documentation of services	3	Out of the 3 claims (6 units) identified by OIG as deficient, DHS takes exception to 2 claims (2 units).
Missing treatment plan	3	Out of 3 claims (20 units) OIG identified as deficient, DHS takes exception to 2 claims (16 units).

Refer to Attachment A for details.

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.

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.





Day Treatment

OIG Finding:

We found that 13 of the 100 sample claims were for services provided as part of day treatment programs that did not meet the Early and Periodic Screening, Diagnosis and Treatment Services requirements. The State plan specified, "*Under EPSDT authority, day treatment services for persons aged 20 or under shall be provided by hospitals with outpatient programs, psychiatric medical institutions for children, and community mental health centers.*" In addition, The Rehabilitative Treatment and Supportive Services Provider Handbook stated, "*Rehabilitative or nonrehabilitative treatment services cannot be paid for when a child or youth is in a psychiatric*

medical institution for children (PMIC), or other medical program, such as partial hospitalization or day treatment."

We found some providers billed RTS Family-Centered Services for 3 to 4 hours per day, covering mealtimes, for each client's regular attendance in their day treatment programs.

DHS Response:

DHS takes exception to the 13 claims (361 units) found to be in error for this reason. There are no services provided under the RTS program that are classified as day treatment. All services mentioned are "therapy and counseling" or "skill development" as regularly provided in the Family-Centered services program. These services do not fall under the umbrella of day treatment as provided under the EPSDT authority. Unfortunately, some providers or staff may have incorrectly referred to these programs as day treatment. The state should not be held liable for the use of colloquial terminology by some when describing a set of services.

DHS requests that the final report be revised to reflect the correct status of these claims and corresponding units found to be in error for this reason, and that any recommended disallowance be adjusted accordingly.

RECOMMENDATIONS

OIG Recommendations:

We recommend that the State:

- Return to the Federal Government $5,268,148 Medicaid FFP claimed for Family-Centered Services for FFY 2001.

  Note: Subsequent to issuing the draft report, OIG reported to DHS that one additional claim representing four units at a value of $165 had been found to be in error and that the recommended disallowed amount had been adjusted to $5,320,514 to reflect this.

- 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.

OTHER MATTERS

Public Places of Service and Sensitive Topics

OIG Statement:

We determined that 15 of the 100 sample claims included documentation of services provided in public settings where client confidentiality could be at risk. Additionally many of these sessions dealt with sensitive topics, such as sexual abuse and children's fears and problems.

The Social Security Act guarantees that a State plan must provide safeguards to restrict disclosure of information concerning recipients. The Iowa State Plan indicates RTS for Medicaid recipients age 20 or under may be provided in various settings, including the recipient's home, school, or workplace, as well as provider facilities; yet also requires that rehabilitative services must be a specific and effective treatment for a client's medical or disabling condition. The effectiveness of treatment services delivered in public settings where the general public may be observing and overhearing the entire treatment session may be questionable, and could pose considerable risk of violating the clients' confidentiality.

DHS Response:

DHS concurs that RTS providers must be ever vigilant regarding the protection of client confidentiality. While OIG notes documentation that services were provided in public settings, there is no evidence that any of the services provided in such settings were provided in a manner that would allow the general public to observe or overhear the treatment sessions. Such implication by OIG is based only on supposition.

Provider Criminal and Child Abuse Background Checks

OIG Statement:

Our review of the Iowa Code and the Iowa Administrative Code did not find any laws or regulations requiring either criminal or child abuse background checks for Family-Centered Services providers. We also found no licensure requirements for providers of Family-Centered Services. Only providers of RTS Family Foster Care and Group Care are required to be licensed and perform staff background checks. This screening is especially important given that Family-Centered Services are frequently provided to clients in their homes, and providers often transport clients.

We believe that the State should require Family-Centered Services providers to: (1) be licensed or held to standards similar to those for Family Foster Care providers, since both offer similar services, and (2) obtain background investigations on all employees.

DHS Response:

DHS concurs that neither federal nor state statutes or regulations require criminal or child abuse background checks or licensure for Family-Centered services providers. Historically, federal and state requirements for criminal and child abuse background checks have primarily been limited to providers of 24-hour services and child care. Despite this, the vast majority of Iowa's largest Family-Centered service providers already conduct criminal and child abuse background checks on all employees. DHS will consider requesting the Iowa Legislature to adopt legislation to require such checks of all Family-Centered service providers.

AUDIT OF TITLE XIX FEDERAL FINANCIAL PARTICIPATION CLAIMED BY IOWA FOR REHABILITATIVE TREATMENT SERVICES FAMILY-CENTERED SERVICES AUDIT REPORT CIN: A-07-02-03023
Comments from Iowa Department of Human Services (September 2, 2003)

ATTACHMENT A

Background

During the weeks of August 11 & August 18, 2003, DHS project managers conducted a "look behind" review of the 100 Family-Centered claims reviewed by OIG with respect to error findings concerning non-rehabilitative services, lack of direct patient care, and documentation. The findings of the project manager review are summarized below.

The comments only relate to 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 may not have reviewed the remaining areas for which deficiencies were found because of time constraints and the need to focus on the number of units for which we would take exception to OIG's recommendations 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 44 claims (215 units) in the amount of $8,041.66 that were identified as deficient in the OIG findings under B, C & E of the OIG report, DHS disputes the finding in whole or in part for 22 claims (102 units) in the amount of $3,897.20.

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:

Sample Order	Mo/Yr Svc	Full Service Code	Claim $ Paid	Units Paid	Units in Error	OIG Documentation Errors: Non-Rehabilitative Services	Lack of Direct Care	Missing Doc	Duplicated Doc	Missing Treatment Plan	max doc err	doc overpay	IDHS DOCUMENTATION FINDINGS: Agree	# Disputed	$ Disputed	Comments
5	09/2000	A110	$ 491	11	11	2	2				2	$89	2		$ -	Agree.
8	11/2000	A210	$ 268	8	6	6	6				6	$201	6		$ -	Agree.
12	08/2000	A210	$ 75	2	2	2	2				2	$75		2	$ 75.40	Disagree on both counts. The SD documented was appropriate and directed towards the client's identified needs and provided in accordance with the treatment paln.
16	03/2001	A210	$ 650	14	4	4	3				4	$186	4		$ -	Agree.
17	04/2001	A120	$ 66	6	6	3					3	$33	3		$ -	Agree.
18	07/2001	A110	$ 742	18	18	7	5				12	$495		12	$ 494.88	Disagree on both counts. Documentation of T&C was present for 20 units which addressed identified rehab needs of the client.
21	06/2001	A110	$ 150	4	4					4	4	$150		4	$ 150.36	Missing treatment plan. Disagree: There was a plan dated 4/26/01 in the file that covered services provided in June of 2001.
22	07/2001	A113	$ 141	3	3			3			3	$141		3	$ 141.36	Disagree. Documentation of 3 units of appropriate T&C was found in treatment record.
23	08/2001	A210	$ 167	5	3	3	2				3	$100	3		$ -	Agree.
24	11/2000	A112	$ 377	9	9				1		1	$42		1	$ 41.92	Disagree. Duplication not found. *Day Treatment Comment: Treatment plan says "Denision Day Treatment" which is a colloquial term for this family centered program. Services provided were family centered services.*
25	01/2001	A111	$ 424	9	9	3	3				3	$141		3	$ 141.36	Disagree on both counts. Documentation of 9 units of T&C which addressed the identified needs of the client was found.
28	12/2000	A212	$ 42	1	1	1	1				1	$42	1		$ -	Agree.
30	01/2001	A110	$ 124	3	3	1					1	$41	1		$ -	Agree.
31	11/2000	A110	$ 164	4	4	4	4				4	$164	4		$ -	Agree.
33	01/2001	A111	$ 300	10	10			10		10	10	$300	10		$ -	Agree with missing documentation. Disagree with missing treatment plan.
36	01/2001	A210	$ 666	15	6	6	6				6	$266	6		$ -	Agree.
40	03/2001	A211	$ 593	17	17	17	13				17	$593	7	10	$ 349.00	Agree for 7 units for both. Disagree for all other units for both where the documented SD was directed towards the client's identified needs and provided in accordance with the treatment plan.
41	05/2001	A117	$ 261	6	6					6	6	$261	6		$ -	Agree.
48	03/2001	A210	$ 101	3	3	3	3				3	$101	3		$ -	Agree.
49	11/2000	A110	$ 271	7	7	5	5				5	$194	3	2	$ 77.50	Non-Rehab Svcs: agree for 3 units, disagree on 2 units. There was a 1.5 hour, 3 unit session, that was a staffing which we agree was out. The other two 1 hour sessions (4 units total) were rehab services delivered with child present. Lack of Direct Care: disagree.
50	04/2001	A110	$ 305	8	8	7	4				7	$267		7	$ 267.19	Disagree on both counts. The T&C documented was appropriate and directed towards the client's identified needs and provided in accordance with the treatment plan.
57	11/2000	A110	$ 411	10	10	3	3				3	$123	3		$ -	Agree.
59	03/2001	A110	$ 79	2	2	2	2				2	$79		2	$ 78.50	Disagree on both counts. T&C was provided which addressed identified rehab needs of client.

Attachment A
Schedule of Sample Items

Error Conditions in Units of Service:

OIG Documentation Errors

DHS DOCUMENTATION FINDINGS

Sample Order	Mo/Yr Svc	Full Service Code	Claim $ Paid	Units Paid	Units In Error	Non-Rehabilitative Services	Lack of Direct Care	Missing Doc	Duplicated Doc	Missing Treatment Plan	aux doc err	doc overpay	Agree	# Disputed	$ Disputed	Comments
63	03/2001	A110	$ 432	11	11	7	7	4			7	$275		7	$ 274.91	Disagree on all counts. T&C was provided which addressed identified rehab needs of client and documentation was present for all 11 units paid.
66	11/2000	A210	$ 134	4	2	2	2				2	$67	2		$ -	Agree.
71	11/2000	A210	$ 226	6	4	2	2	2			4	$151	4		$ -	Agree.
72	04/2001	A222	$ 561	72	72				4		4	$31	4		$ -	Agree on duplication. *Day Treatment Comment: Services clearly labled and documented as family centered skill dev. Provider used colloquial name of "ACT Day Treatment Session Notes" at top of page.*
73	12/2000	A110	$ 393	10	10	10	10				10	$393	10		$ -	Agree.
75	02/2001	A210	$ 225	6	1	1	1				1	$37	1		$ -	Agree.
76	05/2001	A211	$ 252	6	6	6					6	$252	6		$ -	Agree.
78	11/2000	A110	$ 577	14	14			10			10	$412	10		$ -	Agree.
79	01/2001	A211	$ 314	9	9	9	9				9	$314	2	7	$ 244.30	Agree for 2 units for both. Disagree for 7 units on both counts where the documented SD was directed towards the client's identified needs and the treatment plan.
80	04/2001	A210	$ 415	11	11	11					11	$415	4	7	$ 263.90	Agree for 4 units. Disagree for 7 units where the documented SD was directed towards the client's identified needs and provided in accordance with the treatment plan.
83	06/2001	A210	$ 83	2	2	2	2				2	$83	2		$ -	Agree.
84	01/2001	A210	$ 264	7	7	7	5				7	$264		7	$ 263.90	Disagree on both counts. The SD documented was appropriate and directed towards the client's identified needs and provided in accordance with the treatment plan.
88	03/2001	A110	$ 115	3	3	2	2	1			3	$115	1	2	$ 76.34	Agree on missing documentation. Disagree on Non Rehab and Direct Care: The T&C documented was appropriate and was directed towards the client's identified needs and provided in accordance with the treatment plan.
90	03/2001	A117	$ 174	4	4	1	1				1	$44	1		$ -	Agree.
91	06/2001	A110	$ 191	5	5	4	4				4	$153		4	$ 152.68	Disagree on both counts. The T&C documented was appropriate and directed towards the client's identified needs and provided in accordance with the treatment plan.
92	05/2001	A110	$ 305	8	8	8	4				8	$305		8	$ 305.36	Disagree on both counts. The T&C documented was appropriate and was directed towards the client's identified needs and provided in accordance with the treatment plan.
94	12/2000	A210	$ 189	5	5	5	3				5	$189		5	$ 188.50	Disagree on both counts. The SD documented was appropriate and directed towards the client's identified needs and provided in accordance with the treatment plan.
96	08/2000	A110	$ 299	8	8	4	4				4	$149		4	$ 149.44	Non-Rehab Svcs: disagree. Services provided in both sessions were T&C services. Lack of Direct Care: disagree. While child was not present in one session, the treatment provided was directed towards the child's needs.

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	Claim $ Paid	Units Paid	Units in Error	Non-Rehabilitative Services	Lack of Direct Care	Missing Doc	Duplicated Doc	Missing Treatment Plan	max doc err	doc overpay	Agree	# Dispute	$ Disputed	Comments
97	05/2001	A211	$ 178	6	6	6	6				6	$178	2	4	$ 116.48	Agree on both counts for 2 units. Disagree on both counts for 4 units. The SD documented was directed towards the client's 3055 identified needs and was provided in accordance with the treatment plan.
98	04/2001	A112	$ 335	8	8			1			1	$42		1	$ 41.92	Disagree: Duplication not found. *Day Teatment Comment: Treatment plan says "Fort Dodge Enhanced Family Centered Day Treatment" which is a colloquial term for this family centered program. Services provided were family centered services.*
100	05/2001	A117	$ 131	3	2			2			2	$87	2		$ -	Agree.
Totals			$ 28,099	966	783	166	126	32	6	20	215	$8,041.66	113	102	$3,897.20	
Total Claims with Error					83	35	31	7	3	3	0.0					
											56.14%	28.62%				
			late oig change										0.47		51.54%	% OF $ IN DOCUMENTATION ERRORS
															13.70%	% OF TOTAL Units IN SAMPLE in error
															14.75%	% OF TOTAL $ IN SAMPLE in error
			sublotal of units			166	126	32	6	20	215					
			sub count of cases			35	31	7	3	3	44					

Non-Rehabilitation Services	**Out of 35 cases/166 units**	**Agree 18 cases/ 76 units**	**Disagree 17 cases/ 90 units**
Lack of Direct Care	**Out of 31 cases/126 units**	**Agree 15 cases/ 61 units**	**Disagree 16 cases/ 65 units**
Missing Documentation	**Out of 7 cases/32 units**	**Agree 5 cases/ 25 units**	**Disagree 2 cases/ 7 units**
Duplicated Documentation	**Out of 3 case/6 units**	**Agree 1 case/ 4 units**	**Disagree 2 cases/ 2 units**
Missing Treatment Plan	**Out of 3 cases/20 units**	**Agree 1 case/ 4 units**	**Disagree 2 cases/ 16 units**

AUDIT OF TITLE XIX FEDERAL FINANCIAL PARTICIPATION CLAIMED BY IOWA FOR REHABILITATIVE TREATMENT SERVICES FAMILY- CENTERED
AUDIT REPORT CIN: A-07-02-03023
Comments from Iowa Department of Human Services (September 2, 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.