DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAR 23 2005

TO: Dennis G. Smith
Director, Center for Medicaid and State Operations
Centers for Medicare & Medicaid Services

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

SUBJECT: Audit of Iowa's Adult Rehabilitation Services Program (A-07-03-03041)

Attached is an advance copy of our final report on Iowa's adult rehabilitation services program. We will issue this report to the Iowa Department of Human Services within 5 business days. We conducted this audit at the request of the Centers for Medicare & Medicaid Services.

Our objective was to determine whether the State's claims for adult rehabilitation services met Federal and State Medicaid reimbursement requirements. During our audit period, Federal fiscal year (FFY) 2002, the State claimed $10,563,635 in Federal Medicaid matching funds for adult rehabilitation services.

Of the 100 adult rehabilitation services claims in our statistically valid sample, 65 were unallowable under Federal and State requirements. Pursuant to Federal law, the Medicaid State plan, the State Medicaid Manual, or the Iowa Administrative Code:

- Documentation must support each patient encounter and each item of service reported on the Medicaid claim form.
- Services must be rehabilitative in nature and may not be primarily habilitative.
- A targeted case planner may not have a financial interest in any services rendered as specified in the comprehensive treatment plan.
- Medicaid services must involve direct patient care.

Of the 65 unallowable claims, 64 contained more than 1 error:

- Documentation was missing or inadequate for 65 claims.
- The services were nonrehabilitative for 53 claims.
- A conflict of interest existed because the provider both authorized and rendered the services for 30 claims.
- No services were provided or the beneficiaries were not present for 11 claims.

The errors occurred because the State lacked adequate internal controls over the adult rehabilitation services program to ensure that services claimed for Medicaid reimbursement met applicable requirements. We estimate that $6,244,154 of the $10,563,635 in Federal funds that the State claimed for FFY 2002 was unallowable.

We recommend that the State:

- refund $6,244,154 to the Federal Government and

- strengthen policies and procedures to ensure that services claimed for Medicaid reimbursement are directed exclusively to the beneficiary's rehabilitative needs and meet other Federal and State requirements.

In response to our draft report, the State generally concurred, agreeing overall with 59 of the 65 claims found in error. It generally agreed with our findings on documentation errors, nonrehabilitative services, and claims for which no services actually were provided or the beneficiaries were not present. However, the State disagreed with the in-house targeted case management errors in their entirety. The State requested that we revise the report and refund recommendation to the extent of the claims it disputed. It also requested that we adjust the total dollars in question because it considered the sample results to be somewhat biased on the high side for estimating the universe book value and error dollars.

We do not agree with the State in regard to any of the claims that it disputed for nonrehabilitative services and in-house targeted case management. Although we did not contest the State's position on two claims questioned for lack of documentation, these two claims had other errors. Therefore, even though we revised the final report, we did not revise the refund recommendation. We also disagree with the State's position regarding the sample results.

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-07-03-03041 in all correspondence.

Attachment

Office of Inspector General
Office of Audit Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

MAR 28 2005

Report Number: A-07-03-03041

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

Dear Mr. Concannon:

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

The HHS action official will make final determination as to actions taken on all matters reported. 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-07-03-03041 in all correspondence.

Sincerely,

James P. Aasmundstad
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Mr. Dick Brummel
Acting Regional Administrator
Centers for Medicare & Medicaid Services, Region VII
Department of Health and Human Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106-2808

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF IOWA'S ADULT REHABILITATION SERVICES PROGRAM

MARCH 2005

A-07-03-03041

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

Title XIX of the Social Security Act (the Act) allows optional coverage of rehabilitation services under the Medicaid program. Federal regulations define "rehabilitation services" as any medical or remedial services recommended by a physician or another licensed practitioner of the healing arts and provided to reduce physical or mental disability and restore an individual to the best possible functional level.

Iowa established an adult rehabilitation services program for persons with chronic mental illness in January 2001. Services for Medicaid beneficiaries are described in the Iowa Medicaid State plan. For Federal fiscal year (FFY) 2002, the State claimed $10,563,635 in Federal Medicaid matching funds for adult rehabilitation services.

Concerned about the allowability of claims and rising program costs, the Centers for Medicare & Medicaid Services (CMS) requested that we review Iowa's program.

OBJECTIVE

Our objective was to determine whether the State's claims for adult rehabilitation services met Federal and State Medicaid reimbursement requirements.

SUMMARY OF FINDINGS

Of the 100 adult rehabilitation services claims in our statistically valid sample, 65 were unallowable under Federal and State requirements. Pursuant to Federal law, the Medicaid State plan, the State Medicaid Manual, or the Iowa Administrative Code:

- Documentation must support each patient encounter and each item of service reported on the Medicaid claim form.
- Services must be rehabilitative in nature and may not be primarily habilitative.
- A targeted case planner may not have a financial interest in any services rendered as specified in the comprehensive treatment plan.
- Medicaid services must involve direct patient care.

Of the 65 unallowable claims, 64 contained more than 1 error:

- Documentation was missing or inadequate for 65 claims.
- The services were nonrehabilitative for 53 claims.

- A conflict of interest existed because the provider both authorized and rendered the services for 30 claims.

- No services were provided or the beneficiaries were not present for 11 claims.

The errors occurred because the State lacked adequate internal controls over the adult rehabilitation services program to ensure that services claimed for Medicaid reimbursement met applicable requirements. We estimate that $6,244,154 of the $10,563,635 in Federal funds that the State claimed for FFY 2002 was unallowable.

RECOMMENDATIONS

We recommend that the State:

- refund $6,244,154 to the Federal Government and

- strengthen policies and procedures to ensure that services claimed for Medicaid reimbursement are directed exclusively to the beneficiary's rehabilitative needs and meet other Federal and State requirements.

AUDITEE COMMENTS

In response to our draft report, the State generally concurred, agreeing overall with 59 of the 65 claims found in error. It generally agreed with our findings on documentation errors, nonrehabilitative services, and claims for which no services actually were provided or the beneficiaries were not present. However, the State disagreed with the in-house targeted case management errors in their entirety. The State requested that we revise the report and refund recommendation to the extent of the claims it disputed. It also requested that we adjust the total dollars in question because it considered the sample results to be somewhat biased on the high side for estimating the universe book value and error dollars.

OFFICE OF INSPECTOR GENERAL RESPONSE

We do not agree with the State in regard to any of the claims that it disputed for nonrehabilitative services and in-house targeted case management. Although we did not contest the State's position on two claims questioned for lack of documentation, these two claims had other errors. Therefore, even though we revised the final report, we did not revise the refund recommendation. We also disagree with the State's position regarding the sample results.

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INTRODUCTION

BACKGROUND

Medicaid Program

Pursuant to Title XIX of the Act, the Medicaid program, which the Federal and State Governments jointly fund, provides 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 funds are available to match expenditures under the Medicaid State plan. In Iowa, the Department of Human Services is the Medicaid State agency responsible for administering the Medicaid program and for safeguarding against unnecessary or inappropriate use of Medicaid services and against excess payments.

Title XIX of the Act allows optional coverage of rehabilitation 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.

Iowa Rehabilitation Services for Adults With Chronic Mental Illness

In 1999, Iowa's General Assembly directed the State to work with county representatives toward implementing a rehabilitation option for services to adults with chronic mental illness under the Medical Assistance Program. This legislative mandate resulted from a proposal by several counties that adult rehabilitation services be covered in a manner similar to coverage of these services to children under the Medicaid Rehabilitation Treatment and Support Services program. Consequently, the adult rehabilitation services program was established in January 2001.

Iowa State Plan

Adult rehabilitation services for Medicaid beneficiaries are described in the Iowa State plan under "Rehabilitation Services for Persons With Chronic Mental Illness." Services include (1) rehabilitation support services (which include community living skills training services and employment-related services) and (2) day program services (which are limited to the day program for skills training and the day program for skills development).

According to the State plan:

- Services must be demonstrated to be rehabilitative (medical or remedial services provided to reduce physical or mental disability and restore an individual to the best possible functional level) and may not be primarily habilitative (services designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills).

- A licensed practitioner of the healing arts must certify the individual's diagnosis of chronic mental illness and the medical necessity and appropriateness of the rehabilitation services for the individual's chronic mental illness.

- A case planner must develop a comprehensive treatment plan that includes a rehabilitation service component. The case planner must be designated by the beneficiary and must be a "targeted case planner" enrolled in the Iowa Medicaid program or an individual who otherwise meets the qualifications of and can enroll as a targeted case manager. The case planner may not have a financial interest in any services rendered as specified in the comprehensive plan.

State Regulations

The Iowa Administrative Code states that adult rehabilitation services must be designed to promote the beneficiary's integration and stability in the community, quality of life, and ability to obtain or retain employment or to function in other nonwork, role-appropriate settings. To be eligible for rehabilitation services, the Iowa Administrative Code requires that individuals be "adults with chronic mental illness," defined as persons 18 years of age or older with a persistent mental or emotional disorder that seriously impairs their functioning relative to primary aspects of daily living, such as personal relations, living arrangements, or employment. According to a State official, chronic mental illness is a regulatory, not a clinical, diagnosis.

CMS Review and Request for Audit

In 1994, CMS initiated a review of Iowa's rehabilitative treatment and support services program for children because of several concerns, including the nontraditional Medicaid services that the program covered and the significant program cost. The CMS report, issued March 3, 1996, found that:

- Some program services billed to Medicaid were not rehabilitative.

- Social, educational, vocational, and/or leisure services were delivered under the program.

- Some service claims had no documentation.

CMS had similar concerns with these issues, as well as with rising costs, in the adult rehabilitation services program. For FFY 2002, the State submitted Federal adult rehabilitation service claims that totaled $16,805,019, which was a substantial increase over the prior year. Subsequently, CMS requested that the Office of Inspector General (OIG) audit the Iowa adult rehabilitation services program to determine whether the State had procedures to safeguard against unnecessary or inappropriate use of Medicaid services and against excess payments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State's claims for adult rehabilitation services met Federal and State Medicaid reimbursement requirements.

Scope

Our audit period was October 1, 2001, through September 30, 2002 (FFY 2002). We selected a simple random sample of 100 claims from a population of 104,465 adult rehabilitation service claims for FFY 2002. The 104,465 claims totaled $16,805,019 ($10,563,635 Federal share). The 100 sampled claims totaled $21,658 ($13,614 Federal share) and included 34 of the 144 adult rehabilitation service provider sites in Iowa. We performed fieldwork at the 34 sites, where we analyzed supporting documentation for the 100 claims.

We did not review the State's overall internal control structure. Rather, we limited our internal control review to those controls pertaining directly to the adult rehabilitation services program.

Methodology

To accomplish our audit objective:

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

- We held discussions with CMS staff from the central and regional offices to gain an understanding of the CMS role in approving the State plan and of CMS guidance to the State for the adult rehabilitation services program.

- We held discussions with State officials to determine State policies and procedures for claiming Federal Medicaid funds for adult rehabilitation services.

- We obtained data files from Affiliated Computer Services, the State's fiscal agent, for all adult rehabilitation service claims for FFY 2002 and reconciled the claim amounts to the Quarterly Medicaid Statements of Expenditures for the Medical Assistance Program (Form CMS 64) for FFY 2002.

- We obtained cost reports and interviewed providers concerning their method of cost allocation for the adult rehabilitation services program. Rates for services are set retrospectively based on the submission of provider cost reports.

- We held discussions with contractors responsible for the authorization of adult rehabilitation services (targeted case managers), certification of adult rehabilitation service providers (the fiscal agent), and transmission of adult rehabilitation service claims data (the fiscal agent).

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

FINDINGS AND RECOMMENDATIONS

Of the 100 adult rehabilitation services claims in our sample, 65 were unallowable under Federal and State requirements. The unallowable claims occurred because the State did not have adequate policies and procedures to ensure that services claimed for Medicaid reimbursement were directed exclusively to the rehabilitative needs of the beneficiary and were in compliance with other Federal and State requirements. We estimate that $6,244,154 of the $10,563,635 in Federal funds that the State claimed for FFY 2002 was unallowable.

Of the 65 unallowable claims, 64 contained more than 1 error:

- Documentation was missing or inadequate for 65 claims.
- The services were nonrehabilitative for 53 claims.
- A conflict of interest existed because the provider both authorized and rendered the services for 30 claims.
- No services were provided or the beneficiaries were not present for 11 claims.

DOCUMENTATION ERRORS

Section 2500.2(A) of the CMS State Medicaid Manual requires that all supporting documentation, in readily reviewable form, be compiled and immediately available when the claim is filed. Supporting documentation includes, at a minimum, date of service; name of beneficiary; Medicaid identification number; name of provider agency and person providing the service; nature, extent, or units of service; and place of service. Section 441-IAC 79.3(2) of the Iowa Administrative Code states that documentation must support each patient encounter with a narrative containing information necessary to support each item of service reported on the Medicaid claim form. In addition, section 441-IAC 78.48(3)(4) of the Iowa Administrative Code requires a certification by a licensed practitioner of the healing arts and a comprehensive treatment plan, and sections 441-IAC 24.4(3) and 441-IAC 62.12(1) require an individual plan for beneficiaries.

The billed services were not supported properly for 65 of the 100 sampled claims. The only support for some claims was a monthly census sheet showing that the beneficiary was present in the facility (but not necessarily present for the service offered), calendars with activities for the month, or weekly and/or monthly progress notes. Table 1 summarizes the documentation errors identified.

Table 1: Documentation Errors

Type of Error	Number of Claims
Missing required elements of documentation	56
No narrative	17
No documentation	12
Missing practitioner certification	2

For the 56 claims that were missing required elements of documentation of services, most of the case notes supporting the claims were missing multiple elements. All 56 were missing the Medicaid identification number; 35 were missing the name of the provider; 22 were missing the name of the person providing the service; 40 were missing the nature, extent, or units of service; and 29 were missing the place of service.

NONREHABILITATIVE SERVICES

The Iowa State plan requires that services be rehabilitative in nature and not primarily habilitative. The Iowa Administrative Code defines habilitative services as designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills. In addition, section 4385(B) of the State Medicaid Manual states that although a social service, in the course of addressing an individual's basic life needs (adequate food, housing, or income), may indirectly affect the individual's health as well, it is not covered under Medicaid because it is not directly and primarily concerned with the individual's health. A social service may be furnished directly to an individual beneficiary, but it typically is directed broadly at the individual's overall well-being rather than specifically at the individual's health.

The services for 53 of the 100 sampled claims were social services or habilitative services as defined above and therefore were not allowable for Federal Medicaid reimbursement. For example, some services involved teaching beneficiaries about personal hygiene, housecleaning, cooking, grocery shopping, budgeting, and filling medication boxes. In other cases, services focused on leisure skills (such as recreation, exercise, and sports) or socialization skills, which included group activities (such as bingo games and social clubs).

Other nonrehabilitative services included transportation of beneficiaries and/or collateral contacts billed as rehabilitative services. Case notes for these services detailed transporting beneficiaries to the grocery store, bank, pharmacy, and restaurants. Collateral contacts involved a phone call with the beneficiary. Neither transportation nor collateral contacts are considered rehabilitation services. Iowa's Medicaid Provider Manual for Adult Rehabilitation Services, Chapter E, section III(B)(1) specifically excludes transportation and collateral contacts as billable rehabilitation services.

Employment-related services also were billed, generally while the beneficiary worked at a supported employment facility. Employment-related services involved basic job supervision such as keeping the beneficiary on task and observations about the beneficiary's general appearance. Staff did not provide any interventions beyond what would be expected in any working environment. Documentation of services included observations about the beneficiary's

task-specific activities, including sweeping, vacuuming, and hanging up clothes. One provider informed us that there was no separate documentation of service because "the work is the service."

IN-HOUSE TARGETED CASE MANAGEMENT

Section 1915(g)(2) of the Act defines "case management" as services that will assist an individual eligible under the State plan in gaining access to needed medical, social, educational, and other services, but excludes the direct provision of these services. Case management services are referred to as "targeted case management" when the services are directed toward a specific population, such as individuals with chronic mental illness. Section 13d(2) of the State plan and section 441-IAC 78.48(1) of the Iowa Administrative Code both state that a targeted case planner may not have a financial interest in any services rendered as specified in the comprehensive treatment plan.

In-house targeted case management was provided for 30 of the 100 sampled claims. These claims were from four provider agencies that used their own employees for targeted case management for beneficiaries and also provided the direct services. The services provided in these claims were authorized in a comprehensive plan developed by a case planner who did not meet Iowa's State plan requirements for the segregation of the authorization and provision of services. In our opinion, a conflict of interest exists when the same provider agency authorizes and provides the services. Thus, the 30 claims were unallowable for Medicaid reimbursement because the services were authorized in a comprehensive plan that did not meet the requirements of the State plan or the Iowa Administrative Code.

LACK OF DIRECT PATIENT CARE/NO SERVICES OFFERED

Section 4385(B) of the State Medicaid Manual provides that Medicaid services must involve direct patient care, and section 13d(7)(k) of the State plan excludes any services not provided directly to an eligible beneficiary. Section 441-IAC 79.3(2) of the Iowa Administrative Code requires documentation for each patient encounter, including information necessary to support each item of service reported on the Medicaid claim form.

Of the 100 sampled claims, 11 were unallowable for Medicaid reimbursement because they did not meet these criteria. For 4 of the 11 claims, the beneficiary was not present for the services billed. For example, some services were billed when the monthly census listed the beneficiary as present at the facility, even if the beneficiary was not present for the service. For the remaining seven claims, no services were offered. In some cases, services were billed for every day of the month even though services were not provided on weekends and holidays.

RECOMMENDATIONS

We recommend that the State:

- refund $6,244,154 to the Federal Government and

- strengthen policies and procedures to ensure that services claimed for Medicaid reimbursement are directed exclusively to the beneficiary's rehabilitative needs and meet other Federal and State requirements.

AUDITEE COMMENTS AND OIG RESPONSE

The State generally concurred with the findings in this report, with the exception of in-house targeted case management. Overall, it agreed with 59 of the 65 unallowable claims. The State's comments are summarized below with the OIG response and are included in their entirety as Appendix B.

Adjustment to Recommended Disallowance To Compensate for Excessive Average Cost Per Claim in the Sample

Auditee Comments

Although the State did not specifically address our recommendation that it refund $6,244,154 to the Federal Government, it said that any final recommended disallowance resulting from our audit must be adjusted to compensate for an excessive average cost per claim for the 100 claims sampled. The State asserted that although the audit sample results were not statistically different from the universe, the average cost per claim in the audit sample was higher than the average cost per claim in the universe. The State concluded that the sample results appeared to be somewhat biased on the high side for estimating the universe book value and error dollars and recommended that the sample results be adjusted to more closely reflect the universe results.

OIG Response

We disagree with the State's comments. As the State asserted in its response, "the audit sample results are not statistically different from the universe." Using the sample to estimate the universe total, the point estimate is $22,624,769. (The State estimate is similar: $22,625,029.) The 90-percent confidence interval is $9,687,334 to $35,562,203. This confidence interval includes the actual universe total of $16,805,019, indicating that the sample results are not statistically different from the universe.

We selected our sample according to principles of probability, i.e., every sampling unit has a known nonzero chance of selection. Our estimate of unallowable Federal Medicaid funding is valid. The point estimate is $12,090,868. The 90-percent confidence interval is $6,244,154 to $17,937,582. The confidence interval takes into account the variation due to sampling. We recommend refunds at the lower limit of the confidence interval to take sampling variation into account. No further modifications to the estimate are appropriate.

Documentation Errors

Auditee Comments

The State agreed with most of our findings. After further review of documentation, it disputed only 12 claims involving missing elements of documentation (10 claims) and no documentation

(2 claims). The State cited documentation requirements for billed services from section 441-IAC 79.3(2) of the Iowa Administrative Code and maintained that we had interpreted documentation requirements too narrowly.

OIG Response

After reviewing the State's documentation, we agreed with the State on some claims and disagreed on others. However, the two claims on which we agreed with the State did not change our recommendation because the claims had other errors. Only 10 claims remain in dispute. Table 2 summarizes the documentation errors questioned in this report and those that remain in dispute.

Table 2: Documentation Errors Remaining in Dispute

Documentation Errors	Claims Questioned	Claims Remaining in Dispute
Missing required elements of documentation	56	10
No narrative	17	0
No documentation	12	0
Missing practitioner certification	2	0

We disagree with the State's position disputing 10 claims for missing elements of documentation. Section 2500.2(A) of the State Medicaid Manual requires seven elements of supporting documentation that must be in readily reviewable form, compiled, and immediately available when the claim is filed.

Some of the errors in the 10 disputed claims included omissions of the service code describing the nature or extent of the service, staff name, place of service, provider name, and Medicaid identification number.

Nonrehabilitative Services

Auditee Comments

The State generally agreed with our conclusions and took exception to only 11 of the 53 claims in error, saying that these claims were for rehabilitative services.

OIG Response

We agree that 2 of the 11 contested claims involved some rehabilitative services. However, all 11 claims also involved services regarding income and budgeting, socialization skills, nature study, and poetry writing, as well as services provided over the phone or while transporting the beneficiary. Section 4385(B) of the State Medicaid Manual states that even though a social service, in the course of addressing an individual's basic life needs (adequate food, housing, or income), may indirectly affect the individual's health as well, it is not covered under Medicaid because it is not directly and primarily concerned with the individual's health.

In its response, the State described adult rehabilitation services as "specifically focused on skills training." We believe that the services in question more closely approximate those defined under section 441 IAC 78.48(249A) of the Iowa Administrative Code as "habilitative services," or services designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills.

During our fieldwork, providers told us that they were frustrated by the lack of guidance and training that the State provided on the adult rehabilitation services program in general and, specifically, on how to determine the difference between rehabilitative and nonrehabilitative services.

In-House Targeted Case Management

Auditee Comments

The State contested all 30 of the claims, citing Attachment 3.1-A(13)(d)(1), page 36b of the Iowa State plan and section 441 IAC 78.48(2)(a) of the Iowa Administrative Code. It maintained that although Iowa rules required that individuals acting as adult rehabilitation services case planners must not provide direct services or have any financial interest in any services, these requirements did not prohibit the same agency from providing both services as long as the two functions were segregated sufficiently.

OIG Response

We disagree with the State's position. Section 1915(g)(2) of the Act defines case management as services that will assist an individual eligible under the State plan in gaining access to needed medical, social, educational, and other services, but excludes the direct provision of these services. Section 13d(2) of the State plan and section 441-IAC 78.48(1) of the Iowa Administrative Code both state that a targeted case planner may not have a financial interest in any services rendered as specified in the comprehensive treatment plan.

In our opinion, the targeted case planner and provider agency are one and the same because the individual case planner represents, and is compensated by, the agency. Therefore, a financial interest does appear to exist. The provider whose agency provided 83 percent of the 30 in-house targeted case management claims in error told us that all of its residents who received adult rehabilitation services also received targeted case management services in the same facility.

Lack of Direct Patient Care/No Services Offered

Auditee Comments

The State originally contested 1 of the 11 claims found in error. Upon further review of documentation, it changed its position and now agrees with all 11 claims.

OIG Response

The State agreed with our findings that for 4 of the 11 erroneous claims, the beneficiary was not present for the services billed and that for the remaining 7 claims, no services were offered.

APPENDIXES

SAMPLE METHODOLOGY

POPULATION

The population consisted of State claims for Title XIX Federal reimbursement during FFY 2002 for payments made to providers. The State submitted 104,465 claims for adult rehabilitation services for FFY 2002 that totaled $16,805,019, with a Federal share of $10,563,635 ($16,805,019 × 0.6286 Federal matching rate).

SAMPLE UNIT

The sample unit consisted of an individual claim for Federal reimbursement made by the State during FFY 2002 for payments to adult rehabilitation service providers. Each claim record details one type of rehabilitation service that an individual beneficiary received.

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 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. We reported the estimate of unallowable claims 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	$21,657.75	65	$18,412.48

VARIABLE PROJECTIONS

	Claim Dollars	**Federal Dollars**
Point Estimate	$19,234,597	$12,090,868
90-Percent Confidence Interval		
Lower Limit	$9,933,430	$6,244,154
Upper Limit	$28,535,765	$17,937,582

Fields of Opportunities

STATE OF IOWA

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

OCT 15 2004

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 ADULT REHABILITATION SERVICES – AUDIT REPORT CIN: A-07-03-03041

Dear Mr. Aasmundstad :

This is in response to a draft report dated July 14, 2004, concerning the Office of Inspector General's (OIG) audit of Iowa's claim for federal financial participation (FFP) under title XIX for Adult Rehabilitation Services for federal fiscal year 2002. 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 104,465 Adult Rehabilitation Services claims for federal fiscal year 2002. The report indicates that OIG found errors in 65 of the 100 claims sampled with 64 of these having multiple errors. OIG summarized the errors it found into four (4) categories. OIG extrapolated its findings from the 100 claims sampled to all Adult Rehabilitation Services claims during the audit period resulting in a recommended disallowance of $6,244,154 of the FFP claimed for these services for that period. The draft report also identifies five (5) 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. DHS would welcome the opportunity to work with OIG to resolve areas of disagreement or other concerns before the final report is issued.

Questions about the attached response can be addressed to:

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Sincerely,

Kevin W. Concannon

Kevin W. Concannon
Director

KCW/rk

AUDIT OF TITLE XIX FEDERAL FINANCIAL PARTICIPATION CLAIMED BY IOWA FOR ADULT REHABILITATION SERVICES
AUDIT REPORT CIN: A-07-03-03041
Comments from Iowa Department of Human Services (October 15, 2004)

IDHS GENERAL COMMENTS

Adjustment to Recommended Disallowance to Compensate for Excessive Average Cost Per Claim in the Sample

The Iowa Department of Human Services (IDHS) contends that any final recommended disallowance resulting from the Office of Inspector General's (OIG) audit of the state's Adult Rehabilitation Option (ARO) services program must be adjusted to compensate for an excessive average cost per claim from the 100 claims used for the audit sample. IDHS makes this request based on the following analysis by the department's Results Based Accountability Division.

1. As described under the **Scope** section of the draft report, OIG used an audit period of October 1, 2001 through September 30, 2002 (federal fiscal year 2002) resulting in a universe of 104,465 ARO claims totaling $16,805,019. This amount is the net result from a combination of both positive book values for claims paid or adjusted and negative book values for adjusted claims where the provider returned dollars to the state; i.e., this is the amount for which the state claimed federal financial participation (FFP) under title XIX during the audit period. Using these figures, the average cost per claim from the universe comprising the audit period was $160.87 ($16,805,019 ÷ 104,465).

   1.1. The OIG audit took a random sample of 100 claims from the universe. These claims were also composed of claims with positive and negative values. The total net book value of the 100 sampled claims was $21,657.75 for an average book value of $216.58 per claim ($21,657.75 ÷ 100). There were 86 positive claims that had a book value of $28,315.19 and 14 negative (adjusted) claims with a book value of -$6,657.44.

   1.2. The assumptions going into the OIG audit report and to the following discussion are:

      1.2.1. The sample is random and representative of the universe.

      1.2.2. The results of the audit are correct (additional adjustments will be needed to reflect any changes in the value of sample errors resulting from other comments in this response).

   1.3. Although the audit sample results are not statistically different from the universe, the average cost per claim of $216.58 from the audit sample is nearly 35% higher than the average cost per claim of $160.87 from the universe [($216.58 – 160.87 = $55.71) ÷ $160.87 = .346].

      1.3.1. If $216.58 was the average cost per claim for the universe as well as the sample, then the universe would have an estimated total net book value of $22,625,029 ($216.58 x 104,465) or 35% above the established book value. Although this could be possible, it is not likely that the universe book value is this greatly understated.

1.3.2. When the error dollars (disallowed dollars) are computed from the sample, the average error dollars per claim is $184.1248 ($18,412.48 ÷ 100). [Note: to compare to the OIG report, the dollars per claim were not rounded to the nearest two places.] When projecting this to the universe of 104,465 claims the estimated universe error dollars is $19,234,597 ($184.1248 x 104,465), which is 14+% higher than the universe book value of $16,805,019 [{$19,234,597 - $16,805,019 = $2,429,578} ÷ $16,805,019 = .1446].

1.3.3. The sample results therefore are biased on the high side for estimating both the universe book value and error dollars as both exceed the actual universe book value of $16,805,019 for which FFP was claimed. The estimated universe book value of $22,625,029 would have to be reduced by approximately 25.7% to arrive at the actual universe book value [{$22,625,029 - $16,805,019 = $5,820,010} ÷ $22,625,029]. Applying a corresponding reduction to the estimated error amount for the universe results in an adjusted error value of $14,291,306 [$19,234,597 - ($19,234,597 x 0.257 = $4,943,291)]. IDHS contends that this figure more accurately represents the error value of the universe.

1.3.4. Because the maximum dollars for which the State of Iowa would be responsible is the federal portion (.6286 for FFY 2002) of the value of any claims paid in error, this percentage should be applied to the adjusted estimated error amount for the universe above when determining the federal share of any disallowance.

Conclusion: The sample results appear to be somewhat biased on the high side for estimating universe book value and error dollars. It is recommended that the sample results be adjusted to more nearly reflect the universe results. This would adjust the total error dollars in question as follows:

Projections	OIG Estimated Dollars	IDHS Adjusted Dollars
Estimated Total Error Dollars	$19,234,597	$14,291,306
Upper 90% Confidence Level	$28,535,765	$21,202,073
Lower 90% Confidence Level	$9,933,430	$7,380,538
Federal Share of the Lower Limit (.6286)	$6,244,154	$4,639,406

Recommendation: The total Federal dollars in error to be repaid would be $4,639,406 ($1,604,748) less than previously calculated.

OIG Interpretation of State Requirements:

It is the position of the Iowa Department of Human Services (IDHS) that OIG has too narrowly interpreted departmental administrative rules pertaining to the required elements for documenting Adult Rehabilitation Option (ARO) services. In reviewing documentation

requirements of ARO services for the sampled claims, OIG relied on Iowa Administrative Code (IAC) rule 441-79.3(2). This rule, which is applicable to all Medicaid providers rather than only to ARO providers, states:

79.3(2) Clinical records. Providers of service shall maintain complete and legible clinical records for which a charge is made to the program documenting that the services are medically necessary, the services are consistent with the diagnosis of the patient's condition, and the services are consistent with professionally recognized standards of care. Providers shall make the records available to the department or its duly authorized representative on request. The documentation for each patient encounter shall include the following ***when appropriate (emphasis added)***:

a. Complaint and symptoms; history; examination findings; diagnostic test results; assessment,

clinical impression or diagnosis; plan for care; date; and identity of the observer.

b. Specific procedures or treatments performed.

c. Medications or other supplies.

d. Patient's progress, response to and changes in treatment, and revision of diagnosis.

e. Information necessary to support each item of service reported on the Medicaid claim form.

The rule states that the listed items shall be documented for each patient encounter **when appropriate.** OIG has interpreted this to mean that every item must be documented for every patient encounter and more specifically, that paragraph (e) of this rule requires the ARO provider to document each item reported on the Medicaid claim form for each encounter. IDHS maintains that while it is appropriate to document certain elements with each separate patient encounter, such as the date of service, the specific procedures or treatment performed and the name of the person performing the actual service, the rule does not require repeating elements that remain constant from one encounter to the next, or, which would be obvious from the context and circumstances associated with each encounter being billed. As ARO provider records are patient specific, the following elements do not change: name of the beneficiary, Medicaid identification number and the name of the provider agency (the individual providing the service may change, but not the agency). It is appropriate that these three (3) elements be documented at least once in the provider record and readily and immediately available; however, as these elements do not change it is unnecessary to repeat them with each encounter. IDHS applied this more reasonable interpretation in addressing specific documentation error findings in the next section of these comments as well as in Attachment A.

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FINDINGS

Documentation Errors

OIG Finding:

Section 2500.2(A) of the State Medicaid Manual requires that all supporting documentation, in readily reviewable form, be compiled and immediately available when the claim is filed. Supporting documentation includes, at a minimum, date of service; name of beneficiary; Medicaid identification number; name of provider agency and person providing the service; nature, extent, or units of service; and place of service. The Iowa Administrative Code § 441-IAC 79.3(2) states that documentation must support each patient encounter with a narrative containing information necessary to support each item of service reported on the Medicaid claim form. In addition, § 441-IAC 78.48(3)(4) of the Iowa Administrative Code requires a certification by a licensed practitioner of the healing arts and a comprehensive treatment plan, and §§ 441-IAC 24.4(3) and 441-IAC 62.12(1) require an individual plan for beneficiaries.

The billed services were not properly supported for 65 of the 100 sampled claims. The only support for some claims was a monthly census sheet showing that the beneficiary was present in the facility (but not necessarily present for the service offered), calendars with activities for the month, or weekly and/or monthly progress notes.
The following table summarizes the documentation errors identified.

Type of Error	Number of Claims
Missing required elements of documentation of services	56
No narrative	17
No documentation	14
Missing licensed practitioner of the healing arts certification	2

For the 56 claims that were missing required elements of documentation of services, most of the case notes supporting the claims were missing multiple elements. All 56 were missing the Medicaid identification number; 35 were missing the name of the provider; 22 were missing the name of the person providing the service; 40 were missing the nature, extent, or units of service; and 29 were missing the place of service.

IDHS Response:

As discussed in the **GENERAL COMMENTS** section of this response, IDHS maintains that OIG too narrowly interpreted IAC 441--79.3(2) regarding documentation requirements. For claims identified by the OIG as having one or more documentation error, IDHS reviewed each of the 65 claims identified as such (along with the corresponding recipient files received from the affected providers) and found the following (refer to Attachment A for details):

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DOCUMENTATION ERRORS	NUMBER OF CLAIMS FOUND IN ERROR BY OIG	IDHS FINDINGS
Missing required elements of documentation of services	56	IDHS concurs with the OIG finding for 46 claims. IDHS disagrees with the OIG finding for ten (10) claims (44 units). The IDHS review of these ten (10) claims determined that these claims had the elements noted by the OIG as "missing".
No narrative	17	IDHS concurs with the OIG finding for 16 claims. IDHS disagrees with OIG regarding one (1) claim (1 unit).
No documentation	14	IDHS concurs with the OIG finding for ten (10) claims. IDHS disagrees with the OIG finding for four (4) claims (12 units). The IDHS review of these four (4) claims determined that sufficient documentation was present.
Missing licensed practitioner of the healing arts certification	2	IDHS concurs with the OIG finding for these two (2) claims.

IDHS 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 the reasons noted above, and that any recommended disallowance be adjusted accordingly.

Non-Rehabilitative Services

OIG Finding:

The Iowa State plan requires that services be rehabilitative in nature and not primarily habilitative. The Iowa Administrative Code defines habilitative services as designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization and adaptive skills. In addition, section 4385(B) of the State Medicaid Manual states that while a social service, in the course of addressing an individual's basic life needs (adequate food, housing, income), may indirectly affect the individual's health as well, it would not be covered under Medicaid because it is not directly and primarily concerned with the individual's health. A social service may be furnished directly to an individual beneficiary, but it typically is directed broadly at the individual's overall well-being rather than specifically at the individual's health.

The services for 53 of the 100 sampled claims were for social services or habilitative services as defined above and, therefore, were not allowable for Federal Medicaid reimbursement. For example, some services involved teaching beneficiaries about personal hygiene, house cleaning, cooking, grocery shopping, budgeting, and filling medication boxes. In other cases, services focused on leisure skills (such as recreation, exercise, and sports) as well as socialization skills, which included group activities (such as bingo games and social clubs).

Other nonrehabilitative services included transportation of beneficiaries and/or collateral contacts billed as rehabilitative services. Case notes for these services detailed transporting beneficiaries to the grocery store, bank, pharmacy, and restaurants. Collateral contacts involved a phone call with the beneficiary. Neither transportation nor collateral contacts are considered rehabilitation services.

Employment-related services were also billed, generally while the beneficiary worked at a supported employment facility. Employment-related services involved basic job supervision such as keeping the beneficiary on task and observations about the beneficiary's general appearance. Staff did not provide any interventions beyond what would be expected in any working environment. Documentation of services included observations about the beneficiary's task-specific activities, including sweeping, vacuuming, and hanging up clothes. One provider informed OIG that there was no separate documentation of service because the work is the service.

IDHS Response:

IDHS reviewed each of the 53 claims (306 units) identified by OIG as being in error for this reason and takes exception to the findings in 11 claims (24 units). Refer to Attachment A for details.

While IDHS does not dispute that the case records for these claims may contain descriptions of services such as those cited in the report, IDHS maintains that the OIG either: 1) too narrowly interpreted how these services could help address the rehabilitative needs of the client (related to the client's chronic mental illness (CMI); 2) failed to recognize that the service was in fact rehabilitative in nature; or 3) failed to recognize other rehabilitative services being provided concurrently with the examples described. Providers may provide both rehabilitative and nonrehabilitative services for the same client at the same general time making it more difficult for anyone not specifically trained in rehabilitation services to adults with CMI to distinguish between the two.

IDHS requests that the final report be revised to reflect the correct status of these 11 claims and corresponding units and amount found to be in error for this reason, and that any recommended disallowance be adjusted accordingly.

In-House Targeted Case Management

OIG Finding:

Section 1915(g)(2) of the Act defines "case management" as services that will assist an individual eligible under the State plan in gaining access to needed medical, social, educational, and other services, but excludes the direct provision of these services. Case management services are referred to as "targeted case management" when the services are directed toward a specific population, such as individuals with chronic mental illness. Section 13d(2) of the State plan and § 441-IAC 78.48(1) of the Iowa Administrative Code both state that a targeted case planner may not have a financial interest in any services rendered as specified in the comprehensive treatment plan.

In-house targeted case management was provided for 30 of the 100 sampled claims. These claims were from 4 provider agencies that used their own employees for targeted case management for beneficiaries and then also provided the direct services. The services provided in these claims were authorized in a comprehensive plan developed by a case planner who did not meet Iowa's State plan requirements for the segregation of the authorization and provision of services. In our opinion, a conflict of interest exists when the same provider authorizes and provides the services. Thus, the 30 claims were unallowable for Medicaid reimbursement because the services were authorized in a comprehensive plan that did not meet the requirements of the State plan and the Iowa Administrative Code.

IDHS Response:

The draft report finds that 30 of the sampled claims were unallowable because the services provided were authorized in a comprehensive plan that did not meet the requirements of the Iowa Medicaid State Plan and the Iowa Administrative Code.

Both the State Plan and Iowa rules require that covered adult rehabilitation services be included in a comprehensive plan developed as specified in the State Plan and rules. See Iowa State Plan, Attachment 3.1-A, p. 36b, sec. (13)(d)(1)(a); 441 Iowa Admin. Code 78.48(2)(a). The comprehensive plan must be developed by a "case planner," defined in the rules as follows:

> *"Case planner"* means an individual, designated by the recipient, performing the functions described under subrule 78.48(3) who is a targeted case manager enrolled in the Iowa Medicaid program or who has the qualifications to enroll as such, but who does not have a financial interest in any services being rendered as specified in the comprehensive plan, and who meets one of the following qualifications:
> 1. Has a bachelor's degree with 30 semester hours or equivalent quarter hours in a human services field and at least one year of experience in the delivery of services to the population groups served.

2. Has an Iowa license to practice as a registered nurse and at least three years of experience in the delivery of services to the population groups served.

441 Iowa Admin. Code 78.48(1). See also 441 Iowa Admin. Code 78.48(3); State Plan, Attachment 3.1-A, p. 36c, sec. (13)(d)(2).

The problem identified in the draft report with the 30 claims found to be unallowable is that the case planner was an employee of the agency that provided the adult rehabilitation service. The draft report states that this did not meet the "requirements for the segregation of the authorization and provision of services" and that, **in the OIG's opinion**, "a conflict of interest exists when the same provider authorizes and provides the services."

As noted above, Iowa administrative rules define "case planner" as "an individual," not an agency. The individual acting as case planner must be a targeted case manager enrolled in the Iowa Medicaid program, or must have the qualifications to enroll as such, and must "not have a financial interest in any services being rendered as specified in the comprehensive plan." 441 Iowa Admin. Code 78.48(1). See also State Plan, Attachment 3.1-A, p. 36c, sec. (13)(d)(2). The targeted case management requirements, which are incorporated into the definition of case planner, themselves incorporate the standards for providers of services to persons with mental illness, mental retardation, or developmental disabilities in 441 Iowa Admin. Code chapter 24. 441 Iowa Admin. Code 77.29(1). The requirements of chapter 24 provide that case managers may not provide direct services. 441 Iowa Admin. Code 24.9(b)(8).

Thus, Iowa rules require that individuals acting as adult rehabilitation services case planners must not provide direct services or have any financial interest in any service provided. These requirements do not, however, prohibit the same agency from providing adult rehabilitation case planning and direct adult rehabilitation services, as long as the case planning and provision of services are sufficiently segregated so individual case planners do not provide services and have no financial interest in any services provided.

Each of the four agencies that were providing both the case planning and direct services in the 30 claims found to be unallowable on this basis were providing adult rehabilitation case planning as targeted case management reimbursed by the Iowa Medicaid program. As providers of case management services to the chronically mentally ill under the Iowa Medicaid Program, these agencies were subject to 441 Iowa Admin. Code chapter 24. See 441 Iowa Admin. Code 77.29(1). Chapter 24 clearly contemplates the same agency providing both case management and direct services but requires, as noted above, that the individual case managers may not provide direct services. See 441 Iowa Admin. Code 24.4(9)(b)(8). In addition, chapter 24 requires that case managers must advocate for the individuals receiving case management and must document that those individuals are informed about their choice of service providers. See 441 Iowa Admin. Code 24.4(9)(b)(4), (10).

Pursuant to these requirements, agencies providing both case planning and direct services have internal policies segregating case management from direct service provision, insuring that the individual case managers do not provide direct services and have no financial interest in any of the services provided. Copies of the internal policies of Vera French, Abbe Center, and Broadlawns are included as Attachments B, C, and D, respectively. It is noted that the two Broadlawns-affiliated providers (Broadlawns Medical Center SCL Program and Broadlawns Residential Facility) for which the OIG found to be providing both case planning and direct services, such case planning was actually rendered by the Broadlawns case management program that served each of these separately-enrolled Broadlawns-affiliated providers. The State believes that these requirements and agency policies adequately segregate authorization and provision of services, obviating any conflict of interest.

As reflected in the state rules allowing the same agency to provide case management and direct services, prohibiting the same agency from doing both would make it difficult to find qualified case management or case planning services in some parts of the State.

IDHS requests that the final report be revised to reflect the correct status of these 30 claims and corresponding units and amount found to be in error for this reason, and that any recommended disallowance be adjusted accordingly.

Lack of Direct Patient Care/No Services Offered

OIG Finding:

Section 4385(B) of the State Medicaid Manual provides that Medicaid services must involve direct patient care, and § 13d(7)(k) of the State plan excludes any services not provided directly to an eligible beneficiary. Section 441-IAC 79.3(2) of the Iowa Administrative Code requires documentation for each patient encounter, including information necessary to support each item of service reported on the Medicaid claim form.

Eleven of the 100 sampled claims were unallowable for Medicaid reimbursement because they did not meet these criteria. For 4 of the 11 claims the client was not present for the services billed. For example, some services were billed when the monthly census listed the beneficiary as present at the facility, even if the beneficiary was not present for the service. For the remaining seven claims, no services were offered. In some cases, services were billed for every day of the month even though services were not provided on weekends and holidays.

IDHS Response:

IDHS reviewed each of the 11 claims (4 for "lack of direct patient care" and 7 for "no services offered") and corresponding 33 units (5 for "lack of direct patient care" and 28 for "no services offered") identified by OIG as being in error for these reasons and takes exception to the findings in 1 claim (2 units). Refer to Attachment A for details.

IDHS 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.

RECOMMENDATIONS

OIG Recommendations:

We recommend that the State:

- refund $6,244,154 to the Federal Government
- strengthen policies and procedures to ensure that services claimed for Medicaid reimbursement are directed exclusively to the beneficiary's rehabilitative needs and meet other Federal and State requirements

IDHS Response:

With the exception of the issues of: "In-House Targeted Case Management", "Authorization of Services/County Involvement", and "Community Support Services" (as noted elsewhere in this response), IDHS generally concurs with the OIG findings regarding the 65 claims, 438 units and $18,412.48 found to be in error from the audit sample. After accounting for any overlap of claims having multiple error reasons, IDHS is disputing $552.59 of the amount reported in error representing six (6) claims and 15 units. Although IDHS concurs with most of the amount from the sample OIG reported in error, as described under the **GENERAL COMMENTS** section, IDHS is requesting that any final recommended disallowance (after any necessary changes to the sample amount found in error resulting from other IDHS comments) be adjusted to compensate for the excess value of the average cost per claim in the sample.

IDHS believes that, as described throughout this response, its current policies and procedures are generally adequate to ensure Medicaid payments for ARO services are made in accordance with the State Plan and comply with applicable State rules and Federal regulations. However, if based on further review and it is determined that there are policies and procedures that could or should be strengthened to improve program oversight and integrity, IDHS stands ready to make any necessary changes in this regard.

OTHER MATTERS *

Noncompliance with Background Checks

OIG Statement:

***OIG note: Iowa's comments on the other matters are not applicable because we have deleted those matters from this final report.**

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Ten of 34 adult rehabilitation service providers were not in full compliance with the State plan requirement that providers request criminal history information on all employees as authorized under the Iowa Code. Some providers had background checks on some, but not all, of their employees. Other providers were missing documentation of background checks and some providers conducted no background checks. Section 135C.33 of the Iowa Code requires that providers request a criminal history check and that the State perform a dependent adult abuse record check of all prospective employees.

IDHS Response:

The draft report states that 10 of 34 adult rehabilitation services providers had not conducted background checks on employees as required by Iowa Code 135C.33. Iowa Code 135C.33 requires background checks for employees of "facilities," as defined in Iowa Code 135C.1, and for "employees of all of the following, if the provider is regulated by the state or receives any state or federal funding:

a. An employee of a homemaker, home-health aide, home-care aide, adult day services, or other provider of in-home services if the employee provides direct services to consumers.

b. An employee of a hospice, if the employee provides direct services to consumers.

c. An employee who provides direct services to consumers under a federal home and community-based services waiver.

d. An employee of an elder group home certified under chapter 231B, if the employee provides direct services to consumers.

e. An employee of an assisted living program certified under chapter 231C, if the employee provides direct services to consumers.

Iowa Code 135C.33(5).

Adult rehabilitation services providers can fall within these requirements on three grounds:

1. Because they are residential care facilities, which are "facilities" as defined in 135C.1 (see 441 Iowa Admin. Code 77.42(1)(d); State Plan, Attachment 3.1-A, p. 36f, sec. (13d)(d));

2. Because they are providing in-home services to consumers; or

3. Because they are supported employment or support community living providers under a home and community-based waiver (441 Iowa Admin. Code 77.42(1)(e), (f); State Plan, Attachment 3.1-A, p. 36f, sec. (13d)(e), (f)).

However, other qualified adult rehabilitation services providers are not required to conduct background checks. Physicians, community mental health centers, psychologists, supported

employment or support community living providers not providing services under a home and community-based services waiver, adult day care providers, and providers of other mental health services may all provide adult rehabilitation services and are not required to conduct background checks unless they are providing services in the home. See 441 Iowa Admin. Code 77.42(1)(a)-(c), (e)-(h); State Plan, Attachment 3.1-A, p. 36f, sec. (13d)(a)-(c), (e)-(h).

Thus it cannot be assumed that all adult rehabilitation services providers are required to conduct background checks. IDHS will review each of the ten (10) adult rehabilitation services providers identified in the draft report as not having conducted background checks to determine which, if any, were required to do so in accordance with Iowa Code 135C.33. IDHS will instruct any provider required to conduct background checks that has not done so to, to complete and document all necessary checks.

Treatment Goals

OIG Statement:

Treatment goals in comprehensive treatment plans were nonrehabilitative for 60 of the 100 sampled claims. Comprehensive treatment plan goals addressed socialization and leisure activities, vocational skills, housing and environmental issues, topics related to the beneficiary's income, and self-care. As reported in the "Nonrehabilitative Services" section of this report, 53 of the 100 sampled claims involved services that were nonrehabilitative. When the goals are nonrehabilitative, the services provided to achieve the stated goals are usually nonrehabilitative as well.

Section 13.d of Iowa's State plan requires that adult rehabilitation services be medically necessary and included in the individual's comprehensive plan.. The issues addressed by the majority of comprehensive treatment plan goals did not appear to be medical or remedial and therefore did not meet the definition of rehabilitation as stated in § 1905(a)13 of the Act.

IDHS Response:

IDHS reviewed each of the 60 claims identified by OIG (no units were separately identified by the OIG) as being in error for this reason and takes exception to the findings in 8 of these 60 claims. Refer to Attachment A for details.

In its review of submitted provider recipient records related to these claims, IDHS found sufficient documentation in the records associated with the 8 claims noted above to demonstrate that the treatment goals ***were*** in fact rehabilitative in nature and related to the recipients chronic mental illness (CMI) symptomology. Related to these 8 claims, IDHS maintains that the OIG either: 1) too narrowly interpreted how the treatment goals in these instances ***are*** in fact rehabilitative in nature and related to the client's CMI; 2) failed to recognize that the treatment goal noted by the OIG as problematic ***do*** in fact correspond to deficits (due to a given recipient's

CMI) that are explicitly mentioned in both Iowa's approved State Plan and under corresponding state rules; and/or 3) lacked the awareness of and familiarity with CMI and well-recognized rehabilitative service standards related to these conditions. See 441 Iowa Admin. Code 78.48(6)(a)(1)-(2), (b)(1)-(2); State Plan, Attachment 3.1-A, p. 36e, sec. 13d(A)(5)(a)(1)-(2), (b)(1)-(2). IDHS does not take issue with the remaining 52 claims of the 60 identified by the OIG related to this concern, as our review of provider records found no documentation indicating treatment goals were rehabilitative in nature.

As is reflected under the above-cited state rules and State Plan sections, ***all*** of the examples of treatment goals noted by the OIG above as problematic ***are*** in fact consistent with the provisions under these cited authorities. The specific types of treatment goals noted by the OIG as being problematic were related to: "socialization and leisure activities, vocational skills, housing and environmental issues, topics related to the beneficiary's income, and self-care." IDHS's belief that these types of treatment goals ***are*** consistent with the above cited authorities is summarized below, as follows:

- "Socialization and leisure activities." Treatment goals related to these types of activities are explicitly addressed under the above-cited authorities. As an example, "Community Living Skills Training Services" are defined under each cited authority, as follows:

  "Community living skills training services. These services are age-appropriate skills training or supportive interventions that focus on the improvement of ***communication skills, appropriate interpersonal behaviors,*** and other skills necessary for independent living or, when age-appropriate, for functioning effectively with family, peers, and teachers. ***Training for independent living may include, but is not limited to, skills related to*** personal hygiene, ***household tasks, transportation use, money management, the development of natural supports,*** access to needed services in the community (e.g., medical care, dental care, legal services), ***living accommodations, and social skills*** (e.g., communicating one's needs and ***making appropriate choices for the use of leisure time***)." ***(emphasis added)***

  441 Iowa Admin. Code 78.48(6)(a)(1); State Plan, Attachment 3.1-A, p. 36e, sec. 13d(A)(5)(a)(1)

- "Vocational skills." Treatment goals related to these types of skills are explicitly addressed under the above-cited authorities. As an example, "Employment-Related Services" are defined under each cited authority, as follows:

  "Employment-related services. These services are age-appropriate training and supports that are not job- or task-specific and ***have as their focus the development of skills to reduce and manage the symptoms of mental illness that interfere with the person's ability to make vocational choices and to attain or retain employment.*** Included are activities such as skills training related to task focus, maintaining concentration, task completion, planning and managing activities to achieve outcomes, personal hygiene, grooming, communication, and skills training related to securing appropriate clothing, developing natural supports, and arranging transportation. Also included are supportive contacts in an educational setting on

or off the work site to reduce or manage behaviors or symptoms related to the individual's mental illness that interfere with job performance or progress toward the development of skills that would enable the individual to obtain or retain employment." ***(emphasis added)***

441 Iowa Admin. Code 78.48(6)(a)(2); State Plan, Attachment 3.1-A, p. 36e, sec. 13d(A)(5)(a)(2)

- "Housing and environmental issues." Treatment goals related to these types of issues are explicitly addressed under the above-cited authorities. As an example, "Community Living Skills Training Services" are defined under each cited authority, as follows:

  "Community living skills training services. These services are age-appropriate skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other ***skills necessary for independent living*** or, when age-appropriate, for functioning effectively with family, peers, and teachers. ***Training for independent living may include, but is not limited to,*** skills related to personal hygiene, ***household tasks, transportation use,*** money management, the ***development of natural supports, access to needed services in the community*** (e.g., medical care, dental care, legal services), ***living accommodations,*** and social skills (e.g., communicating one's needs and making appropriate choices for the use of leisure time)." ***(emphasis added)***

  441 Iowa Admin. Code 78.48(6)(a)(1); State Plan, Attachment 3.1-A, p. 36e, sec. 13d(A)(5)(a)(1)

- "Topics related to the beneficiary's income." Treatment goals related to a recipient's income are explicitly addressed under the above-cited authorities. As an example, "Community Living Skills Training Services" are defined under each cited authority, as follows:

  "Community living skills training services. These services are age-appropriate skills training or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age-appropriate, for functioning effectively with family, peers, and teachers. ***Training for independent living may include, but is not limited to, skills related to*** personal hygiene, household tasks, transportation use, ***money management***, the development of natural supports, access to needed services in the community (e.g., medical care, dental care, legal services), living accommodations, and social skills (e.g., communicating one's needs and making appropriate choices for the use of leisure time)." ***(emphasis added)***

  441 Iowa Admin. Code 78.48(6)(a)(1); State Plan, Attachment 3.1-A, p. 36e, sec. 13d(A)(5)(a)(1)

- "Self-care." Treatment goals related to a recipient's self-care are explicitly addressed under the above-cited authorities. As an example, "Community Living Skills Training Services" are defined under each cited authority, as follows:

"Community living skills training services. ***These services are age-appropriate skills training or supportive interventions that focus on the improvement of*** communication skills, appropriate interpersonal behaviors, ***and other skills necessary for independent living*** or, when age-appropriate, for functioning effectively with family, peers, and teachers. ***Training for independent living may include, but is not limited to, skills related to personal hygiene, household tasks,*** transportation use, money management, ***the development of natural supports, access to needed services in the community (e.g., medical care, dental care, legal services), living accommodations,*** and social skills (e.g., communicating one's needs and making appropriate choices for the use of leisure time)." ***(emphasis added)***

441 Iowa Admin. Code 78.48(6)(a)(1); State Plan, Attachment 3.1-A, p. 36e, sec. 13d(A)(5)(a)(1)

IDHS requests that the final report be revised to reflect the correct status of these eight (8) claims.

Community Support Services

OIG Statement:

For 18 of the 100 claims reviewed, the beneficiaries received Community Support Services concurrently through Magellan Behavioral Health (Magellan), the contractor for the State's behavioral health managed care program. Community Support Services are funded and implemented through a waiver under § 1915(b)(3) of the Act. According to information provided by Magellan, adult rehabilitation service beneficiaries receiving services during FFY 2002 also received approximately $1.4 million in Community Support Services.

Magellan receives a monthly capitation fee regardless of whether services are provided. There is no charge to the user. Magellan's services are described as being designed to address mental or functional disabilities that negatively affect integration and stability in the community and are nearly identical to the description of Rehabilitation Support Services in the State plan. In fact, a targeted case planner informed us that it was difficult to determine which services to use because of their similarity. Additionally, for one claim, the same case note was used to support billing for adult rehabilitation services and Community Support Services. Another claim even had a third funding source.

The Act requires Medicaid to consider the availability of other sources of funding before paying for services. Because Rehabilitation Support Services appear to be nearly identical to Community Support Services, which are already funded by Magellan without charge to the user, payment by Medicaid may not be reasonable and necessary and could potentially duplicate payments under another program.

IDHS Response:

IDHS reviewed each of the 18 claims identified by OIG (no units were separately identified by the OIG) as being in error for this reason and takes exception to the findings for all 18 claims. Refer to Attachment A for details.

In its review of submitted provider recipient records related to these claims, IDHS found nothing in the records associated with the 18 claims that would demonstrate that Community Support Services (CSS) under Magellan funding and which were billed by these providers was duplicative of any services billed under ARO funding, under fee-for-service Medicaid. The fundamental reason for this is because the two types of services are themselves otherwise separate and distinct in terms of the underlying focus of each. The only similarity between the two types of services is that they are each provided to persons with chronic mental illness (CMI). In particular, CSS services are specifically "clinically-based" and "treatment-oriented" services. Whereas ARO services are specifically "rehabilitative" in nature and focus primarily on skills training. These differences will be more fully addressed in the overviews of each service, below.

An excel spread sheet is included as Attachment E lists of Medicaid recipients who received ARO and CSS services during the same month. Encounter data has been obtained for these recipients. The attached spreadsheet indicates the Medicaid recipients received different services from each source during the same time period. Based on a review of the data provided by the ARO fee-for-service system and the CSS encounter data, none of the 25 persons who received both ARO and CSS services during the same time period received duplicate services.

Overview of Adult Rehabilitation Services (ARO)

ARO provides Medicaid coverage for rehabilitation services for people with a chronic mental illness (CMI). ARO services are fee-for-service benefits. To be Medicaid payable, ARO services must relate to a rehabilitative goal(s) specified in a comprehensive plan prepared by an ARO case planner. The ARO case planner is typically a targeted case manager (TCM) who is already providing covered TCM services to the recipient related to the recipient's CMI. The need for ARO services must be certified by a licensed practitioner of the healing arts (LPHA), which Iowa Medicaid ARO rules define as either a physician or a psychologist who meets the standards under ARO rules. The LPHA certifies that the recipient meets the definition of an adult with CMI as defined under the ARO rules and has a need for rehabilitation services.

Per Iowa's approved State Plan and corresponding state rules, ARO services must be rehabilitative in nature and may not be primarily habilitative. The services must be designed to promote integration and stability in the community, quality of life, and the person's ability to obtain or retain employment or to function in other non-work, role-appropriate settings. Further, the rehabilitation service(s) must be: 1) included in a comprehensive plan prepared by the ARO case planner; 2) consistent with professionally accepted guidelines and standards of practice for the rehabilitation service being provided; 3) furnished in the most appropriate and least restrictive available setting in which the service can be safely provided and at the most

appropriate level for the individual; and 4) provided by or through a provider enrolled in the Iowa Medicaid program.

Medicaid providers may employ or contract with paraprofessionals or licensed professionals to deliver rehabilitation services to recipients, subject to the conditions enumerated under ARO rules at 441—78.48(2) "d"(1) - (5). Providers can include physicians, community mental health centers, psychologists, residential care facilities, supported employment service providers, supported community living services providers, adult day care services providers, and providers of other accredited mental health services. Covered services include community living skills training, employment-related services, day program for skills training and day program for skills development.

Overview of Community Support Services (CSS)

Iowa Medicaid mental health and substance abuse benefits are provided to most Medicaid recipients through a managed mental health waiver called the Iowa Plan, administered by Magellan Behavioral Care (MBC). The Iowa Plan contractor is required to provide beneficiaries with services that are provided to fee-for-service Medicaid beneficiaries under the State Plan. A cost savings occurs for the Medicaid program through this contract. Through the contractor's care management practices additional savings occur. The resulting cost savings to the contractor are used to provide enrollees with additional services, services not covered in the State Plan and not provided by the fee-for-service system. These services are called "b(3)" services. Current "b(3)" services provided to Iowa Medicaid recipients enrolled in the Iowa Plan include, but are not limited to, Assertive Community Treatment (ACT), Intensive Psychiatric Rehabilitation services (IPR) and Community Support Services (CSS).

CSS program components include monitoring of mental health symptoms and functioning/reality orientation, transportation, supportive relationship, communication with other providers, ensuring the client attends appointments/obtains medications, crisis intervention/developing crisis plan, and coordination and development of natural support systems for mental health support.

CSS is inherently a clinically oriented service. Aside from the other limitations noted above while CSS does have a rehabilitative component, it is intended to be far more integrated with the recipient's clinical needs than ARO. ARO, by comparison, is strictly limited to rehabilitative services only. ARO services are specifically not intended to be clinically oriented. Rather, ARO services are specifically focused on skills training, relative to the recipient's CMI symptoms and the desire to learn such skills to better manage their symptoms and, as a result, to become more fully integrated in the community and to reduce the need for institutionalization. CSS, by comparison, does not provide "skills training" rehabilitative services. It is noted that skills training under ARO are specifically not intended to teach general skills, such as how to cook, do laundry, etc.

Oversight of State Fiscal Agent

OIG Statement:

Of the 100 sampled claims, 33 were zero reimbursements and/or adjustments to correct original claims. The zero reimbursements were claims with $0 paid amounts. The adjustments were valid corrections to previous claims. None of the 33 claims were counted as errors in our report. However, ACS's inability to adequately explain the cause of these zero reimbursements/ adjustments indicates that the State's oversight of ACS needs improvement.

According to ACS, some of the adjustments were rate adjustments from providers' cost settlements. When questioned about the large number of zero reimbursements, ACS replied that they probably resulted from claims that were denied due to third-party liability. However, ACS also acknowledged that there was no attempt at recovery of third-party liability for adult rehabilitation service claims.

Many of the adjustments occurred because the ACS system was not set up to accept and pay for the same service code more than once per day. The system accepted only one claim and denied the rest (calling them zero reimbursements). In addition, a billing consultant arranged for several providers to electronically bill ACS, but the number position in the ACS system differed from that in the providers' system. As a result, billings for $12 per unit, for example, were recognized and paid by ACS at $1.20 per unit. The ACS system did not flag these invalid rates, causing providers to identify these errors upon cash reconciliation. Since providers are reimbursed for their costs, the consultant fees and staff costs required to develop, correct, and reconcile the electronic billing systems were included in Federal reimbursement. Further, ACS was paid for each claim processed and each claim resubmitted.

Additional errors occurred because the ACS system did not recognize partial units of service. These errors caused a large number of adjustments to the original claims. A State program official indicated that ACS had not informed the State of these problems.

IDHS Response:

As a cost-based service, and one sanctioned as such under our approved State Plan, IDHS believes that cost-settlements and other related rate adjustments do account for the majority of $0.00 adjustments noted by the OIG. To the extent that there are other issues that may have contributed to this result, IDHS intends to look into such matters further, so as to more fully understand the other reasons why such adjustments occurred.

OIG observed that many of these adjustments occurred due to ACS's inability to accept and pay for the same service code more than once per day. IDHS takes particular notice of this observation. It should be clarified that this is no different than how any other Medicaid-payable service is currently treated. Perhaps this is best illustrated by looking at an example involving

physician/medical services. If two physicians bill the same level of office visit for an established patient (e.g. 99211) on the same date of service (DOS), the latter claim for that DOS will suspend (not deny) for review to assure that it is not a duplicate service. IDHS maintains that this is not only fiscally prudent, but otherwise required a Federal requirement (i.e. "Check each claim prior to payment against all current and previously paid claims for which a duplicate payment could exist."). See Section 11325 of the State Medicaid Manual.

In this same regard, if two ARO providers submit claims for the same procedure code, for the same recipient on the same DOS, then the claim received last will suspend for review to determine whether it is a duplicate service. It should be recognized that there is the potential for an acceptable range of variation in the rehabilitative nature of the types of services offered under any one of the four billable ARO procedure codes. Therefore, two claims with the same DOS are not automatically presumed to be a duplicate service. However, such potentially duplicate claims nonetheless need to be suspended to assure that they are not duplicative.

The OIG also raised a concern related to a non-specific example of a billing consultant for a number of ARO providers being unable to successfully complete electronic billing transactions with ACS, as well as resultant errors in ACS payment. Without further research, IDHS is not prepared to acknowledge that this is a deficiency on ACS's part. Rather, it is also just as probable that some or most of the cause of these occurrences are the result of data or data transmission errors on the providers' or providers' billing agent's part.

Lastly, the OIG noted a concern regarding ACS's purported inability to recognize claims for partial units of service and that such presumed errors resulted in incorrect payments and corresponding adjustments. Without further research, IDHS is not prepared to agree that this is a deficiency on ACS's part. This occurrence is just as likely to be the result of provider billing errors (e.g. submitting claims with the erroneous amount).

Relative to the foregoing concerns about the current fiscal agent and its ability to execute these types of activities, then IDHS stands ready to aggressively address such issues with ACS.

Authorization of Services/County Involvement

OIG Statement:

The counties' case managers provided targeted case management for 16 of the 100 claims reviewed. The State plan and the Iowa Administrative Code specify that the targeted case planner may have no financial interest in the services provided in the comprehensive treatment plan.
State officials told us that the targeted case planner is the "gatekeeper" for the authorization of services. This appears to be a conflict of interest since mental health services were previously 100 percent funded by counties prior to adult rehabilitation services. Giving counties authority to provide targeted case management makes them "gatekeepers" to authorize adult rehabilitation

services for which they can then draw Federal funding, thus reducing their costs. It should be noted that officials of the counties also participated in developing the rules for the Adult Rehabilitation Services program.

IDHS Response:

The draft report states that allowing a county's case managers to provide targeted case management services for persons receiving Adult Rehabilitation Option (ARO) services appears to create a conflict of interest because it gives counties the authority to authorize ARO services for which they can then draw federal funding, thus reducing their costs. It must be noted that case managers employed by a county and who are serving as case planners for the purposes of rehabilitation services are subject to the same requirements as any other case planner, including the requirements discussed above under the issue of in-house case planning. Pursuant to those requirements, the Iowa State Association of Counties' County Case Management Services recommended that policies and procedures for county case management include the adoption, by the governing board, of policies to address conflict of interest issues. (Individual county policies can be made available on request.) See Attachment F.

More fundamentally, this concern is incongruent with the limited role of adult rehabilitation services case planners. Case planners do not determine the service recipient's eligibility for Medicaid, which determines whether needed services can be provided with federal funding. The case planner ***does*** play a role in identifying necessary and appropriate services (subject to certification by a licensed practitioner of the healing arts that the recipient has a chronic mental illness and a need for rehabilitation services). 441 Iowa Admin. Code 78.48(3)-(4). The availability of federal funding does not create an incentive to provide unnecessary or inappropriate services. Unnecessary or inappropriate services could be denied on those grounds regardless of the source of funding. Furthermore, the fact that counties pay the state share of costs for adult rehabilitation services under the Iowa Medicaid Program means that they retain an appropriate incentive ***not*** to have unnecessary or inappropriate services provided, as this would result in added expenditures for any given county.

The draft report also notes that county officials participated in the development of the rules for the adult rehabilitation services program. Because they were interested parties, it was perfectly appropriate that county officials participate in the development of those rules. Indeed, Iowa law requires that state agencies afford interested parties the opportunity to participate in the development of state administrative rules. Iowa Code 17A.4. Beyond that, the Iowa legislative mandate that required the Iowa Medicaid program to implement the rehabilitation option for persons with a chronic mental illness specifically required involvement by county representatives in developing this program. This was consistent with the above-mentioned Iowa statutory requirement that interested parties are afforded an opportunity to participate in such processes.

APPENDIX

Attachment A

APPENDIX B

Review of Adult Rehabilitation Services in Iowa
A-07-03-03041
Attachment A

Summary of IDHS/Iowa Medicaid Review of OIG DRAFT/PRELIMINARY Findings

			B	A	A/B	C	A/B*C																	Other Matters						Overall IDHS Agree/Disagree			
																														Units			
Smpl Ordr #	Date of Service	Proc Code	Paid Units	Reimb Amt	Unit Rate	Units Disalwd	Dollars Disalwd	[redacted]	Agree (A)/ Disagree (D)	[redacted]	Agree (A)/ Disagree (D)	? Rehab Nature (Units)	Agree (A)/ Disagree (D)	[redacted]	Agree (A)/ Disagree (D)	No Documentation* (Units)	Agree (A)/ Disagree (D)	[redacted]	Agree (A)/ Disagree (D)	No Narrative (Units)	Agree (A)/ Disagree (D)	[redacted]	Agree (A)/ Disagree (D)	Trtmnt Goals (By Claim)	Agree (A)/ Disagree (D)	[redacted]	Agree (A)/ Disagree (D)	Cnty TCM (By Claim)	Agree (A)/ Disagree (D)	Agree	Disagree	Dollars Disputed	IDHS Comments
1	2/14/2002	W0720	1	$60.00	$60.00	1	$60.00					1	A		D				A					1	D					1		$0.00	Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation. Disagree w/ missing treatment goal, per documentation indicating that recip wanted to be "stable", relative to her CMI.
2	2/7/2002	W0725	5	$7.20	$1.44	5	$7.20					5	D (5)			5	D (5)		A (5)									1	D	5		$0.00	Disagree w/ absence of rehab nature, per documentation (ICP goal & prvdr svc pln) demonstrating same and, as such, disagree w/ no documentation. Disagree w/ cnty TCM finding, per cnty being bona fide TCM and authorized under state law to provide TCM, including having appropriate non-
3	1/21/2002	W0720	1	$0.00	$0.00	0	$0.00					A				A				A				A				A		0		$0.00	
4	3/26/2002	W0724	1	$33.83	$33.83	1	$33.83					1							A	1	A			1				1		1		$0.00	
5	4/1/2002	W0722	11	($343.64)	($31.24)	0	$0.00					A				A				A				A				A		0		$0.00	
6	1/14/2002	W0720	1	$61.34	$61.34	1	$61.34					1	A						A					1	A					1		$0.00	
7	8/9/2002	W0719	1	$45.97	$45.97	1	$45.97					1	D			1	D		D					1	D		D	1	D		1	$45.97	Disagree w/ absence of rehab nature, per documentation (ICP goal & prvdr svc pln) demonstrating same and, as such, disagree w/ no documentation, which supported rehab goals linked to bona fide MI symptoms. Disagree w/ missing elements, for general reasons outlined in our response and also since documentation showed many of the missing elements mentioned by OIG (staff rendering actual service); As to other missing elements (recipient ID, and provider name), we contend such would be present on the claim and that it isn't necessary for same to appear in progress notes. We believe that focus on these "missing" elements is based on too narrow an interpretation of the State rule on which the OIG relied (i.e. 441 IAC 79.3). Disagree w/ absence of treatment goal, since documentation supported presence of same. Disagree w/ CSS finding, per general rationale that CSS is a distinct different service, under other funding. Disagree w/ cnty TCM finding, per cnty being bona fide TCM and authorized under state law to provide TCM, including having appropriate non-conflict prov

			B	A	A/B	C	A/B*C															Other Matters								Overall IDHS Agree/Disagree			
																														Units			
Smpl Ordr #	Date of Service	Proc Code	Paid Units	Reimb Amt	Unit Rate	Units Disalwd	Dollars Disalwd	[redacted]	Agree (A)/ Disagree (D)	[redacted]	Agree (A)/ Disagree (D)	? Rehab Nature (Units)	Agree (A)/ Disagree (D)	[redacted]	Agree (A)/ Disagree (D)	No Documentation* (Units)	Agree (A)/ Disagree (D)	[redacted]	Agree (A)/ Disagree (D)	No Narrative (Units)	Agree (A)/ Disagree (D)	[redacted]	Agree (A)/ Disagree (D)	Trtmnt Goals (By Claim)	Agree (A)/ Disagree (D)	[redacted]	Agree (A)/ Disagree (D)	Cnty TCM (By Claim)	Agree (A)/ Disagree (D)	Agree	Disagree	Dollars Disputed	IDHS Comments
8	8/28/2002	W0719	1	$69.16	$69.16	1	$69.16					1	D						D					1	D			1	D		1	$69.16	Disagree w/ absence of rehab nature, per documentation (ICP) demonstrating same and, as such, disagree w/ no documentation, which supported rehab goals linked to bona fide MI symtoms and that service rendered was rehab in nature. Disagree w/ missing elements, for general reasons outlined in our response and also since documentation for service rendered showed the missing elements mentioned by OIG (i.e. staff rendering service, provider name, and nature/extent/units/place of service, and recipient name). It is acknowleged that service documentation did not include recipient ID, but did include recipient name). Disagree w/ absence of treatment goal, since documentation supported presence of same. Disagree w/ cnty TCM finding, per cnty being bona fide TCM and authorized under state law to provide TCM, including having appropriate non-conflict provisions.
9	7/1/2002	W0726	28	$3,664.92	$130.89	0	$0.00					A				A			A	A				A				A		0		$0.00	
10	12/12/2001	W0720	1	$60.00	$60.00	1	$60.00					1	D		D				D	1	D			1	D						1	$60.00	Disagree w/ absence of rehab nature, per documentation (ICP goal) demonstrating same and, as such, disagree w/ no documentation, which supported rehab goals linked to bona fide MI symptoms (anxiety) and that service rendered was rehab in nature. Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation. Disagree w/ missing elements, for general reasons outlined in our response and also since documentation for service rendered showed the missing elements mentioned by OIG (i.e. staff rendering service, provider name, and nature/extent/units/place of service, and recipient name). It is acknowleged that service documentation did not include recipient ID, but did include recipient name). Disagree w/ absence of treatment goal, since documentation supported presence of same. Disagree w/ cnty TCM finding, per cnty being bona fide TCM and authorized under state law to provide TCM, including having appropriate non-conflict provisions.
11	9/1/2001	W0721	48	$330.96	$6.90	48	$330.96				A(4)	28	A(28)						A(44)					1	A			1	D	48		$0.00	Disagree w/ cnty TCM finding, per cnty being bona fide TCM and authorized under state law to provide TCM, including having appropriate non-conflict provisions.

Summary of IDHS/Iowa Medicaid Review of OIG DRAFT/PRELIMINARY Findings

			B	A	A/B	C	A/B*C														Other Matters				Overall IDHS Agree/Disagree		
																									Units		
Smpl Ordr #	Date of Service	Proc Code	Paid Units	Reimb Amt	Unit Rate	Units Disalwd	Dollars Disalwd	Agree (A)/ Disagree (D)		Agree (A)/ Disagree (D)	? Rehab Nature (Units)	Agree (A)/ Disagree (D)		Agree (A)/ Disagree (D)	No Documentation* (Units)	Agree (A)/ Disagree (D)		Agree (A)/ Disagree (D)	No Narrative (Units)	Agree (A)/ Disagree (D)		Agree (A)/ Disagree (D)	Trtmnt Goals (By Claim)	Agree (A)/ Disagree (D)		Agree (A)/ Disagree (D)	Cnty TCM (By Claim)	Agree (A)/ Disagree (D)	Agree	Disagree	Dollars Disputed	IDHS Comments
12	5/21/2002	W0719	34	$1,098.54	$32.31	34	$1,098.54				20	D (4)			14	D (4)			D (4)				1	D					30	4	$129.24	Disagree w/ absence of rehab nature (4 of 20 units disallowed), per documentation (i.e. ICP goal demonstrating same. Disagree w/ no documentation (4 of 14 units disallowed), which supported rehab goals linked to bona fide MI symtoms. Disagree that service rendered was rehab in nature (4 of 20 units disallowed). Disagree w/ missing elements (4 of 20 units disallowed), for general reasons outlined in our response and also since documentation for service rendered showed the missing elements mentioned by OIG (i.e. staff rendering service, recipient name, and nature/extent/units/date of service). It's acknowleged that: service documentation did not include recipient ID, but did include recipient name; provider name was not present in progress notes, but that such would not be expected on this since it's obvious who the provider is (the provider number would have been on the claim). Disagree w/ absence of treatment goal, since documentation supported presence of same. Disagree w/ cnty TCM finding, per cnty being bona fide TCM under state law.
13	2/1/2002	W0720	20	$960.00	$48.00	0	$0.00				A				A				A				A				A		0		$0.00	
14	2/9/2002	W0719	2	$70.88	$35.44	0	$0.00				A				A				A				A				A		0		$0.00	
15	2/1/2002	W0719	6	$531.54	$88.59	6	$531.54				6	A (6)				A (6)			6	A (6)			1	A			1	D	6		$0.00	Disagree w/ cnty TCM finding, per cnty being bona fide TCM and authorized under state law to provide TCM, including having appropriate non-conflict provisions.
16	8/28/2001	W0720	1	$60.00	$60.00	1	$60.00				1	A		D		A							1	A					1		$0.00	Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.
17	6/13/2001	W0760	1	$12.00	$12.00	0	$0.00				A				A				A				A				A		0		$0.00	
18	12/25/2001	W0762	2	$17.50	$8.75	2	$17.50				2	A (2)				A (2)							1	A		D			2		$0.00	Disagree w/ CSS finding, per general rationale that CSS is a distinctively differently oriented service, under other funding.
19	12/4/2001	W0726	1	$65.00	$65.00	1	$65.00							D		A	1	A					1	A		D			1		$0.00	Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation. Disagree w/ CSS finding, per general rationale that CSS is a distinctively differently oriented service, under other funding.

Summary of IDHS/Iowa Medicaid Review of OIG DRAFT/PRELIMINARY Findings

			B	A	A/B	C	A/B*C												Other Matters					Overall IDHS Agree/Disagree			
Smpl Ordr #	Date of Service	Proc Code	Paid Units	Reimb Amt	Unit Rate	Units Disalwd	Dollars Disalwd	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	? Rehab Nature (Units)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	No Documen-tation* (Units)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	No Narrative (Units)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	Trtmnt Goals (By Claim)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	Cnty TCM (By Claim)	Agree (A)/ Disagree (D)	Units Agree	Units Disagree	Dollars Disputed	IDHS Comments
20	11/2/2001	W0760	6	$52.50	$8.75	6	$52.50			6	A (6)					D (6)			1	A		D		6		$0.00	Disagree w/ missing elements, for general reasons outlined in our response and also since documentation for service rendered showed the missing elements mentioned by OIG (i.e. staff rendering service, recipient name, and nature/extent/units/date of service). It is acknowledged that service documentation did not include recipient ID, but did include recipient name. It is also acknowledged that provider name was not present in progress notes, but that such would not be expected on a progress note entry retained in the provider's file, since it's obvious who the provider is. Furthermore, the provider number would have been on the claim. Disagree w/ CSS finding, per general rationale that CSS is a distinctively differently oriented service, under other funding.
21	6/27/2001	W0760	-1	$0.00	$0.00	0	$0.00			A			A			A			A			A		0		$0.00	
22	2/8/2002	W0720	1	$60.00	$60.00	1	$60.00			1	A	A			A	1	A		1	A				1		$0.00	
23	6/5/2002	W0719	1	$52.50	$52.50	1	$52.50			1	A	D			D				1	A				1		$0.00	Disagree w/ missing elements, for general reasons outlined in our response and also since documentation for service rendered showed some of the missing elements mentioned by OIG (i.e. staff rendering service, recipient name, and nature/extent/units/date of service). It is acknowledged that service documentation did not include recipient ID, but did include recipient name. It is also acknowledged that provider name was not present in progress notes, but that such would not be expected on a progress note entry retained in the provider's file, since it's obvious who the provider is. Furthermore, the provider number would have been on the claim. Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.
24	7/1/2002	W0722	18	$1,062.00	$59.00	18	$1,062.00			18	A (18)					D (18)			1	A				18		$0.00	Disagree w/ missing elements, for general reasons outlined in our response and also since documentation for service rendered showed some of the missing elements mentioned by OIG (i.e. staff rendering service, provider name, recipient name, and nature/extent/units/date of service). It is acknowledged that service documentation did not include recipient ID, but did include recipient name. Disagree w/ cnty TCM finding, per cnty being bona fide TCM and authorized under state law to provide TCM, including having appropriate non-conflict provisions.
25	5/30/2002	W0719	2	$104.99	$52.50	2	$104.99			2	A (2)	D (2)	1	A		A (2)			1	A				2		$0.00	Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.
26	11/6/2001	W0760	4	$35.00	$8.75	4	$35.00			4	A (4)					A (4)			1	A		D		4		$0.00	Disagree w/ CSS finding, per general rationale that CSS is a distinctively differently oriented service, under other funding.
27	6/4/2001	W0760	-1	$0.00	$0.00	0	$0.00			A			A			A			A			A		0		$0.00	
28	4/2/2002	W0719	2	$58.81	$29.41	2	$58.81			2	A (2)	D (2)	1	A		A (2)			1	A				2		$0.00	

Summary of IDHS/Iowa Medicaid Review of OIG DRAFT/PRELIMINARY Findings

			B	A	A/B	C	A/B*C												Other Matters					Overall IDHS Agree/Disagree			
Smpl Ordr #	Date of Service	Proc Code	Paid Units	Reimb Amt	Unit Rate	Units Disalwd	Dollars Disalwd	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	? Rehab Nature (Units)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	No Documen-tation* (Units)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	No Narrative (Units)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	Trtmnt Goals (By Claim)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	Cnty TCM (By Claim)	Agree (A)/ Disagree (D)	Units Agree	Units Disagree	Dollars Disputed	IDHS Comments
29	10/8/2001	W0724	1	$33.83	$33.83	1	$33.83			1	A					A	1	A	1	A	D	1	D	1		$0.00	Disagree w/ CSS finding, per general rationale that CSS is a distinctively differently oriented service, under other funding. Disagree w/ cnty TCM finding, per cnty being bona fide TCM and authorized under state law to provide TCM, including having appropriate non-conflict provisions.
30	7/1/2001	W0720	31	$4,202.67	$135.57	31	$4,202.67	A	A (9)	21	A (21)		D (31)			A (31)	31	A (31)	1	D				31		$0.00	Disagree w/ lack of treatment goals, based on rehab goal being present in documentation (ICP) related to learning appropriate social behaviors and independent living skills. Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.
31	4/24/2001	W0760	-4	($4.80)	$1.20	0	$0.00			A			A			A			A			A		0		$0.00	
32	1/28/2002	W0719	1	($35.00)	($35.00)	0	$0.00			A			A			A			A			A		0		$0.00	
33	4/27/2001	W0760	1	$12.00	$12.00	0	$0.00			A			A			A			A			A		0		$0.00	
34	6/17/2001	W0760	-1	($1.20)	$1.20	0	$0.00			A			A			A			A			A		0		$0.00	
35	8/1/2001	W0720	31	$1,170.00	$37.74	0	$0.00			R			R			R			R			R		0		$0.00	
36	5/1/2002	W0720	1	$60.00	$60.00	1	$60.00			1	A		D			A			1	D				1		$0.00	Disagree w/ rehab goal to the extent documentation indicated rehab goals (related to improving social skills and improving job skills. This 1 unit is tied to the 1 unit listed under "treatment goals (by claim).
37	3/20/2002	W0719	1	$79.32	$79.32	1	$79.32			1	A		D			A			1	D	D			1		$0.00	Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation. Disagree w/ rehab goal to the extent documentation indicated rehab goals (related to improving social skills and improving money management skills. This 1 unit is tied to the 1 unit listed under "treatment goals (by claim). Disagree w/ CSS finding, per general rationale that CSS is a distinctively differently oriented service, under other funding. Additionally, documentation showed that CSS services were separate and distinct from rehab services billed.
38	3/3/2002	W0719	12	$425.28	$35.44	0	$0.00			A			A			A			A			A		0		$0.00	
39	7/1/2002	W0719	7	$620.13	$88.59	7	$620.13			7	A					A	7	A (7)						7		$0.00	While there is agreement on total disallowance for this sample claim, it is noted that narrative in documentation does suggest rehab nature of services rendered, but does not provide conclusive proof of same.
40	2/17/2002	W0719	3	$106.32	$35.44	0	$0.00			A			A			A			A			A		0		$0.00	
41	2/1/2002	W0722	20	$773.60	$38.68	20	$773.60			19	A (19)		1	A		A (19)			1	A				20		$0.00	
42	12/28/2001	W0719	1	$44.25	$44.25	1	$44.25			1	A					A			1	A	D	1	D	1		$0.00	Disagree w/ CSS finding, per general rationale that CSS is a distinctively differently oriented service, under other funding. Disagree w/ cnty TCM finding, per cnty being bona fide TCM and authorized under state law to provide TCM, including having appropriate non-conflict provisions.
43	6/21/2002	W0720	1	$60.00	$60.00	1	$60.00			1	A		D			A			1	A				1		$0.00	Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.

			B	A	A/B	C	A/B*C																Other Matters					Overall IDHS Agree/Disagree			
Smpl Ordr #	Date of Service	Proc Code	Paid Units	Reimb Amt	Unit Rate	Units Disallwd	Dollars Disallwd	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	? Rehab Nature (Units)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	No Documen-tation* (Units)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	Nc Narrative (Units)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	Trtmnt Goals (By Claim)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	Cnty. TCM (By Claim)	Agree (A)/ Disagree (D)	Units Agree	Units Disagree	Dollars Disputed	IDHS Comments
44	6/18/2002	W0726	1	$65.00	$65.00	1	$65.00			1	A	D			A	1	A			1	A	D			1		$0.00	Disagree w/ CSS finding, per general rationale that CSS is a distinctively differently oriented service, under other funding. Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.
45	8/12/2002	W0720	1	$60.00	$60.00	1	$60.00					D	1	A						1	A				1		$0.00	Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.
46	4/27/2001	W0760	5	$6.00	$1.20	5	$6.00			5	A (5)	D			A (5)	5	A (5)			1	A				5		$0.00	Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.
47	7/1/2001	W0723	2	($96.82)	($48.41)	0	$0.00			A			A			A				A			A		0		$0.00	
48	10/29/2001	W0719	1	$50.08	$50.08	0	$0.00			A			A			A				A			A		0		$0.00	
49	4/1/2002	W0719	9	$434.52	$48.28	9	$434.52			9	A (9)				A (9)					1	A				9		$0.00	While there is agreement on all units being disallowed for the reasons indicated, the context of the documentation reviewed nonetheless strongly suggests rehab nature of serivces rendered. However, documentation does not clearly demonstrate this.
50	5/1/2002	W0719	42	$1,443.54	$34.37	42	$1,443.54	D (2)		42	D (6)				D (8)					1	D				36	6	$206.22	Disagree w/ disallowance of 6 of 42 units related to the rehab nature. Disagree w/ disallowance of 6 of 42 units related to missing elements. These disagreements are based on review of recipient's records and finding documentation to support the 6 units, both in terms of the rehab nature and missing elements. In other words, these were presumed to be the same 6 units. Disagree w/ disallowance of 2 units for lack of direct care provided. It is presumed that these two units are also subsumed within the 6 units associated with the other areas noted by the OIG.
51	9/4/2001	W0726	1	$65.00	$65.00	1	$65.00					D			A	1	A			1	A	D			1		$0.00	Disagree w/ CSS finding, per general rationale that CSS is a distinctively differently oriented service, under other funding. Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.
52	6/7/2001	W0760	9	$108.00	$12.00	0	$0.00			A			A			A				A			A		0		$0.00	
53	11/6/2001	W0760	4	$35.00	$8.75	4	$35.00			4	A (4)		4	A (4)	A (4)				A (4)	N	???				4		$0.00	Unsure what OIG symbol "N" stands for in "treatment goals (by claim)" column.
54	1/29/2002	W0720	1	$60.00	$60.00	1	$60.00		A			D								1	A				1		$0.00	Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.
55	4/1/2002	W0723	4	$193.64	$48.41	4	$193.64			4	A (4)				A (4)					1	A				4		$0.00	While there is agreement on all units being disallowed for the reasons indicated, the context of the documentation reviewed nonetheless strongly suggests rehab nature of serivces rendered. However, documentation does not clearly demonstrate this.
56	9/10/2001	W0720	1	$60.00	$60.00	1	$60.00		A			D								1	A				1		$0.00	Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.

Smpl Ordr #	Date of Service	Proc Code	B Paid Units	A Reimb Amt	A/B Unit Rate	C Units Disalwd	A/B*C Dollars Disalwd	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	? Rehab Nature (Units)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	No Documentation* (Units)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	No Narrative (Units)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	Other Matters: Trtmnt Goals (By Claim)	Other Matters: Agree (A)/ Disagree (D)	Other Matters: Agree (A)/ Disagree (D)	Other Matters: Cnty TCM (By Claim)	Other Matters: Agree (A)/ Disagree (D)	Overall IDHS Agree/Disagree Units: Agree	Overall IDHS Agree/Disagree Units: Disagree	Overall IDHS: Dollars Disputed	IDHS Comments
57	1/14/2002	W0719	2	$42.00	$21.00	2	$42.00			2	D (2)		2	D (2)	D (2)							1			2	$42.00	Disagree w/ disallowance, based upon documentation reviewed showing units on DOS were: 1) provided; 2) rehab in nature and related to stated rehab goal; 3) missing elements were present. Disagree w/ cnty TCM finding, per cnty being bona fide TCM and authorized under state law to provide TCM, including having appropriate non-conflict provisions.
58	6/28/2002	W0720	1	$60.00	$60.00	1	$60.00	A				D							1	A				1		$0.00	Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.
59	8/1/2001	W0721	6	$238.92	$39.82	6	$238.92						6	A (6)					1	A				6		$0.00	
60	12/28/2001	W0760	4	$35.00	$8.75	4	$35.00			4	A (4)				D (4)				1	A				4		$0.00	While there is agreement on all units being disallowed for the reasons indicated, the context of the documentation reviewed nonetheless strongly suggests rehab nature of serivces rendered. However, documentation does not clearly demonstrate this. It is further noted that some of the missing elements were in documentation reviewed by IDHS, including funding notification form. Finally, it is noted that the 4 units billed were under a previous code used for 15 minutes, whereby 4
61	1/20/2002	W0719	1	$35.00	$35.00	1	$35.00			1	A				A									1		$0.00	
62	12/21/2001	W0719	1	$47.05	$47.05	0	$0.00			R			R			R			R			R		0		$0.00	
63	1/1/2002	W0719	19	$554.23	$29.17	19	$554.23			19	A (19)				A (19)	19	A (19)		1	A		1	D	19		$0.00	While there is agreement on all units being disallowed for the reasons indicated, the context of the documentation reviewed nonetheless suggests likely rehab nature of serivces rendered. However, documentation does not clearly demonstrate this. Disagree w/ cnty TCM finding, per cnty being bona fide TCM and authorized under state law to provide TCM, including having appropriate non-conflict provisions.
64	6/6/2001	W0760	5	$60.00	$12.00	0	$0.00			A			A			A			A			A		0		$0.00	
65	2/28/2002	W0719	1	$44.25	$44.25	1	$44.25			1	A				A				1	A	D	1		1		$0.00	
66	10/30/2001	W0720	1	$60.00	$60.00	1	$60.00			1	A	D	1	A	A	1	A		1	A				1		$0.00	Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation. Disagree w/ CSS finding, per general rationale that CSS is a distinctively differently oriented service, under other funding.
67	5/1/2002	W0719	1	$48.50	$48.50	0	$0.00			A			A			A			A			A		0		$0.00	
68	11/6/2001	W0719	1	$44.25	$44.25	1	$44.25			1	A				A				1	A	D	1	D	1		$0.00	Disagree w/ CSS finding, per general rationale that CSS is a distinctively differently oriented service, under other funding. Disagree w/ cnty TCM finding, per cnty being bona fide TCM and authorized under state law to provide TCM, including having appropriate non-conflict provisions.
69	10/17/2001	W0723	2	$10.38	$5.19	2	$10.38			2	A (2)				A (2)				1	A		1	D	2		$0.00	Disagree w/ cnty TCM finding, per cnty being bona fide TCM and authorized under state law to provide TCM, including having appropriate non-conflict provisions.
70	9/1/2001	W0725	-30	#########	$35.03	0	$0.00			A			A			A			A			A		0		$0.00	

Summary of IDHS/Iowa Medicaid Review of OIG DRAFT/PRELIMINARY Findings

			B	A	A/B	C	A/B*C													Other Matters						Overall IDHS Agree/Disagree			
Smpl Ordr #	Date of Service	Proc Code	Paid Units	Reimb Amt	Unit Rate	Units Disallwd	Dollars Disallwd	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	? Rehab Nature (Units)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	No Documen-tation* (Units)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	No Narrative (Units)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	Trtmnt Goals (By Claim)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	Cnty TCM (By Claim)	Agree (A)/ Disagree (D)	Units Agree	Units Disagree	Dollars Disputed	IDHS Comments
71	8/27/2001	W0720	1	$42.67	$42.67	1	$42.67			1	A					A			1	A		D	1	D	1		$0.00	While there is agreement on all units being disallowed for the reasons indicated, the context of the documentation reviewed nonetheless suggests likely rehab nature of services rendered. However, documentation does not clearly demonstrate this. Disagree w/ CSS finding, per general rationale that CSS is a distinctively differently oriented service, under other funding. Disagree w/ cnty TCM finding, per cnty being bona fide TCM and authorized under state law to provide TCM, including having appropriate non-conflict provisions.
72	10/1/2001	W0719	6	$236.46	$39.41	6	$236.46			6	A (6)					A (6)			A (6)	1	A	D			6		$0.00	Disagree w/ CSS finding, per general rationale that CSS is a distinctively differently oriented service, under other funding.
73	12/1/2001	W0720	18	$1,587.06	$88.17	0	$0.00			A			A			A			A			A		0		$0.00	
74	5/30/2002	W0720	1	$60.00	$60.00	1	$60.00			1	A	D				A			1	A					1		$0.00	Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.
75	3/1/2002	W0720	23	$885.50	$38.50	0	$0.00			A			A			A			A			A		0		$0.00	
76	1/17/2002	W0719	2	($70.00)	($35.00)	0	$0.00			A			A			A			A			A		0		$0.00	
77	9/12/2001	W0719	.1	$44.25	$44.25	1	$44.25			1	A		1	A		A			1	A		D	1		1		$0.00	Disagree w/ no rehab nature (i.e. no rehab goal, only to extent comprehensive plan does reflect a an apparent rehab goal. However, other supporting documentation does not support same. Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation. Disagree w/ CSS finding, per general rationale that CSS is a distinctively differently oriented service, under other funding.
78	5/14/2001	W0760	-1	($1.20)	$1.20	0	$0.00			A			A			A			A			A		0		$0.00	
79	10/25/2001	W0720	1	$60.00	$60.00	1	$60.00			1	A	D				A	1	A	1	A					1		$0.00	Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.
80	11/1/2001	W0720	22	$844.80	$38.40	22	$844.80			11	A (11)		11	A (11)		A (11)			1	A					22		$0.00	
81	4/1/2002	W0719	23	##########	($48.28)	0	$0.00			A			A				A		A			A			0		$0.00	
82	4/20/2002	W0720	1	$60.00	$60.00	1	$60.00		A			D							1	A					1		$0.00	Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.
83	12/1/2001	W0725	-31	##########	$35.03	0	$0.00			A			A				A		A				A		0		$0.00	
84	2/1/2002	W0721	53	$598.90	$11.30	53	$598.90						53	A (53)					1	A					53		$0.00	
85	3/3/2002	W0719	3	$106.32	$35.44	0	$0.00			A			A				A		A			A			0		$0.00	
86	7/8/2002	W0720	.1	$60.00	$60.00	1	$60.00	A				D							1	A					1		$0.00	Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.
87	3/1/2002	W0720	27	##########	($73.01)	0	$0.00			A			A			A			A				A		0		$0.00	
88	5/1/2002	W0719	3	($141.00)	($47.00)	0	$0.00			A			A			A			A				A		0		$0.00	
89	2/1/2002	W0719	4	$158.06	$39.52	0	$0.00			A			A			A			A				A		0		$0.00	
90	6/12/2001	W0760	-1	($12.00)	$12.00	0	$0.00			A																		
91	7/3/2001	W0720	1	$65.00	$65.00	1	$65.00					D				A	1	A	1	A		D			1		$0.00	Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation. Disagree w/ CSS finding, per general rationale that CSS is a distinctively differently oriented service, under other funding.
92	4/14/2002	W0720	1	$60.00	$60.00	1	$60.00		A			C							1	A					1		$0.00	Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.

Summary of IDHS/Iowa Medicaid Review of OIG DRAFT/PRELIMINARY Findings

Smpl Ordr #	Date of Service	Proc Code	B Paid Units	A Reimb Amt	A/B Unit Rate	C Units Disallwd	A/B*C Dollars Disallwd	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	? Rehab Nature (Units)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	No Documen-tation* (Units)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	No Narrative (Units)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	Trtmnt Goals (By Claim)	Agree (A)/ Disagree (D)	Agree (A)/ Disagree (D)	Cnty TCM (By Claim)	Agree (A)/ Disagree (D)	Overall IDHS Agree/Disagree Units Agree	Units Disagree	Dollars Disputed	IDHS Comments
93	5/15/2002	W0720	1	$60.00	$60.00	1	$60.00			1	D	D				A	1	A	1	A				1		$0.00	Disagree w/ no rehab nature (i.e. no rehab goal, only to extent comprehensive plan does reflect a an apparent rehab goal. However, other supporting documentation does not support same. Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.
94	5/16/2002	W0726	1	$65.00	$65.00	1	$65.00			1	D	D				A			1	A	D			1		$0.00	Disagree w/ no rehab nature (i.e. no rehab goal, only to extent comprehensive plan does reflect a an apparent rehab goal. However, other supporting documentation does not support same. Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation. Disagree w/ CSS finding, per general rationale that CSS is a distinctively differently oriented service, under other funding.
95	3/15/2002	W0719	1	$47.05	$47.05	1	$47.05			1	D	D				A			1	A				1		$0.00	Disagree w/ no rehab nature (i.e. no rehab goal, only to extent comprehensive plan (ICP) does reflect a an apparent rehab goal. Additionally, ICP does identify action steps and interventions and supports that suggest rehab nature. However, other supporting documentation does not support same. Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.
96	3/1/2002	W0723	116	($733.12)	($6.32)	0	$0.00			A			A			A			A			A		0		$0.00	
97**	12/1/2001	W0720	31	$2,635.00	$85.00	30	$2,550.00		A (11)	23	A (23)				A (23)	23	A (23)		1	A				30		$0.00	Disagree w/ no rehab nature (i.e. no rehab goal, only to extent comprehensive plan (ICP) does reflect 3 apparent rehab goals. However, other supporting documentation does not support same. It is noted that the records did include an LPHA certification form for the period in question. While such was not identified as a specific error, it is unclear how this would affect the number of units in "missing elements".
98	10/1/2001	W0719	6	$345.72	$57.62	0	$0.00			A			A			A			A			A		0		$0.00	
99	11/1/2001	W0719	6	$258.48	$32.31	8	$258.48			8	A (8)				A (8)				1	A				8		$0.00	
100	1/22/2002	W0721	1	$12.50	$12.50	1	$12.50			1	D	D				A			1	A				1		$0.00	Disagree w/ no rehab nature (i.e. no rehab goal, only to extent comprehensive plan (ICP) does reflect a an apparent rehab goals that suggest rehab nature. However, other supporting documentation does not support same. Disagree w/ in-house TCM, per agency being bona fide TCM provider w/ appropriate non-conflict documentation.
								Units	D (2)	D (0)	306	D (24)	D (66)	102	D (12)	D (44)	102	D (1)	D (0)	N/A		N/A					
								Claims	D (1)	D (0)	63	D (11)	D (30)	33			33										
								Adjust Claims (A)			33			33			33											
								Repaid Claims (R)			2			2			2											

Other Matters

Overall IDHS Agree/Disagree

Total Units Disallowed	438
Total Dollars Disallowed	$18,412.48

* = *No Documentation* includes: No documentation provided for claim, no IPP/ISP, missing or incomplete CTP, as well as rounding errors

** = 1 unit of this claim (#97) was repaid by the provider because the client was not present at the facility on this day, therefore while all 31 units were in error, only 30 are considered for this review.

Attachment B

(Vera French)

ARTICLE IV: CONFLICT RESOLUTION

In the event that either party identifies a deficiency in the performance of the contract, or a violation of the terms of this contract, the following procedure shall be followed to resolve that deficiency or violation:

A. Concerning alleged deficiencies or violations, which do not endanger the immediate health or safety of consumers for whom services are being purchased by the County:

1. Prior to terminating the contract, the complaining party shall notify the other party in writing of the alleged deficiency or violation, identify the recommended corrective action, and request a written response to the allegation.

2. If the parties agree on appropriate corrective action, the party responsible for implementing that action shall forward a written description of such action to the other party.

3. In the event that the offending party fails to respond within 30 days, or in the event that the County and the CMHC fail to agree on appropriate corrective action, the complaining party may notify the offending party in writing that the contract will terminate within 30 days of receipt of written notice.

B. Concerning alleged deficiencies or violations, which may endanger the immediate health or safety of consumers for whom services are being purchased by the County:

1. Upon discovering such deficiency or violation, the complaining party shall immediately orally notify the offending party of the alleged deficiency or violation and shall confirm such oral notice in writing.

2. The County and the CMHC shall meet within five (5) working days following issuance of such oral notice. At such meeting, it shall be determined whether appropriate corrective action can be negotiated, or whether there is cause for the complaining party to give notice to the offending party of the termination of this contract.

C. In the event that the contract is terminated pursuant to this Article, the CMHC will transfer the cases it is responsible for to a new provider selected by the County. The County agrees that it will expeditiously select a provider of targeted case management services so that the safety and well being of consumers will not be jeopardized. The County agrees that it will pay at the rate established by this contract for all services provided by the CMHC following notification of termination of this contract until such time as all cases have been transferred to the new provider.

Attachment C

Attachment C

(Abbe Center)

CASE MANAGEMENT

CONFLICT OF INTEREST

Reviewed: December, 2003

SECTION NUMBER:
24.4(9) 10

Policy: Abbe Center has the following procedures to minimize any conflict of interest between case management responsibilities and other responsibilities of the provider:

1. Identification of where conflicts do or could exist.
2. Description of steps to eliminate or minimize those conflicts; and
3. When conflicts arise, documentation of what the conflict is and how it was resolved in accordance with the best interests of the individual utilizing the service.

Procedure:

1. Description of steps to eliminate conflict of interest: all duties, policies, and procedures will be in writing. Job descriptions will be specific for case management responsibilities. Case managers will be assigned to case management responsibilities.

2. Case managers could be criticized for referring individuals to mental health services at the Abbe Center for Community Mental Health. Case managers will identify to the individual all choices for mental health services as well as services available within Linn County for housing, vocational, medical, academia, and self-care as provided in the county management plan and will document that individual choice in providers was explained. The individual's choice will be documented in their file. The delivery of services will be recommended according to the individual's strengths, needs, preferences and in accordance with the standards and principles for the delivery of individual case management.

3. Case managers could be criticized for accepting only Abbe Center individuals for case management. Case managers will determine individual eligibility for case management services according to the admission criteria and priority policies. No individual will be refused for case management if they meet the criteria and is a priority. A waiting list, not to exceed 90 days, will be established if the case managers have a maximum caseload.

The identified case manager will be assigned to case management responsibilities as described in the case manager's position description. The case manager will decline any request for providing direct service and will offer the names of alternative service providers to the individual. If a conflict does arise, the case manager will immediately notify the coordinator. The Coordinator will notify the Vice President/Executive Director of Abbe Center. A corrective action plan will be documented in the individual's file by the coordinator. Any disciplinary measures will be documented in the personnel file of the case manager.

Attachment D

(Broadlawns) Attachment B

and who are accepted by PCHS and the Contractor. Consumers may apply directly to the Contractor to receive services or may be referred by community or governmental agencies familiar with the consumers' needs. Services will be provided in accordance with:

1. Applicable appropriation bill(s) for the Iowa Department of Human Services;
2. [441] IAC, Chapter 24;
3. 42 United States Code 1396a;
4. Iowa Code Chapters 331 (County Home Rule Implementation), 249A (Medical Assistance), and 225C (Mental Health, Mental Retardation, and Developmental Disabilities);
5. Any mutually agreed upon implementation details unique to the County, attached as Exhibit A; and
6. The terms of this subcontract.

B. PCHS shall maintain a list of consumers waiting to receive case management services. If the Contractor has no vacancies for case management, the Contractor shall refer applicants to PCHS after initial intake and screening in accordance with PCHS intake procedures. If the Contractor has the ability to accept one or more new consumers into case management, the Contractor shall notify PCHS, and PCHS will refer appropriate individuals to the Contractor from the case management waiting list.

C. The Contractor shall verify that consumers who seek to receive or who are referred by other agencies for case management services are eligible for Medicaid case management services. Nothing in this subcontract obligates the County to pay for Medicaid case management services beyond current statutory obligations.

D. The Contractor agrees to serve Medicaid case management consumers. The Contractor agrees to notify Polk County Health Services immediately if the projected units of services to be billed to Polk County in the fiscal year ending June 30, 1998, exceed 1,230 units to persons with chronic mental illness.

E. The Contractor agrees to comply with all of the requirements of [441] IAC Chapter 24 which regulations are hereby incorporated into this subcontract as if set forth in full herein. For purposes of this paragraph, the Contractor shall be deemed to be the "provider" of services as that term is used in Chapter 24 and agrees to hold sole responsibility and authority to seek, obtain, and maintain accreditation for case management services as provided in those regulations. The Contractor will notify PCHS of all Contractor requests for temporary or permanent variances, on such matters as staff-to-consumer ratios or staff qualifications, from the standards for the provision of case management services as identified in [441] IAC Chapter 24. Temporary variances may be necessary for the time it takes to replace departing staff or to rearrange caseloads. Prior to seeking a permanent variance, the Contractor will secure the approval of PCHS.

F. The Contractor shall perform all functions of a designated access point and delegated functions of the CPC within the PCHS managed system of care as specified in the CMP, which shall be deemed incorporated into this subcontract by this reference. These functions include:

1. Performing all intake, eligibility determination, enrollment, and information and referral functions of the designated access points.
2. Use of PCHS eligibility and service access standards to arrange for additional clinical assessments, as necessary, and to determine appropriateness of levels of care.
3. Compliance with PCHS standards and protocols for internal and CPC utilization management, service authorization and re-authorization, and service plan approvals for certain high cost and congregate service types.
4. Compliance with all PCHS service access and service responsiveness standards, including:
   a. Time from initial contact to completion of enrollment or referral to other source of services

Attachment E

AUDIT OF TITLE XIX FEDERAL FINANCIAL PARTICIPATION CLAIMED BY IOWA FOR ADULT REHABILITATION SERVICES
AUDIT REPORT CIN: A-07-03-03041
Comments from Iowa Department of Human Services
October 15, 2004

Attachment E

Community Support Services (CSS)
Audit of Sample Claims Where OIG Identified CSS Services Also Provided

Recipient ID	OIG Audit DOS	CSS DOS	CSS Procedure Code	Units	Paid	ARO Procedure Code	ARO DOS
0076332F	8/27/2001	8/1/2001	W3960	1	$ 220.00	W0720	8/27/2001
0108928C	1/21/2002	1/1/2002	W3961	1	$ 110.00	W0720	1/21/2002
0324381C	12/4/2001	12/1/2001	W3960	1	$ 220.00	W0726	12/4/2001
0341926D	5/16/2002	5/1/2002	W3961	1	$ 110.00	W0726	5/16/2002
0377470J	10/29/2001	10/1/2001	W3960	1	$ 220.00	W0719	10/29/2001
0435455A	12/25/2001	12/1/2001	W3960	1	$ 220.00	W0762	12/25/2001
0551815D	11/8/2001	11/1/2001	W3961	1	$ 110.00	W0760	11/8/2001
0612453A	1/17/2002	1/1/2002	W3959	1	$ 400.00	W0719	1/17/2002
0689028I	10/8/2001	10/1/2001	W3960	1	$ 220.00	W0724	10/8/2001
0773942H	1/1/2002	1/1/2002	W3961	1	$ 110.00	W0719	1/1/2002
0856636F	10/17/2001	10/1/2001	W3961	1	$ 110.00	W0723	10/17/2001
0930361D	9/12/2001	9/1/2001	W3960	1	$ 220.00	W0719	9/12/2001
1002873F	3/3/2002	3/1/2002	W3959	1	$ 400.00	W0719	3/3/2002
1008806A	11/6/2001	11/1/2001	W3961	1	$ 110.00	W0719	11/6/2001
1227094H	8/9/2002	8/1/2002	W3961	1	$ 110.00	W0719	8/9/2002
1278190A	8/28/2002	8/1/2002	W3960	1	$ 220.00	W0719	8/28/2002
1311139A	2/1/2002	2/1/2002	W3961	1	$ 110.00	W0720	2/1/2002
1341448I	9/4/2001	9/1/2001	W3960	1	$ 220.00	W0726	9/4/2001
1515240B	5/1/2002	5/1/2002	W3960	1	$ 220.00	W0719	5/1/2002
1582045G	3/26/2002	3/1/2002	W3961	1	$ 110.00	W0724	3/26/2002
1636696A	4/1/2002	4/1/2002	W3961	1	$ 110.00	W0719	4/1/2002
1647342D	12/26/2001	12/1/2001	W3961	1	$ 110.00	W0719	12/26/2001
2045418J	10/1/2001	10/1/2001	W3961	1	$ 110.00	W0179	10/1/2001
2104662F	2/28/2002	2/1/2002	W3961	1	$ 110.00	W0719	2/28/2002

Attachment F

County Case Management Policies and Procedures
Furnished by: Iowa State Association of Counties
County Case Management Services Division

POLICY AND PROCEDURE:

1. The governing body has the following authority:

   a. Establishment, review, and approval of all policies.

   b. Adoption of the organizational plan.

   c. Appointment, evaluation, and removal, if necessary, of the case management director (CMD).

   d. Establishment of effective fiscal policies.

   e. Review and approval of all contracts and agreements to which the program is a party or delegate authority for approval.

   f. Review and approval of the annual budget, including the approval of all revisions in the budget.

   g. Review of program evaluation

   h. **Adoption of policies to address conflicts of interest issues.**

   i. Schedule regular meetings with staff from the TCM program for the purpose of providing oversight of the operation of the program, and client progress.

   j. Comply with all federal and state laws and regulations regarding confidentiality when they exercise their authority to access client specific information.

   k. The governing body shall keep minutes of meetings.

(County) Notice of Decision Appeal Procedures

Individuals who believe the decision was in error may seek a review of the decision. Individuals facing discharge from service may request a review. Individuals contesting the delivery of service
may seek a review in accordance with Chapter 24 of the Iowa Administrative Code.

1. A written appeal must be presented by hand delivery or by first class mail within fifteen (15) days after notice is mailed, or within 15 days of the event or action being appealed. The written appeal must include the following:

   a. The name, address and telephone number of the petitioner.

County Case Management Policies and Procedures
Furnished by: Iowa State Association of Counties
County Case Management Services Division

b. The name, address and telephone number of the person on whose behalf the petition is being filed.

c. The specific action which gives rise to the appeal.

d. The statute, rule, policy or decision which has been or will be violated by any action or intended action.

e. A concise statement of issue, the reason for the petition, pertinent facts, people involved, and efforts made to resolve the dispute prior to the appeal.

2. The Case Management Director shall, within five (5) days from the receipt of the appeal, make a determination as to whether or not the written appeal meets the criteria of Section II of this policy and therefore presents an appealable issue. Within said five (5) day time period, the Case Management Director shall mail his/her written determination of appealability to the petitioner.

a. If the Case Management Director determines that no appealable issue exists, the dispute resolution process shall be deemed concluded.

3. If the Case Management Director determines that an appealable issue has been presented, the CMD shall verbally communicate with the petitioner and schedule a negotiation meeting for the purpose of attempting to resolve the appeal..

a. The meeting shall be conducted at the TCM office at a date and time agreeable to the petitioner and the case management director, however, said meeting shall not be conducted more than fifteen (15) days after the date of the presentation of the appeal; unless the petitioner and case management director mutually agree to an extension of such deadline.

4. In the interest of resolving disputes, the following persons shall be entitled to attend the negotiation meeting: the petitioner; the applicant or consumer; the applicant or consumer's legal representative; TCM staff; County Board of Supervisors; a representative from the State Division of MH/DD, at the request of the petitioner.

5. Minutes of the meeting shall be kept by the TCM agency.

6. Negotiations may be continued and scheduled for subsequent meetings with the mutual consent of the petitioner and the agency.

7. The petitioner and the case management director may mutually waive the process of negotiation.

Attachment F

County Case Management Policies and Procedures
Furnished by: Iowa State Association of Counties
County Case Management Services Division

8. Should the negotiation process resolve the dispute, the dispute resolution process shall be deemed concluded and the parties shall jointly sign a written statement setting forth the resolution which was reached.
9. Should the negotiation process fail to resolve the dispute, the petitioner may request an informal hearing before a quorum of the County Board of Supervisors. This request must be in writing within fifteen (15) days from the date of the last negotiation meeting.
10. After receipt of such written request, the Board of Supervisors shall proceed to hear the petitioner's informal appeal within the next 30 days.
11. The Board of Supervisors shall issue a written conclusion within 30 days from the date of the informal hearing.
12. Either party may request the State Division of MH/DD to conduct a formal appeal. This request must be filed within 20 days of the final action of the procedure.