CHAPTER 185
REHABILITATIVE TREATMENT SERVICES

DIVISION I
GENERAL PROVISIONS

PREAMBLE

These rules define and structure the department of human services' rehabilitative treatment services program. Rehabilitative treatment services are designed to address the treatment needs of children and their families in the following four programs: family-centered services, family preservation, family foster care and group care.

These rules outline the application process, eligibility, service necessity determination and service authorization process, documentation requirements, service termination and appeal procedures, and establish service provision, rate-setting and payment mechanisms associated with rehabilitative treatment services. These rules also establish standards for provider certification, audits, and sanctions for providers. The provisions for rate setting are also applicable to supportive services as defined in this chapter.

441—185.1(234) Definitions.

"Adverse authorization action" means an authorization determination decreasing the requested scope, amount, or duration of services, or denying rehabilitative treatment services.

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

"Agency" means any entity, public or private, which provides or represents itself as providing rehabilitative treatment or supportive services.

"Amount" means the number of units of a service core or level of care within a rehabilitative treatment service.

"Authorization action" means an authorization determination approving rehabilitative treatment services.

"Authorized representative" within the context of rule 441—185.13(234) means that person appointed to carry out audit procedures, including assigned auditors, fiscal consultants, or agents contracted for specific audits or audit procedures.

"Behavioral management for children in therapeutic foster care" means services to design, assess, or revise therapeutic treatment strategies in therapeutic treatment family foster homes in order to meet the specific medical-behavioral health needs of children identified by a licensed practitioner of the healing arts. The focus of the service is to develop an intervention plan with the therapeutic treatment foster family to address the specific medical-behavioral health needs of the child, assess the effectiveness of the treatment strategies and interventions in measurable terms on an ongoing basis, and revise the treatment strategies when they are found not to be addressing the specific medical-behavioral condition of the child.

"Care plan" means the plan developed by the provider and treatment foster family for the interventions to be provided by the treatment foster family in accordance with the provider's treatment plan.

"Case permanency plan" shall mean the plan identifying goals, needs, strengths, problems, services, time frames for meeting goals and for delivery of the services to the child and parents, objectives, desired outcomes, and responsibilities of all parties involved; and reviewing progress.

"Certification" means the decision made by the department that the provider has met the applicable standards.

"Certified psychiatric mental health nurse practitioner" means a person who meets the requirements of a certified psychiatric mental health nurse and is eligible for certification by the American Nursing Association and is licensed by the state of Iowa to practice nursing as defined in Iowa Code chapter 152.

"Child" means a person under 21 years of age.

"Claim" means each record received by the department or the Iowa Medicaid enterprise that tells the amount of requested payment and the service rendered by a provider to a child and family.

"Clinical record" means a tangible and legible record which meets the criteria established for clinical records set forth in rule 441—185.10(234).

"Community residential setting" means a group care residential setting licensed as a community residential facility under 441—Chapter 114.

"Community residential setting for mentally retarded children" means a group care residential setting licensed as a community residential facility for children with mental retardation licensed under 441—Chapter 116.

"Comprehensive residential setting" means a group care residential setting licensed as a comprehensive residential facility under 441—Chapter 115.

"Comprehensive residential setting for mentally retarded children" means a facility licensed as a comprehensive residential facility for children with mental retardation under 441—Chapter 116.

"Confidence level" means the probability that an overpayment or underpayment rate determined from a random sample of charges is less than or equal to the rate that exists in the universe from which the sample was drawn.

"Deemed status" means an acceptance of an outside body's review, assessment, and accreditation of a rehabilitative treatment services provider's functioning and services in lieu of certification based on review and evaluation by the department.

"Department" means the Iowa department of human services.

"Department worker" means the worker who is responsible for providing social casework as described in 441—Chapter 131.

"Duration" means the maximum period of time for which the service core or level of care within rehabilitative treatment service is authorized.

"Enhanced residential treatment" means a treatment program in a facility licensed under 441—Chapter 115.

"Experience in the delivery of child welfare and juvenile justice services" means experience working with families at risk of child abuse, children at risk of delinquency, children who have been abused, children adjudicated CINA or delinquent, and children with emotional or behavioral disorders.

"Experience in the delivery of human services" means paid or volunteer experience providing social casework, therapy, or skill development services to children or families; supervision of children; as well as other experiences providing direct care to children and families. It does not include activities engaged in as part of a practicum or internship for academic credit.

"Extrapolation" means that the total amount of overpayment or underpayment will be estimated by using sample data meeting the confidence level requirement.

"Family" includes the following members:

1. Legal spouses (including common law) who reside in the same household.
2. Natural, adoptive, or step mother or father, and children who reside in the same household.
3. A child who lives alone or who resides with a person, or persons, not legally responsible for the child's support.

"Family preservation" means treatment services provided in the family preservation program that have duration limited to 60 calendar days, but are expected to last an average of 45 calendar days.

"Family skill development" means services to train or educate parents on specific therapeutic interventions to enable them to meet the specific medical-behavioral health treatment needs of the child including guidance and interventions that address the specific medical-behavioral health needs of the child, techniques for caring for a child with special needs, and guidance and intervention to alleviate a pattern of impaired interactions associated with a specific medical-behavioral need of a child.

"Fiscal record" means a tangible and legible history which documents the criteria established for fiscal records as set forth in subrule 185.102(3).

"Generally accepted auditing procedures" means those procedures published in Standards for Audit of Governmental Organizations, Programs, Activities & Functions, 1988 Edition, by the Comptroller General of the United States.

"Highly structured juvenile program" means a treatment program for adjudicated delinquent youth, aged 15 to 17, licensed as either community residential facilities under 441—Chapter 114 or as comprehensive residential facilities under 441—Chapter 115.

"Imminent risk of placement" means that the family at issue includes one or more children considered by the referral worker to be either at high risk or immediate risk of placement. Cases considered at immediate or high risk of placement are defined as follows:

1. Immediate. Immediate-risk cases are those in which the referral worker has determined that a child needs to be placed out of home, at least one family member's safety is in immediate jeopardy, and either emergency placement procedures or emergency and intensive preventive services need to commence immediately.
2. High. High-risk cases are those in which the referral worker has determined that a child needs an out-of-home placement, but the family's condition is such that the immediate safety of any family member is not jeopardized. Nonemergency placement procedures would commence if some type of preventive services were not provided. These cases may include families already receiving preventive services but for whom the referral worker has determined client progress is such that a continuation of the nonfamily preservation services would not ensure family unity and self-sufficiency upon termination of the services.

"Individual provider" means a person who seeks certification pursuant to rule 441—185.10(234) or who is under contract pursuant to 441—Chapter 152 and who delivers rehabilitative treatment and supportive services independent of a partnership, corporation, agency, governmental unit or any other legal entity.

"Juvenile court officer (JCO)" means a person appointed as a juvenile court officer under Iowa Code chapter 602 and a chief juvenile court officer appointed under Iowa Code chapter 602.

"Level of care" means a level of treatment services within the group care program that is differentiated by the intensity of skill development and therapy services provided, the hours of awake supervision, and the ratio of skill development staff to child. There are four levels of rehabilitative treatment in the group care program:

1. Community residential.
2. Comprehensive residential.
3. Enhanced comprehensive residential.
4. Highly structured juvenile program.

"Licensed independent social worker" for purposes of this chapter means a person who is licensed as an independent social worker under Iowa Code chapter 154C in activities which are directed at enhancing or restoring people's capacity for social functioning, whether impaired by environmental, emotional, or physical factors, with particular attention to the person-in-situation configuration.

"Licensed practitioner of the healing arts" means one of the following who is licensed to practice in the state of Iowa as:

1. A psychologist.
2. A certified psychiatric mental health nurse practitioner.
3. A licensed independent social worker.
4. A marital and family therapist.
5. A mental health counselor.

"Marital and family therapist" means a person who is licensed to practice marital and family therapy in the state of Iowa pursuant to Iowa Code chapter 154D.

"Mental health counselor" means a person who is licensed to practice mental health counseling in the state of Iowa pursuant to Iowa Code chapter 154D.

"Nonprime programming time" means any period of the day in a group care program other than prime programming time and sleeping time.

"Nonrehabilitative treatment need" means the child and family have a protective, supportive or preventative need for which the child has no identified rehabilitative behavioral health treatment need. Services to address a nonrehabilitative treatment need may be directed at a family member to meet the child's safety, treatment, or permanency need.

"Nonrehabilitative treatment service" means a service to address the nonrehabilitative treatment need of a child. Nonrehabilitative treatment services are designed either to restore a skill or function or teach a new skill or function to achieve maximum independence and functioning. These services may also be directed toward family members to help them meet the treatment, safety, or permanency needs of a child. Nonrehabilitative treatment services are designed to meet treatment needs in one of the following programs:

1. Family-centered program.
2. Family preservation program.

"Other adult caretaker" for purposes of the family foster care program means any adult other than a foster parent living in the foster family home who provides care to the foster child on a routine basis in the absence of the foster parent.

"Overpayment" means any payment or portion of a payment made to a provider which is incorrect according to the laws and rules applicable to rehabilitative treatment and supportive services which results in a payment greater than that to which the provider is entitled.

"Physician" means an individual who is a doctor of medicine or osteopathy and is licensed to practice in the state of Iowa pursuant to Iowa Code chapter 148.

"Prime programming time" means any period of the day in a group care program when special attention, supervision, or treatment is necessary; for example, upon awakening in the morning until departure for school, during meals, after school, transition between activities, evenings and bedtime, and on nonschool days such as weekends, holidays, and school vacations.

"Probation" means a specified period of conditional participation in the provision of rehabilitative and supportive services.

"Provider" means any natural person, company, firm, association, or other legal entity seeking certification pursuant to rule 441—185.10(234) or under contract with the department pursuant to this chapter or 441—Chapter 152.

"Psychologist" for the purposes of this chapter means a person who is licensed to practice psychology in the state of Iowa pursuant to Iowa Code chapter 154B.

"Psychosocial evaluation" means services to evaluate the basic strengths of the child and family; assess the emotional needs, health and safety of the child and family; identify the goals and treatment services needed to obtain these goals and expected outcomes; identify the resources available to promote and support these goals; and identify the general functioning of the child.

"Random sample" means a systematic (or every nth unit) sample for which each item in the universe has an equal probability of being selected.

"Referral worker" means the department worker or juvenile court officer who refers the case to the review organization and who is responsible for carrying out the follow-up activities after the service necessity determination and service authorization process is completed.

"Rehabilitative treatment need" means a medical-behavioral health need of a child with a deficit in function or skill that the child lost or never gained as a result of interference in the normal maturational and learning process due to the child or parental dysfunction. The child must have the capability to benefit from the rehabilitative treatment services.

"Rehabilitative treatment services" involves services designed to restore a function or skill that an individual lost or never gained as a result of interference in the normal maturational and learning process due to individual or parental dysfunction. The individual must have the capability to learn the function or skill. Rehabilitative treatment services are designed to address the specific medical-behavioral health needs of the child. Rehabilitative treatment services are designed to address the treatment needs of a child in one of the following programs:

1. Family-centered.
2. Family preservation.

3. Family foster care.
4. Group care.

"Related human service field" means psychology; mental health counseling; family therapy; child and family services; family services; child, parent, and community services; human services; sociology; family studies; human relations; criminal justice; chemical dependency counselor program; or nursing. It also includes other degrees in which the student receives educational preparation in the following: therapy and counseling techniques; the development of interview, relationship building, and assessment skills; group dynamics; crisis intervention techniques; social change theories; social system theories; abnormal psychology; sociological concepts and theories as they relate to individuals, families, and groups; and sociological and psychological methods to analyze social problems. Special education, law enforcement administration, political science, and elementary education are not considered related human service fields.

"Restorative living skills development" means rehabilitative services to restore the child's and family's ability to function independently in the community on a daily basis. Skills training and supervision include, but are not limited to: food planning and preparation, maintenance of living environment, time and money management, personal hygiene and self-care.

"Review organization" means the entity designated by the department to make rehabilitative treatment services authorization determination.

"Scope" means the rehabilitative treatment service selected and the service cores or level of care within the program that is selected.

"Service authorization" means the process of service necessity determination and service authorization of scope, amount and duration by the review organization.

"Service code" means the identifier which describes services provided.

"Service core" means a set of treatment services within a rehabilitative treatment service delivered to a child and family that addresses the needs of the child and family.

"Site" means a location from which services are delivered, staff report, and records are kept. In the family foster care and group care programs each separately licensed location would be a site.

"Sleeping time" means any period of the day in a group care program in which children are normally sleeping.

"Social skills development" means services to restore a child's and family's communication and socialization skills. Interventions would restore a child's and family's ability to solve problems, resolve conflicts, develop appropriate relationships with others and develop techniques for controlling behavior.

"Supportive services" means family-centered supportive services as defined in 441—Chapter 182, supervision and home studies in family foster care provided pursuant to 441—Chapter 156, and group care maintenance pursuant to 441—Chapter 156.

"Suspension of payments" means the withholding of all payments due a provider until the resolution of the matter in dispute between the provider and the department.

"Termination from participation" means a permanent exclusion from participation in the provision of rehabilitative treatment and supportive services.

"Therapy and counseling services" means services to halt, control or reverse undue stress and severe social, emotional or behavioral problems that threaten, or have negatively affected the child's and the child's family's stability. Activities under this service can include counseling and therapy to children, groups and families, including interventions to ameliorate difficult behaviors.

"Treatment plan" means a written, goal-oriented plan of service developed for a child and family by the provider.

"Treatment services" means the individual service types included in the services cores or levels of care. These include:

1. Restorative living skills development.
2. Family skill development.
3. Social skills development.
4. Therapy and counseling services.
5. Psychosocial evaluation.

6. Behavioral management for children in therapeutic foster care.

"Underpayment" means any payment or portion of a payment not made to a provider for services delivered to eligible recipients according to the laws and rules applicable to the rehabilitative treatment and supportive services program and to which the provider is entitled.

"Universe" means all items (claims), submitted by a specific provider for payment during a specific time period, from which a random sample will be drawn.

"Withholding of payments" means a reduction or adjustment of the amounts paid to a provider on pending and subsequently submitted claims for purposes of offsetting overpayments previously made to the provider.

441—185.2(234) Eligibility. Rescinded IAB 4/11/07, effective 7/1/07.

441—185.3(234) Referral for service authorization. Rescinded IAB 4/11/07, effective 7/1/07.

441—185.4(234) Review organization. Rescinded IAB 4/11/07, effective 7/1/07.

441—185.5(234) Adverse authorization actions by the review organization. Rescinded IAB 4/11/07, effective 7/1/07.

441—185.6(234) Appeals. Rescinded IAB 4/11/07, effective 7/1/07.

441—185.7(234) Transition to the review organization. Rescinded 4/11/07, effective 7/1/07.

441—185.8(234) Appeals. Rescinded IAB 7/1/98, effective 8/15/98.

441—185.9(234) Interim provider certification standards. Rescinded IAB 11/5/97, effective 1/1/98.

441—185.10(234) Provider certification standards. Certification is the process by which the department shall ensure that providers meet the requirements for provision of rehabilitative treatment services.

Each provider of rehabilitative treatment services shall meet the following criteria for certification:

185.10(1) *Staff qualifications.* The provider of the following services shall document the credentials and experience of the individuals providing services under the rehabilitative treatment program.

a. Therapy and counseling services, psychosocial evaluation and behavioral management services for children in therapeutic foster care shall be provided by staff who meet one of the following minimum education and experience or professional licensing criteria:

(1) Graduation from an accredited four-year college, institute or university and the equivalent of three years of full-time experience in social work or experience in the delivery of human services in a public or private agency. These individuals shall have been employed prior to September 1, 1993, by an agency with interim certification under rule 441—185.9(234) published on January 5, 1994, and subrule 185.11(1) published on January 5, 1994, or be an individual with interim certification under rule 441—185.9(234) published on January 5, 1994, and subrule 185.11(1) published on January 5, 1994. Persons meeting this criterion shall not be qualified to provide therapy and counseling, psychosocial evaluation, or behavioral management services for children in therapeutic foster care if they change place of employment.

(2) Graduation from an accredited four-year college, institute or university with a bachelor's degree in social work from a program accredited by the council on social work education.

(3) Graduation from an accredited four-year college, institute or university with a bachelor's degree in a human service field related to social work and the equivalent of two years of full-time experience in social work or experience in the delivery of human services in a public or private agency.

(4) A master's degree in social work or related human service field from an accredited college, institute or university.

(5) Graduate education in the social work or related human services field from an accredited college, institute or university may be substituted for up to a maximum of 30 semester hours for one year of the required experience.

(6) Graduation from an accredited four-year college, institute or university with a bachelor's degree in social work or related human service field. These individuals shall have had continuous employment in the same agency since August 31, 1993, and the agency shall have received interim certification under rule 441—185.9(234) published on January 5, 1994, and subrule 185.11(1) published on January 5, 1994, or be an individual who received interim certification under rule 441—185.9(234) published on January 5, 1994, and subrule 185.11(1) published on January 5, 1994. Persons meeting this criterion shall not be qualified to provide therapy and counseling, psychosocial evaluation, or behavioral management services for children in therapeutic foster care if they change place of employment before they have two years of experience.

(7) Licensed in Iowa as an independent social worker, master social worker, psychologist, psychiatric mental health nurse practitioner, marital and family therapist or mental health counselor.

b. Skill development services shall be provided by staff who meet one of the following minimum education and experience or professional licensing criteria:

(1) Graduation from an accredited four-year college, institute or university with a bachelor's degree in social work, or related human service field.

(2) Graduation from an accredited four-year college, institute or university and the equivalent of one year of full-time experience in social work or in the delivery of human services in a public or private agency. Individuals with this level of education who provided skill development services prior to September 1, 1993, can provide skill development services without the one year of experience, if they have maintained continuous employment since August 31, 1993, with an agency that received interim certification under rule 441—185.9(234) published on January 5, 1994, and subrule 185.11(1) published on January 5, 1994, or if they had a family-centered contract with the department prior to September 1, 1993, and were granted interim certification under rule 441—185.9(234) published on January 5, 1994, and subrule 185.11(1) published on January 5, 1994. Persons meeting this criterion shall not be qualified to provide skill development if they change place of employment before they have one year of experience.

(3) Graduate education in social work, or a related human service field from an accredited college, institute or university may be substituted for up to a maximum of 30 semester hours for one year of required experience.

(4) A high school diploma or GED and the equivalent of one year of full-time experience in social work, or experience in the delivery of human services in a public or private agency. Individuals with this level of education who provided skill development services prior to September 1, 1993, can provide skill development services without the one year of experience if they have maintained continuous employment since August 31, 1993, with an agency that received interim certification under rule 441—185.9(234) published on January 5, 1994, and subrule 185.11(1) published on January 5, 1994, or had a family-centered contract with the department prior to September 1, 1993, and received interim certification under rule 441—185.9(234) published on January 5, 1994, and subrule 185.11(1) published on January 5, 1994. Persons meeting this criterion shall not be qualified to provide skill development if they change place of employment before they have one year of experience.

(5) Graduation from an accredited community college with a two-year associate degree in a related human service field or an associate of science career option degree, or graduation from a certified two-year nursing program.

(6) Sixty college credit hours toward a degree in social work or a related human service field from an accredited four-year college, institute or university may be substituted for the one year of required experience when at least 12 of the 60 hours are in the field of social work or a related human service field.

(7) Licensed in Iowa as an independent social worker, master social worker, bachelor social worker, psychologist, psychiatric mental health nurse practitioner, marital and family therapist or mental health counselor.

185.10(2) *Staffing requirements.* The agency or individual shall certify that they meet the staffing ratios set forth in this chapter. The agency or individual shall maintain records to demonstrate that qualified staff responsible for direct provision or supervision of rehabilitative treatment services are present in sufficient number to meet the requirements.

185.10(3) *Supervision requirements.* Provider staff who provide skill development services and who do not meet the qualifications for provision of therapy and counseling pursuant to 185.10(1)*"a"* shall receive supervision by an employee or consultant with those qualifications. Supervision shall occur on a face-to-face basis, and may be conducted on an individual or group basis. The provider shall document the date of supervision meetings, who was present, and the general focus of discussion. Supervision requirements may be waived for staff who are absent due to vacation or sick leave.

a. For individuals who meet the qualifications in 185.10(1)*"b"*(4) and who work full-time, supervision shall occur no less than once per week. For individuals who meet the qualifications in 185.10(1)*"b"*(4) and who work part-time, supervision shall occur no less than once every two weeks.

b. For individuals who meet the qualifications in 185.10(1)*"b"*(1), 185.10(1)*"b"*(2), 185.10(1)*"b"*(3), 185.10(1)*"b"*(5), or 185.10(1)*"b"*(6) and who work full-time, supervision shall occur at least two times per month. For individuals who meet the qualifications in 185.10(1)*"b"*(1), 185.10(1)*"b"*(2), 185.10(1)*"b"*(3), 185.10(1)*"b"*(5), or 185.10(1)*"b"*(6) and who work part-time, supervision shall occur no less than once a month.

185.10(4) *Treatment plan development.* The provider shall develop a treatment plan for each individual and family receiving treatment services except for the psychosocial evaluation services core. Treatment plans shall meet the following conditions:

a. The treatment plan shall be developed in collaboration with the referral worker, child, family, and, if applicable, the foster parents unless the treatment plan contains documentation for the treatment rationale for the lack of involvement of one of these parties. The provider shall document the dates and content of the collaboration on the treatment plan. The provider shall provide a copy of the treatment plan to the family and the referral worker, unless otherwise ordered by the court.

b. Initial treatment plans shall be developed after services have been authorized and within 30 calendar days of initiating services, except in the case of the family preservation program the treatment plan shall be developed within 10 calendar days of initiating services.

c. The treatment plan shall identify the following:

(1) Strengths and needs of the child and family.

(2) Goals, which are statements of outcomes to be achieved to meet the medical-behavioral health care needs of the child identified on Form 470-3055, Referral of Client for Rehabilitative Treatment and Supportive Services.

(3) Objectives, which are specific, measurable, and time-limited statements of indicators, levels of competence or accomplishments of the child which are necessary for progress toward each goal.

(4) Specific treatment service activities to be provided to achieve the objectives.

(5) Designation of the persons responsible for providing the services. When providing restorative living and social skill development in a group care setting, designation may be by job title.

(6) Date of service initiation and date of treatment plan development.

185.10(5) *Treatment plan review and revision.* Individuals qualified to provide therapy and counseling services pursuant to paragraph 185.10(1)*"a"* shall review the services identified in the treatment plan to ensure that the services are necessary, appropriate, and consistent with the identified medical-behavioral health care needs of the child listed on Form 470-3055, Referral of Client for Rehabilitative Treatment and Supportive Services.

a. All treatment plans shall be reviewed as follows:

(1) Ninety calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

(2) When any changes are made by the review organization to the identified medical-behavioral health care need of the child listed on Form 470-3055, Referral of Client for Rehabilitative Treatment and Supportive Services.

(3) Five working days after a skill development qualified staff has developed an initial or revised treatment plan for skill development services.

b. All treatment plans shall be revised when any of the following occur:

(1) Treatment goals or objectives have been achieved.

(2) Progress is not being made.

(3) Changes have occurred in the identified medical-behavioral treatment needs of the child listed on Form 470-3055, Referral of Client for Rehabilitative Treatment and Supportive Services.

(4) The treatment plan is not consistent with the identified medical-behavioral treatment needs of the child listed on Form 470-3055, Referral of Client for Rehabilitative Treatment and Supportive Services.

c. The treatment plan shall be signed and dated by qualified staff after each review and revision. The treatment plan shall be revised in collaboration with the child, family, referral worker and, if applicable, the foster parents. The revision of the treatment plan must reflect the services authorized and the identified medical-behavioral health care needs of the child. The revised treatment plan must meet the requirements for a treatment plan in paragraph 185.10(4)*"c."* The provider shall provide a copy of all the revised treatment plans to the family and referral worker, unless otherwise ordered by the court.

185.10(6) *Treatment records*. The agency or individual shall maintain confidential individual records for each individual or family receiving treatment services. The record shall include the following:

a. Case permanency plan as supplied by the referral worker.

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

c. All initial and revised treatment plans developed by the agency.

d. Correspondence with the referral worker regarding change in the case permanency plan or treatment plan or requests for authorization for additional services and any relevant evaluation activities including procedures and tests completed.

e. Discharge summary which identifies the reason for discharge, date of discharge, the recommended action or referrals upon discharge, treatment progress, and outcomes.

f. Progress reports 90 calendar days after initiating services and every 90 calendar days thereafter which summarize progress and problems in achieving the goals and objectives of the treatment plan. The progress report shall be written in conjunction with the treatment plan review and shall be completed no more than 15 calendar days before the report is due or 15 calendar days after the report is due. This report may serve as either a discharge summary or a recommendation for continued rehabilitative treatment service. If the report serves as a discharge summary, the report shall meet the requirements for a discharge summary. The provider shall provide a copy of all progress reports to the family and referral worker, unless otherwise ordered by the court.

g. For psychosocial evaluation services, evaluation reports.

h. Additional reports if requested by the referral worker.

i. Form 470-3055, Referral of Client for Rehabilitative Treatment and Supportive Services.

185.10(7) *Staff training.* An agency shall provide orientation training on the agency's purpose, policies and procedures within one month of hire and 24 hours of training in the first year of employment for all employed and contracted treatment staff. The 24 hours of training shall include: training on children and families' mental health service topics, and two hours of training related to the identification and reporting of child abuse for all employed or contracted treatment staff in accordance with Iowa Code section 232.69. An agency shall provide 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. The 12 hours of training shall include: training on children and families' mental health service topics and child abuse training every five years

in accordance with Iowa Code section 232.69. The training formats that shall qualify as training are as follows: in-service training, seminars, conferences, workshops, institutes, visiting other facilities, and meeting with consultants.

The training provided shall be documented. The documentation shall include the training topic, format, date and number of hours.

185.10(8) *Other conditions of certification.* To receive full certification providers shall meet the following conditions if applicable:

a. Rescinded IAB 4/11/07, effective 7/1/07.

b. Rescinded IAB 4/11/07, effective 7/1/07.

c. Rescinded IAB 4/11/07, effective 7/1/07.

d. Providers of family-centered psychosocial evaluation shall prepare within 14 calendar days following termination of services evaluation reports which summarize the results and recommendations of the psychosocial evaluation services provided to a child and family. The provider shall provide a copy of this evaluation report to the family and referral worker, unless otherwise ordered by the court. The evaluation report shall contain the following information:

(1) Sources of information and methods of assessing and observing the child and family used to complete the evaluation.

(2) Answers to any specific questions from the referral worker.

(3) Child and family safety and risk factors.

(4) Child and family strengths, including how these strengths may be used in further service delivery.

(5) Recommendations for further services including suggested goals, objectives, and methods of service delivery.

e. Rescinded IAB 4/11/07, effective 7/1/07.

441—185.11(234) Provider certification. Rescinded IAB 4/11/07, effective 7/1/07.

441—185.12(234) Sanctions against providers of rehabilitative treatment and supportive services. Failure to meet the requirements relevant to provider certification, contracting, cost reporting, billing and payment, and documentation may subject providers to sanctions.

185.12(1) *Grounds for sanctioning providers.* Sanctions may be imposed by the department against a provider for any one or more of the following reasons:

a. Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false information for the purpose of obtaining greater compensations than that to which the provider is legally entitled.

c. Submitting or causing to be submitted false information for the purpose of meeting service authorization requirements.

d. Failing to disclose or make available to the department or its authorized agent, records of services provided to a child and family and records of payments made for those services.

e. Failing to provide and maintain the quality of the services to children and families within established standards.

f. Engaging in a course of conduct or performing an act which is in violation of state or federal regulations, or continuing that conduct following notification that it should cease.

g. Overutilizing rehabilitative treatment services by inducing, furnishing or otherwise causing the child or family to receive services or merchandise not authorized.

h. Rebating or accepting a fee or portion of a fee or a charge for referrals of a child or family.

i. Submitting a false or fraudulent application for provider status for rehabilitative treatment services.

j. Violating any laws, regulations, or code of ethics governing the conduct of occupations or professionals subject to this chapter.

k. Being convicted of a criminal offense relating to negligent practice resulting in death or injury to clients.

l. Failing to meet standards required by state or federal law for certification, for example, licensure.

m. Failing to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.

n. Receiving a formal reprimand or censure by an association of the provider's peers for unethical practices.

o. Being suspended or terminated from participation in another governmental medical program such as workers' compensation, crippled children's services, rehabilitation services or Medicaid.

p. Committing fraudulent billing practices.

q. Committing negligent practice resulting in death or injury to the provider's clients.

r. Failing to repay or make arrangement for the repayment of identified overpayments or other erroneous payments.

185.12(2) *Sanctions.* The following sanctions may be imposed on providers based on the grounds specified in subrule 185.12(1).

a. A term of probation for provision of rehabilitative treatment services.

b. Termination from participation in the provision of rehabilitative treatment services.

c. Suspension from provision of rehabilitative treatment services.

d. Suspension or withholding of payments to provider.

e. One hundred percent review of the provider's claims prior to payment.

f. Referral to the state licensing board for investigation.

g. Referral to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.

h. Suspension of rehabilitative treatment services certification.

i. Termination of rehabilitative treatment services certification.

185.12(3) *Imposition and extent of sanction.* The decision on the sanction to be imposed shall be the department's. The following factors shall be considered in determining the sanction or sanctions to be imposed:

a. Seriousness of the offense.

b. Extent of violations.

c. History of prior violations.

d. Prior imposition of sanctions.

e. Prior provision of technical assistance.

f. Provider pattern of failure to follow program rules.

g. Whether a lesser sanction will be sufficient to remedy the problem.

h. Actions taken or recommended by peer review groups or licensing bodies.

185.12(4) *Scope of sanction.*

a. The sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant factors and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the violator is affiliated where the conduct was accomplished in the course of official duty or was effectuated with the knowledge or approval of that person.

b. Suspension or termination from provision of rehabilitative treatment services shall preclude the provider from submitting claims for payment whether personally or through claims submitted by a clinic, group, corporation, or other association to the department for any services provided after suspension or termination.

c. No clinic, group, corporation, or other association which is the provider of services shall submit claims for payments to the department for any services or supplies provided by a person within the association who has been suspended or terminated from provision of rehabilitative treatment services except for those services provided prior to the suspension or termination.

d. When there are grounds for sanction pursuant to subrule 185.12(1) against a clinic, group, corporation, or other association, the department may suspend or terminate the organization, or any other individual person within the organization who is responsible for the violation.

185.12(5) *Notice of sanction.* When a provider has been sanctioned, the department shall notify as appropriate the applicable professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed.

185.12(6) *Notice of violation.* Should the department have information that indicates that a provider may have submitted bills or been practicing in a manner inconsistent with the program requirements, or may have received payment for which the provider may not be properly entitled, the department shall notify the provider of the discrepancies noted. Notification shall set forth:

a. The nature of the discrepancies or violations.

b. The known dollar value of the discrepancies or violations.

c. The method of computing the dollar value.

d. Notification of further actions to be taken or sanctions to be imposed by the department.

e. Notification of any actions required of the provider. The provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken.

185.12(7) *Suspension or withholding of payments pending a final determination.* When the department has notified a provider of a violation pursuant to 185.12(6) or an overpayment, the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payment pending a final determination. When the department intends to withhold or suspend payments, it shall notify the provider in writing.

441—185.13(234) Provider audits.

185.13(1) *Provider monitoring.* The department shall have the authority to conduct a scheduled or an unannounced site visit to evaluate the adequacy of documentation in compliance with the policies and procedures for rehabilitative treatment and supportive services. The provider shall maintain the following documentation for each program.

a. List of all staff and supervisors providing services and their qualifications.

b. Number of staff hired and terminated in the year to date.

c. to *g.* Rescinded IAB 1/4/95, effective 2/1/95.

185.13(2) *Audit of clinical and fiscal records by the department.*

a. Authorized representatives of the department shall have the right, upon proper identification, and using generally accepted auditing procedures, to review the clinical and fiscal records of the provider to determine whether:

(1) The department has accurately paid claims for goods or services.

(2) The provider has furnished the services.

(3) The provider has retained clinical and fiscal records which substantiate claims submitted for payment during the audit period as described at 441—Chapters 156 and 182, subrules 185.10(6) and 185.102(3), and rule 441—79.3(249A).

b. Records generated and maintained by the department or its fiscal agent may be used by auditors and in all proceedings of the department.

c. Any service provider may be audited at any time at the discretion of the department.

d. The department shall select the appropriate method of conducting an audit and shall protect the confidential nature of the records being reviewed. The provider may be required to furnish records to the department. The provider may select the method of delivering any requested records to the department. Audit procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing recipients of services and employees of providers.

e. The department's procedures for auditing rehabilitative treatment services providers may include the use of random sampling and extrapolation. When these procedures are used, all sampling

will be performed within acceptable statistical methods, yielding not less than a 95 percent confidence level. Findings of the sample will be extrapolated to the universe for the audit period.

(1) The audit findings generated through the audit procedure shall constitute prima facie evidence in all department proceedings of the number and amount of requests for payment as submitted by the provider.

(2) When the department's audit findings have been generated through the use of sampling and extrapolation, and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit of the universe of provider records used by the department in the drawing of the department's sample. This audit shall:

1. Be arranged and paid for by the provider.
2. Be conducted by a certified public accountant.
3. Demonstrate that bills and records not reviewed in the department's sample were in compliance with program regulations.
4. Be submitted to the department with all supporting documentation.

(3) The total of the payments determined to be in error in the audit sample shall be divided by the total payments in the reviewed audit sample to calculate the percentage of dollars paid in error. This sample error payment rate shall then be multiplied by the total dollars in the audit universe from which the audit sample was selected to determine the extrapolated overpayment.

f. Actions based on audit findings.

(1) The department shall report the results of an audit of provider records to concerned parties consistent with the provisions of 441—Chapter 9.

(2) When an overpayment is found, the department may proceed with one or more of the following:

1. Request repayment in writing.
2. Impose sanctions provided for in rule 441—185.12(234).
3. Investigate and refer to an agency empowered to prosecute.

g. Appeal by provider. Providers may appeal decisions of the department according to rules in 441—Chapter 7.

These rules are intended to implement Iowa Code sections 234.6 and 234.38.

441—185.14 to **185.20** Reserved.

DIVISION II
FAMILY-CENTERED PROGRAM
Rescinded IAB 4/11/07, effective 7/1/07

441—185.21 to **185.40** Reserved.

DIVISION III
FAMILY PRESERVATION PROGRAM
Rescinded IAB 4/11/07, effective 7/1/07

441—185.41 to **185.60** Reserved.

DIVISION IV
FAMILY FOSTER CARE TREATMENT SERVICES
Rescinded IAB 11/8/06, effective 11/1/06

441—185.61 to **185.80** Reserved.

DIVISION V
GROUP TREATMENT
Rescinded IAB 4/11/07, effective 7/1/07

441—185.81 to **185.100** Reserved.

DIVISION VI
ESTABLISHMENT OF RATES

441—185.101(234) Definitions. These definitions shall apply to this division of 441—Chapter 185 only.

"Accrual basis accounting" means the generally accepted accounting principle which requires that revenue be recognized as earned and expenses be recognized as incurred.

"Across-the-board increase" means a uniform percentage or fixed dollar increase of those rates established by nonexceptional means.

"Benefits" means compensation in the form of access to services made available by the employer.

"Common ownership" means that relationship existing when an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

"Control" means that relationship existing where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

"Co-therapy" means the use of two qualified therapists for group therapy and counseling services.

"Department" means the Iowa department of human services.

"Group service" refers to a service in which two or more nonrelated persons participate. For purposes of this definition, one or more persons from a family represent one person.

"Host area" means the department service area that is responsible for administering the provider's contract with the department to provide rehabilitative treatment and supportive services.

"Indirect cost" means those expenses which cannot be related directly to a specific program and are, therefore, allocated to more than one program.

"Individual provider" means a person under contract pursuant to 441—Chapter 152 who delivers rehabilitative treatment and supportive services independent of a partnership, corporation, agency, governmental unit or any other legal entity.

"Individual service" refers to a service in which one person participates in a service. For purposes of this definition, one or more persons from a family represent one person.

"Interest" means the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

"Multiple program provider" means a provider which delivers more than one program under a contract with the department pursuant to 441—Chapter 152.

"Necessary costs" means costs essential to the provision of rehabilitative treatment and supportive services and to the achievement of service requirements and outcomes up to the extent required by standards established for the services.

"Negotiated rate" means the rate of payment established by the department as a result of negotiations between the provider and the department based upon the allowable reasonable and necessary costs of service provision.

"Occupancy costs" means expenses related to the acquisition, maintenance, and financing of a property, or rental of property necessary for service.

"Program" means the specific support service, core, level of care, or in the case of group care, maintenance.

"Provider" means any natural person, company, firm, association, or other legal entity seeking certification pursuant to rule 441—185.9(234) or 441—185.10(234) or under contract with the department pursuant to 441—Chapter 152.

"Rate resolution process" means a time-limited structured process involving an independent mediator to facilitate discussions with the goal of producing mutual agreement when the department and the provider have been unable to reach agreement on a rate during the rate negotiation process.

"Reasonable costs" means the level of costs which will be recognized for reimbursement purposes.

"Related to provider" means that the provider to a significant extent is associated or affiliated with or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies.

"Similar or same services" means services which have the same first three digits in their service code.

441—185.102(234) Financial and statistical report. The Rehabilitative Treatment and Supportive Services Financial and Statistical Report, Form 470-3049, shall be the basis for establishing the rates to be paid to all providers, both in-state and out-of-state. The Rehabilitative Treatment and Supportive Services Financial and Statistical Report, Form 470-3049, shall be completed by providers according to the following requirements:

185.102(1) *Accounting procedures.* Financial information shall be based on the agency's financial records. Providers are required to comply with the following specific requirements:

a. Providers shall report on an accrual basis of accounting. Providers not using the accrual basis of accounting shall adjust amounts to the accrual basis when the financial and statistical report is completed. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expenses.

b. Revenues shall be reported as recorded in the general ledger and adjusted for accruals. Allowance and expense recoveries shall be reflected as revenues.

c. Income received from fund-raising efforts or donations shall be reported as revenue on the financial and statistical report and used to offset fund-raising costs. Fund-raising costs remaining after the offset shall be an unallowable cost.

All contributions shall be accompanied by a schedule showing the contribution and anticipated designation by the provider. No private moneys contributed to the provider shall be included by the department in its reimbursement rate determination unless these moneys are contributed for services provided to specific individuals for whom the reimbursement rate is established by the department.

d. Depreciation expense reported on the Capital Asset Use Allowance Schedule shall be computed according to 42 CFR 413.130 as amended to September 23, 1992, and the method (straight line depreciation) used as described at 42 CFR 413.134(a)(3)(i) as amended to September 23, 1992. For assets acquired on or after November 1, 1993, useful lives may be based on the 1988 American Hospital Association publication "Estimated Useful Lives of Depreciable Hospital Assets." The 1981 edition of the AHA Guide shall continue to be used to compute useful lives of assets acquired prior to November 1993.

e. Assets shall be depreciated when the asset has a useful life of more than one year and a cost in excess of $500.

185.102(2) *Cost allocation.* The cost allocation schedule shall be prepared in accordance with recognized methods and procedures, including the following:

a. Direct program expense shall include all direct client contact personnel involved in a program including the time of a supervisor of a program, or the apportioned share of the supervisor's time when the supervisor has supervised more than one program.

b. Expenses other than salary and fringe benefits shall be charged as direct program expenses when the expenses are identifiable to a program.

c. A multiple program provider shall establish a method of cost allocation acceptable to the department. All expenses which relate jointly to two or more programs shall be allocated to programs by utilizing a documented cost allocation method consistently applied. The allocation method shall equitably distribute indirect program costs to reflect the benefit of the cost incurred to all applicable programs.

d. Occupancy expenses shall be allocated on a space utilization formula.

e. Family-centered, family foster care or group treatment optional therapy and counseling services may have a rate determined in common.

Family-centered, family foster care or group treatment optional skill development services may have a rate determined in common.

All services with rates determined in common shall have their maximum occupancy costs established pursuant to subrule 185.105(5) for family-centered, family preservation, or family foster care.

All services with rates determined in common shall have their maximum administrative costs established pursuant to subrule 185.105(7) for family-centered, family preservation, or family foster care.

185.102(3) *Records retention.* All revenue and expenses reported on Form 470-3049 shall be supported by a provider's general ledger and documentation on file in the provider's office. Failure to maintain records adequate to support the Rehabilitative Treatment and Supportive Services Financial and Statistical Report, Form 470-3049, may result in sanction or termination of the contract or other sanctions pursuant to rule 441—185.12(234). These records include, but are not limited to:

a. Payroll information.

b. Capital asset schedules.

c. All canceled checks, deposit slips, invoices (paid and unpaid).

d. Audit reports (if any).

e. Board of directors' minutes (if applicable).

f. Loan agreements and other contracts.

g. Reviewable, legible census reports and documentation of units of service provided to department clients which identify the individual client shall be available on a daily basis and summarized on a monthly report. For nondepartment clients, sufficient documentation of utilization shall be maintained and made available to establish a complete unit of service count. The documentation prepared shall be retained by the provider for use at the time the financial and statistical report is prepared and for review by the department's fiscal consultant.

h. Financial records must be retained for five years from the date of report submission as specified in 441—subrule 152.2(14).

185.102(4) *Independent audits.* When a provider has an independent audit conducted, the provider shall submit a copy of the independent audit report to the department within 30 days of receipt. A firm not related to the provider shall conduct the independent audit. The bureau of purchased services shall receive and maintain the report and provide a copy of the report to the bureau's fiscal consultant.

a. The department requires independent audits on an annual basis when a provider receives from the department $500,000 or more from funds paid under contracts for rehabilitative treatment and supportive services and purchase of services for services provided in any state fiscal year.

(1) The legal entity that has contracted with the department must be the subject of this independent audit.

1. When the legal entity that has contracted with the department is a subsidiary of another legal entity and a separate independent audit of the contracting entity is not performed because a consolidated or combined audit of the larger entity is required by American Institute of Certified Public Accountants (AICPA) standards, the department will accept the consolidated or combined audit if supplemental schedules that separately identify the financial statements of the contracting legal entity are provided.

2. When contract services are provided by a subsidiary entity of the contracting entity and a consolidated or combined audit is performed, the department may require supplemental schedules to separately identify the financial statements of the subsidiary entity and the contracting entity. If a consolidated or combined audit is not performed, the department may require that the subsidiary entity also be the subject of an independent audit.

(2) Required audits shall be completed within six months of the end of a provider's established fiscal year end for the provider's established fiscal year that ends during the state fiscal year in question. The bureau of purchased services may approve an extension of this time period upon written request from the provider.

(3) Not-for-profit providers shall ensure that the audit of their financial statements follows one of the uniform audit report formats recommended by the American Institute of Certified Public Accountants in the most recent version of the AICPA Audit and Accounting Guide for Not-for-Profit Organizations.

(4) Other types of providers shall ensure that the audit of their financial statements follows the formats prescribed by the AICPA for their specific industry.

b. Providers receiving less than $500,000 from funds paid under contracts for rehabilitative treatment and supportive services and purchase of services for services provided in any state fiscal year

annually are not required to have an independent audit. They shall submit a copy, as set forth in this rule, of any independent audit report they receive as a result of conducting an independent audit.

441—185.103(234) Submission of reports.

185.103(1) *New providers or current providers adding a new program.* New providers or current providers adding a program not currently under a contract developed pursuant to 441—Chapter 152 shall:

a. Submit a projected budget using the Rehabilitative Treatment and Supportive Services Financial and Statistical Report, Form 470-3049, 60 days prior to the desired contract effective date. The projected budget shall not duplicate direct or indirect costs paid by established program rates. New costs to be incurred as a result of the new program shall be included in the initial program budget.

b. Submit Form 470-3049 for the first six months of service (first actual report). The report shall be submitted within two months of the close of the reporting period. The first actual report shall not duplicate direct or indirect costs paid by established program rates. New costs incurred in the delivery of the new program shall be included in the first actual report. When the first actual report is contained in the year-end fiscal report, direct and indirect costs shall be allocated across all programs according to existing practice rules for cost allocations pursuant to 185.102(2)*"c"* and these costs shall be prorated according to the length of time each program was in operation during the fiscal year.

185.103(2) *Ongoing providers.* All providers shall submit Form 470-3049 no later than three months after the close of the provider's established fiscal year. The year-end fiscal report shall allocate direct and indirect costs across all programs according to existing practice rules for cost allocation pursuant to 185.102(2)*"c"* and shall prorate these costs according to the length of time each program was in operation during the fiscal year.

185.103(3) *Review by project manager.* The project manager shall review Form 470-3049, and transmit it to the bureau of purchased services within two weeks of receipt.

185.103(4) *Untimely submission of financial report.*

a. Failure by providers to submit the report in time without written approval from the chief, bureau of purchased services or designee may be cause to reduce payment to 75 percent of the current rate.

b. Failure to submit a complete and correctly prepared report within six months of the date the report is due shall be cause for terminating the contract.

185.103(5) *Periodic review and audit.* Providers may be subject to periodic financial reviews and audits. Exceptions to costs identified by the department or its fiscal consultant shall be communicated to the provider in writing.

185.103(6) *Noncompliance.* When adjustments to prior financial and statistical reports indicate noncompliance with reporting instructions, the department may require the provider to submit an audited financial and statistical report and the certified public accountant's or public accountant's opinion.

185.103(7) *Reimbursement of individual providers.* A provider who is an individual shall have the option of obtaining a rate by completing the Rehabilitative Treatment and Supportive Services Financial and Statistical Report, Form 470-3049, or accepting a rate established by adding the following. Costs not specified below, including transportation costs, shall not be allowed.

1. The maximum salary established for skill development or therapy and counseling pursuant to 185.105(1)*"c"* or *"f,"* as applicable to the service provider.
2. The maximum level established for benefits pursuant to subrule 185.105(2).
3. The maximum occupancy established pursuant to subrule 185.105(5) for family-centered, family preservation, or treatment in foster family care.
4. The maximum administrative costs allowed pursuant to subrule 185.105(7) for family-centered, family preservation, or treatment services in foster family care.

Rates shall be established upon initial submission and recalculated annually on the anniversary of the effective date of the contract.

441—185.104(234) Expenses not allowed. The following expenses are not reimbursable to rehabilitative treatment providers and shall be excluded from rehabilitative treatment service costs.

1. Fees paid to directors and nonworking officers' salaries.
2. Bad debts.
3. Entertainment expenses.
4. Memberships in recreational clubs paid for by a provider (country clubs, dinner clubs, health clubs, or similar places) which are primarily for the benefit of the provider's employees, owners, executives, board members, and related parties.
5. Legal assistance on behalf of clients.
6. Costs for health care services other than the rehabilitative treatment services.
7. Food and lodging expenses for personnel incurred in the county of the personnel's residence or office of employment. Exceptions will be allowed for food and lodging expenses incurred as part of programmed activities on behalf of clients, their parents, or guardians when documentation to support the expense, those benefiting from the expense and the specific therapeutic necessity is available for audit purposes.
8. Business conferences, conventions, and meetings of a provider not required for licensure, contracting for or certification of rehabilitative treatment or supportive services. Expenses associated with meetings called by the department will be reimbursable.
9. Awards and grants to recognize board members, employees, and community citizens for achievement. Awards and grants to clients as part of rehabilitative treatment or supportive services are reimbursable.
10. Survey costs other than those specifically required for certification of rehabilitative treatment and supportive services.
11. Federal and state income taxes.
12. Contributions to a contingency reserve or any similar provision for unseen events are unallowable. Contributions to a reserve for a self-insurance program are allowable to the extent that the type of coverage, extent of coverage, and the rates and premiums would have been allowed had insurance been purchased to cover the risks.
13. Outlays of cash with no prospective benefit to the facility or program, such as deposits, down payments and retainers.
14. Only assets acquired at a cost to a provider shall be depreciated. The depreciation level is limited to the amount expended to acquire the asset and place the asset in service.
15. Cost of fines and penalties resulting from failure to comply with federal, state and local laws or court rulings.
16. Costs of organized fund-raising in excess of revenues and donations received from fund-raising.
17. Costs of investment counsel and staff and similar expenses incurred solely to enhance income from investments and any investment losses.
18. Costs of prohibited activities for Internal Revenue Code Section 501(c)(3) organizations.
19. Organizational costs such as incorporation, fees to accountants, lawyers, brokers, for example, in connection with establishment or reorganization.
20. Advertising for client solicitation and all public relations expense are not reimbursable.
21. Imputed rental costs or other estimates of occupancy costs.
22. Costs for payments to foster parents or on behalf of a foster child, the 12 hours of preservice training, or the six hours of in-service training required for foster parent licensure and foster family insurance. The cost of foster family recruitment and foster family home studies are allowable only when the service for which the rate is being determined is the foster family home study within the conditions set forth at 441—156.7(4).
23. Costs resulting from staffing levels in excess of the minimum required by licensing or certification, whichever is higher and costs specifically limited or not allowed in the rules for a particular service. Group treatment prime programming time costs or costs resulting from staffing levels in excess of the minimum level required by licensing or certification may be allowed only to the extent that it has been determined by the certification process that the hours of prime time and a higher staff-to-client ratio

are required to appropriately meet the needs of the children being served during prime programming time, nonprime programming time and sleeping time.

24. All interest expenses. This rule applies to rates established on or after March 1, 1994.

441—185.105(234) Costs subject to limits. The department intends to reimburse providers for their reasonable and necessary costs of providing rehabilitative treatment and supportive services. For purposes of establishing payment rates for rehabilitative treatment and supportive services, the following necessary costs and categories of cost are limited to the stated reasonable levels:

185.105(1) *Salaries.* Reimbursable salaries per full-time equivalent administrative staff may not exceed the salary range established by the Iowa department of personnel for the comparable positions during the fiscal year. Reimbursable salaries for direct care and clerical staff may not exceed the percents specified in 185.105(1)*"b"* to 185.105(1)*"g"* of salary ranges established by the Iowa department of personnel for the comparable positions. The comparable positions are listed below:

a. Administrative staff described in account 2110 - Step 1, Human Service Area Administrator III.

b. Direct care supervisors. Effective November 1, 1993, the average salary shall not exceed 85 percent of the midpoint for a Social Worker III Supervisor. Effective July 1, 1994, the average salary shall not exceed 87 percent of the midpoint for a Social Worker III Supervisor. Effective July 1, 1995, the average salary shall not exceed 88 percent of the midpoint for a Social Worker III Supervisor. Effective July 1, 1996, the average salary shall not exceed 90 percent of the midpoint for a Social Worker III Supervisor.

c. Professional skill development staff for family-centered, family foster care, family preservation services, and group care optional services. Effective November 1, 1993, the average salary shall not exceed $25,053. Effective July 1, 1995, the average salary shall not exceed 90 percent of the midpoint for a Social Worker II. Effective July 1, 1996, the average salary shall not exceed 90 percent of the midpoint for a Social Worker II.

d. Professional skill development staff in group homes and staff providing family-centered respite care and family-centered supervision services. Effective November 1, 1993, the average salary shall not exceed 70 percent of the midpoint for a Residential Treatment Worker. Effective July 1, 1994, the average salary shall not exceed 77 percent of the midpoint for a Residential Treatment Worker. Effective July 1, 1995, the average salary shall not exceed 84 percent of the midpoint for a Residential Treatment Worker. Effective July 1, 1996, the average salary shall not exceed 90 percent of the midpoint for a Residential Treatment Worker.

e. Direct care staff working during the hours children would normally be asleep. The average salary shall not exceed 90 percent of the salary level established at 185.105(1)*"d."*

f. Therapy and counseling staff, psychosocial evaluation and behavioral management for children in therapeutic foster care staff. Effective November 1, 1993, the average salary shall not exceed 85 percent of the midpoint for a Social Worker III. Effective July 1, 1994, the average salary shall not exceed 87 percent of the midpoint for a Social Worker III. Effective July 1, 1995, the average salary shall not exceed 88 percent of the midpoint for a Social Worker III. Effective July 1, 1996, the average salary shall not exceed 90 percent of the midpoint for a Social Worker III.

g. Clerical and secretarial staff. Effective November 1, 1993, the average salary shall not exceed 80 percent of the midpoint for a Clerk Typist III. Effective July 1, 1994, the average salary shall not exceed 83 percent of the midpoint for a Clerk Typist III. Effective July 1, 1995, the average salary shall not exceed 87 percent of the midpoint for a Clerk Typist III. Effective July 1, 1996, the average salary shall not exceed 90 percent of the midpoint for a Clerk Typist III.

h. Fees paid to subcontractors providing or supervising the provision of rehabilitative or supportive services shall be subject to the applicable limitations described in 185.105(1)*"a"* to *"g"* or the maximum flat rate per full-time equivalent position established by the department by adding the following:

(1) The maximum salary established for therapy and counseling or direct care supervision pursuant to 185.105(1)*"b," "c,"* or *"f,"* as applicable to the provider.

(2) The maximum level established for benefits pursuant to subrule 185.105(2).

(3) The maximum occupancy established pursuant to subrule 185.105(5) for family-centered, family preservation, or treatment in foster family care.

(4) The maximum administrative costs allowed pursuant to subrule 185.105(7).

The costs of subcontractors providing program consultation shall be reported as training costs.

185.105(2) *Employee benefit costs.* Employee benefits costs shall be limited to the percentage of salaries and wages budgeted for benefits by the department for the state fiscal year in which the agency's fiscal year begins. The percentage shall be applied to adjusted salaries. The actual budgeted percentage rate shall be rounded to the nearest one-half percent. The only exception that may be granted to this percentage is when a provider's health care premium increases substantially because the provider's health care group size is small and within the past year employee utilization of health care is the rationale for the increased premium. In order for this exception to be considered by the chief of the bureau of purchased services, the provider shall document that the increase is related to the employee utilization and that bids from three other comparable health care coverage sources have been received and these bids are similar to the provider's current health care rate.

185.105(3) *Food cost.* Food cost per day in group care shall not exceed the weighted average of food costs by child age range published in the U.S. Department of Agriculture, Family Economics Group survey. The published indices for low- and middle-income rural and Midwestern urban families shall be weighted by the percentage of children by age range in group care and shall be updated for inflation using the Consumer Price Index for Food at Home.

185.105(4) *Clothing cost.* Clothing cost per day in group care shall not exceed 65 percent of the weighted average of clothing costs by child age range published in the U.S. Department of Agriculture, Family Economics Group survey. The published indices for low- and middle-income rural and Midwestern urban families shall be weighted by the percentage of children by age range in group care and updated for inflation using the Consumer Price Index - Urban.

185.105(5) *Occupancy costs.* After all other limitations, reimbursable occupancy costs will be limited to the lower of actual provider costs or the applicable limit under *"a"* or *"b"* below:

a. Group care services - 16.7 percent of total group care costs.

b. Family-centered, family foster care and family preservation services - 6.4 percent of the total costs of these services.

185.105(6) *Transportation costs.*

a. All travel mileage by provider employees in personal or provider vehicles other than vans owned or leased by group care providers shall be reimbursed at the average of the state employee and Internal Revenue Service rates per mile. Travel mileage for transportation of group care clients in a van owned or leased by the group care provider shall be reimbursed at the rate for minivans established by the department of management's budget pricing information for vehicle rates. Per diem costs shall be reimbursed according to applicable state employee policies. All transportation and related costs including, but not limited to, depreciation of vehicles, automobile insurance and maintenance, are included in the per mile rate.

b. Reimbursement for air and other commercial travel shall not exceed the lesser of the minimum commercial rate or the rate for mileage in 185.105(6)*"a"* above.

185.105(7) *Administrative costs.* After all other limitations, administrative costs shall be limited to the lower of actual costs or the applicable limit under *"a," "b,"* or *"c"* below:

a. Group care services - 18.9 percent of total group care costs.

b. Family-centered, family foster care and family preservation services - 15.4 percent of the total costs of rehabilitative treatment and supportive services.

c. For rates established for all rehabilitative treatment and supportive services on or after June 1, 1994, administrative costs shall be limited to the lower of the actual costs or 15.4 percent of the total costs of rehabilitative treatment and supportive services.

185.105(8) *Training costs.* Costs for participation in educational conferences and subscriptions for reference publications and program-related materials are limited to 1.4 percent of the agency's actual salary costs, less excluded or limited salary costs as recorded on the financial and statistical report. The

index for training costs will be the Annual American Society of Training and Development survey of U.S. employers.

185.105(9) *Annual meeting costs.* Reasonable annual meeting costs which are required by licensure are allowed.

185.105(10) *Moving and recruitment costs.* Moving and recruitment are allowed as a reimbursable cost only to the extent allowed for state employees. Expenses incurred for placing advertising for purposes of recruiting qualified individuals for staff positions are allowed for reimbursement purposes.

185.105(11) *Related party costs.* Costs applicable to services, facilities, equipment, and supplies furnished to the provider by organizations related to the provider through control, from ownership, capital investment, directorship or other means shall be included in the allowable cost of the provider at the cost to the related organization. Only costs which are determined to be necessary and reasonable at the provider level are allowable at the related organization level, unless these related organization costs are duplicative of provider costs already subject to reimbursement.

a. Allowable costs shall be all actual direct and indirect costs applying to any program or item interchanged between related parties, such as capital use allowance (depreciation), interest on borrowed money, insurance, taxes, and maintenance costs.

b. When the related party's costs are used as the basis for allowable rental or supply costs, the related party shall supply documentation of these costs to the provider. The provider shall complete a schedule displaying the amount paid to related parties, related party cost, and total amount allowable. The resulting costs shall be allocated according to policies in 185.102(2)*"a"* to *"c."*

Financial and statistical records shall be maintained by the related party under the provisions in subrule 185.102(3).

c. Tests for relatedness shall be those specified in paragraph *"a"* and 441—subrule 152.2(18). The department or the department's fiscal consultant shall have access to the records of the provider and landlord or supplier to determine if relatedness exists. Applicable records may include financial and accounting records, board minutes, articles of incorporation, and lists of board members.

185.105(12) *Foster parent training costs.* Costs for foster parent preservice and in-service training are limited to the hours required in 185.9(2)*"b"*(2) and 185.10(8)*"b"*(2).

185.105(13) *Volunteer recognition.* The amount of awards and grants to recognize volunteers whose activities relate to direct client rehabilitative treatment or supportive services shall not exceed $3 per volunteer.

441—185.106(234) Establishment of reimbursement rates. Rates shall be established on the basis of net reasonable and necessary cost per unit of service as reported on the financial and statistical report and adjusted by the department's fiscal consultant.

185.106(1) *Calculation of cost per unit.* Costs per unit of service will be calculated as follows:

a. Aggregate, reasonable and necessary costs as defined in subrules 185.105(1) to 185.105(13).

b. Less non fee-for-service revenues, and certain contributions for services provided to certain individuals.

c. Divided by effective utilization described in 185.106(2)*"a."*

d. Multiplied by the inflation factor as described in 185.106(2)*"b,"* as applicable to costs and cost categories which are not limited or subject to a prospective index.

185.106(2) *Adjusting factors.* Cost-based rates shall be established by applying the following adjusting factors.

a. The effective utilization level shall be 80 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program except for group care, which shall be as follows. The following effective utilization applies to all rates established on or after July 1, 1995, and shall be used to adjust rates established prior to July 1, 1995, for payment of services provided on or after July 1, 1995.

The effective utilization for group care facilities certified to provide community residential treatment and licensed pursuant to 441—Chapter 116 or 481—Chapter 57 or 63 shall be 95 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program.

EXCEPTION: The effective utilization for the service portion of the per diem rate for group care facilities certified to provide community residential treatment and licensed pursuant to 441—Chapter 116 or 481—Chapter 57 or 63 shall be 85 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program.

The effective utilization for all other group care facilities certified to provide community residential treatment and group care facilities certified to provide comprehensive residential treatment or enhanced residential treatment shall be 90 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program.

EXCEPTION: The effective utilization for the service portion of the per diem rate for all other group care facilities certified to provide community residential treatment and group care facilities certified to provide comprehensive residential treatment or enhanced residential treatment shall be 85 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program.

The effective utilization for all services provided by group care facilities certified to provide a highly structured juvenile program, including both the service and maintenance portion of the per diem rate, shall be 90 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program.

However, subsequent to the report submitted pursuant to 185.103(1)*"b,"* when the provider has failed to achieve a utilization rate of 70 percent during a cost report period, the subsequent rate shall be calculated on the basis of 100 percent of licensed or staffed capacity, whichever is less. This penalty shall be applied to cost reports due on or after December 1, 1994.

b. The applicable inflation factor is the percentage which shall be applied to costs for which prospective indices or other limits have not been established. The inflation factor is intended to overcome the time lag between the time period during which the rates will be in effect. The inflation factor shall be the amount by which the Consumer Price Index for all urban consumers increased during the preceding calendar year ending December 31.

(1) The inflation factor shall not be applied to prospective, budgeted costs or when the rate is established based on the report of costs incurred for less than 12 months.

(2) In no event shall the inflation factor cause the occupancy or administrative caps to be exceeded.

c. Rates established at reasonable and necessary cost per unit of service, net of related revenue, shall be subject to 185.106(4).

d. When a ceiling has been authorized by the legislature, the reimbursement rate shall be established by determining on a per unit basis the necessary and reasonable cost plus the current inflation factor subject to the maximum allowable cost ceiling.

e. The indices cited in subrules 185.105(1) to 185.105(4), 185.105(6), and 185.105(8) shall be reviewed and adjusted at the beginning of the state fiscal year and shall be applied to the first actual or the annual cost report due on or after that date. Adjustments shall be based on the most current data available on July 1.

185.106(3) *Rate limits.* Providers will be subject to the following rate limits:

a. Group care floor. For fiscal year 1994, combined service and maintenance components of the reimbursement rate paid to a group care provider shall not be below the rate in effect for that provider on October 31, 1993, or $76.61 per day when a 360-day year is used, whichever is less. The floor shall be $75.56 per day or the rate in effect for that provider on October 31, 1993, when a 365-day year is used.

b. Rates for new providers and for providers adding a new program to an existing contract under 441—Chapter 152. Payment rates for new providers and for providers adding a new program to an existing contract under 441—Chapter 152 shall be established according to the methodology described at 185.106(1)*"a"* to *"d,"* not to exceed the lower of:

(1) Budgeted cost per unit of service as computed under 185.106(1)*"a"* to *"d."*

(2) The seventy-fifth percentile of rates for similar programs as computed at the beginning of the calendar year, beginning January 1, 1995. Rates established pursuant to projected budgets shall not be included in the percentile ranking.

c. Interruptions in a program will not affect the rate. If a provider assumes the delivery of program from another provider, the rate shall remain the same as for the former provider. If a provider ceases

to contract for and provide a service or program and later decides to again contract for and provide that program or service and has a contract for that service in effect within two years, the rate shall remain the same as previously paid unless this rate would be in excess of a ceiling authorized by the legislature. However, while those providers who resume contracting for and providing a service within two years will not submit a projected budget to reactivate their rate, they will be required to submit a first actual cost report in accordance with 185.103(1)*"b."* Providers who resume contracting for and providing a service with an interruption of more than two fiscal years shall submit a projected budget in accordance with 185.103(1)*"a."*

d. Rates for public agencies shall not knowingly be established in excess of their actual costs. Public agencies whose rates do exceed their actual costs are required to notify the department within one month of becoming aware of the situation. Once the department or a public provider becomes aware of a situation that will cause a public provider to receive reimbursement in excess of their actual costs, the provider shall request or the department shall cause the provider's reimbursement rates to be lowered so as to avoid the necessity of a recoupment situation. Recoupment of overpayments, if necessary, will be handled in accordance with 185.122(1).

185.106(4) *Unit of service and unit rates.* For family-centered services, all members of a family shall collectively be considered one recipient of any unit of family-centered service. Service to the family or one or more of its members shall be considered one unit of service. For family foster care and group care, the child shall be considered the recipient of any unit of service.

a. The unit of service for family-centered and family foster care services shall be one-half hour of service provided on a face-to-face basis and directed toward the child. Monthly cumulative units shall be rounded up or down to the nearest whole unit.

b. The unit of service for family preservation shall be the family.

c. The unit of service for the required services provided in group care shall be one day based on a 365-day year. Rates in effect prior to July 1, 1995, shall be adjusted by multiplying them by 360 and dividing the result by 365 to establish the new rates effective July 1, 1995. Rates established on or after July 1, 1995, based on statistical information using a 360-day year shall be similarly adjusted. The unit of service for additional and optional services shall be one-half hour of service provided on a face-to-face basis and directed toward the child.

d. When co-therapy is provided, the provider shall bill at the rate for the unit of service for one therapist except as provided for as follows:

(1) When co-therapy is provided, the payment rates shall be determined by dividing the reasonable and necessary cost for the service by the average number of unrelated persons in attendance in the group.

(2) The co-therapy rate may be billed when the group consists of two or more families and four or more children. The rate for co-therapy shall be no more than 150 percent of the rate for group therapy and counseling services using one therapist. When the provider does not have a rate established for group therapy and counseling services using one therapist, 150 percent of the median rate for group therapy and counseling services using one therapist as determined by the department shall be used as the ceiling.

e. When therapy and counseling, restorative living skill development, and social or family skill development services are provided as a group service, the payment rates shall be determined by dividing the reasonable and necessary cost for that service by the average number of children or families in attendance at the group service.

441—185.107(234) Payment of new rates. New rates shall become effective according to the following four provider and service conditions.

185.107(1) *Rates based on reports of costs for the provider's fiscal year.* Providers shall submit the Rehabilitative Treatment and Supportive Services Financial and Statistical Report, Form 470-3049, within three months of the close of the provider's fiscal year. This form shall be used to report all reasonable and necessary costs for the entire fiscal year. Rates shall be adjusted based on the reported costs and a new rate established effective for programs provided beginning no later than the first day of the second month after receipt by the project manager of a complete financial and statistical report. However, no rate shall be effective prior to the effective date of the contract for a program.

185.107(2) *Rates for new providers and current providers adding a new program.* Rates based on a projected budget or the first actual report shall be effective no later than the first day of the second month after receipt by the project manager of a complete financial and statistical report. The provider handbook shall specify the information to be completed for the projected budget. However, no rate shall be effective prior to the effective date of the contract for a program.

185.107(3) *Liability for payment.* The department shall not be liable for payment for any programs prior to the contract effective date.

185.107(4) *Utilization.* Utilization for new family-centered, family preservation and family foster care programs shall not be budgeted at less than 80 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program. Utilization for new group care programs shall not be budgeted at less than the following: Utilization for group care facilities certified to provide community residential treatment and licensed pursuant to 441—Chapter 116 or 481—Chapter 57 or 63 shall be 95 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program. Utilization for all other group care facilities certified to provide community residential treatment and group care facilities certified to provide comprehensive residential treatment or enhanced residential treatment shall be 90 percent or actual (whichever is greater) of the licensed or staffed capacity (whichever is less) of the program. The new provider or current provider adding a new program shall specify on the financial and statistical report the licensed capacity, when applicable, and the staffed capacity for each new program. Any changes in licensed or staffed capacity shall be reported on any subsequently submitted cost reports.

441—185.108(234) Conversion to fixed fee schedule. Rescinded IAB 11/5/97, effective 1/1/98.

441—185.109(234) Fiscal years 1997 and 1998 determination of rates. Rules 441—185.102(234) to 441—185.107(234) are held in abeyance for purposes of establishing rates effective during the time period beginning July 1, 1996, to June 30, 1998. The subrules set forth below shall be considered to comply with rule 441—185.108(234) for the time period they are in effect. Rates to be effective July 1, 1996, shall be established based on the rate in effect as of June 30, 1996, plus an index factor of 2 percent. Rates to be effective July 1, 1997, shall be established based on the rates in effect as of June 30, 1997. Any increases in rates to be effective July 1, 1997, shall be subject to availability of funding.

185.109(1) *New services.* When a new provider contracts to provide rehabilitative treatment or supportive services or an existing provider adds a new service, the rate for the new services shall be established based on the weighted average rate.

a. The weighted average rate to be effective for new services provided from July 1, 1996, to June 30, 1997, shall be calculated as specified in paragraph 185.109(1)*"b"* based on the rates in effect on July 1, 1996. The weighted average rate to be effective for new services provided on or after July 1, 1997, shall be the weighted average rate in effect for the previous year plus any index factor which has been applied for the establishment of rates for the time period July 1, 1997, to June 30, 1998.

b. The formula for calculation of the weighted average rate shall be as follows:

The weighted average shall be computed by multiplying the rate for each similar service in effect as of July 1, 1996, by the number of units of each service provided to department clients. The products shall be totaled and divided by the total number of units provided to department clients as reported on the most recently submitted financial and statistical reports on which rates were established. All financial and statistical report data shall be annualized to provide equitable treatment of all provider rates. Rates not established through the use of the Rehabilitative Treatment and Supportive Services Financial and Statistical Report, Form 470-3049, shall not be considered when establishing the weighted average rate.

c. New rates shall only be established for services that a provider is not already providing. If a provider already has a rate for a similar service, the provider shall be required to use that rate for all similar services. If a provider has more than one rate for a similar service, the rate shall be the simple average of the rates in effect.

d. If there are less than four rates for a specific service, the department shall determine the rate for that service code by requiring financial and statistical reports reflecting the projected costs for the

new service to be submitted in accordance with rules 441—185.102(234) to 441—185.107(234). When the costs are being submitted for a current provider adding a program not currently under a contract developed pursuant to 441—Chapter 152, the provider shall report the projected costs for the new service on a copy of the most recently submitted Financial and Statistical Report, Form 470-3049, on which rates have been established. This report shall show any adjustments to the Certification Page. The salary schedule, Schedule B, is to be adjusted on the correct line item for that position. Adjustments shall also be made to any line item on Schedule D-1 so that the dollar volume increase because of the new services is reflected on Schedule D-1.

The report of actual costs pursuant to paragraph 185.103(1)*"b"* shall be a report of costs only for the new service.

185.109(2) *Transition provisions.*

a. If a provider has submitted an annual financial and statistical report but no rate has been established based on that report, the rate to be in effect July 1, 1996, shall be the rate in effect June 30, 1996, plus the 2 percent index factor.

b. If a provider has submitted a first actual financial and statistical report, but no rate has been established based on that report, the rate to be in effect July 1, 1996, shall be the projected rate in effect June 30, 1996, plus the 2 percent index factor.

c. If a provider has submitted a projected budget but no rate has been established based on that budget, the rate to be effective July 1, 1996, shall be the weighted average rate.

d. If a provider has had a rate of zero due to lack of utilization, the rate shall be established using the weighted average rate for that service upon request from the provider and to be effective the first of the month following receipt of the request.

185.109(3) *Public agencies.* Public agencies shall comply with paragraph 185.106(3)*"d."*

185.109(4) *Interruptions in a program.* Interruptions in a program shall not affect the rate. If a provider assumes the delivery of a program from another provider, the rate shall remain the same as for the former provider. If a provider ceases to contract for and provide a service or program and later decides to again contract for and provide that program or service and has a contract for that service in effect within two years, the rate shall be established at the rate in effect when service was interrupted unless otherwise specified below. If the service was interrupted prior to July 1, 1996, and reinstated between July 1, 1996, and June 30, 1997, the rate shall be the rate in effect at the time of interruption plus 2 percent. If the service was interrupted prior to July 1, 1996, and the service is reinstated between July 1, 1997, and June 30, 1998, the rate shall be the rate in effect when the interruption occurred plus 2 percent and any index factor applied for rates effective July 1, 1997. If the service was interrupted after July 1, 1996, and is reinstated after July 1, 1997, the rate shall be the rate in effect when the interruption occurred and any index factor applied for rates effective July 1, 1997.

185.109(5) *Maintenance of fiscal records.* Subrules 185.102(1) to 185.102(3), rule 441—185.104(234), subrules 185.105(11) and 185.106(1), paragraph 185.106(3)*"d,"* and subrule 185.106(4) shall be used as the basis for maintenance of fiscal records.

185.109(6) *Certified audits.* Certified audits shall be conducted and the reports submitted to the department as set forth in subrule 185.102(4).

185.109(7) *Billing.* For billing purposes, subrule 185.106(4) remains in effect.

185.109(8) *Rates for services provided on or after July 1, 1998.* In absence of an alternative rate-setting methodology effective July 1, 1997, rules 441—185.102(234) to 441—185.107(234) shall be the basis of establishing rates to be effective for services provided on or after July 1, 1998.

a. In absence of a fixed fee schedule pursuant to rule 441—185.108(234) or other new rate-setting methodology set forth in rule, all providers, regardless of when their fiscal year ends, shall submit a Financial and Statistical Report, Form 470-3049, for the time period July 1, 1997, to December 31, 1997, based on the cost principles set forth in rule 441—185.101(234) to 441—185.107(234). This report shall be submitted no later than March 31, 1998. Rates based on reports submitted pursuant to this paragraph shall be effective no earlier than July 1, 1998, and no later than August 1, 1998, when the report is sufficient for the establishment of rates. However, if a provider with a contract in effect as of June 30, 1996, has a fiscal year which ends at the end of January, February, or March 1998, the provider

shall submit the financial and statistical report for the time period July 1, 1997, through the end of the provider's fiscal year, 1998. The report shall be submitted no later than three months after the close of the provider's established 1998 fiscal year. Rates shall be effective no later than the first day of the second full month after receipt by the project manager of a complete financial and statistical report.

b. Failure by providers to submit the report within the established time frames without written approval from the chief of the bureau of purchased services or the chief's designee shall be cause to reduce the payment to 75 percent of the rate in effect June 30, 1998, or the weighted average rate as of July 1, 1997, whichever is less. Approval for an extension for the submission shall be granted only when the provider can demonstrate that there have been catastrophic circumstances prohibiting timely submission.

c. If an extension is granted, the rate in effect as of June 30, 1998, shall be continued until the new rate is established. If a new rate is not established by the date set forth by the chief of the bureau of purchased services or the chief's designee in the notice of approval of the request to extend the time frame for submission of the Financial and Statistical Report, Form 470-3049, the provider's rate in effect as of June 30, 1998, shall be reduced to 75 percent of the rate in effect June 30, 1998, or the weighted average rate as of July 1, 1997, whichever is less, until such time as the new rate can be established.

d. If a provider has submitted the report on time, but a rate cannot be established within four months of the original due date due to incomplete or erroneous information, payment shall be reduced to 75 percent of the rate in effect June 30, 1998, or the weighted average rate as of July 1, 1997, whichever is less, until such time as the new rate can be established.

e. All subsequent financial and statistical reports shall be submitted within the time frames established pursuant to subrule 185.103(1).

f. Rates for individual providers shall be established pursuant to subrule 185.103(7) with the exception of rates to be in effect July 1, 1998. Individual providers shall submit to the department the information required by subrule 185.103(7) no later than March 31, 1998, to establish rates to be effective July 1, 1998. Rates shall be recalculated annually on the anniversary of the effective date of the contract from that point forward.

185.109(9) *Audit adjustments.* If the department or its authorized representatives conduct an audit and the audit findings result in exceptions to costs and adjustment to the rate in effect June 30, 1996, and the June 30, 1996, rate was the basis of the rate established effective July 1, 1996, the July 1, 1996, rate shall be adjusted in accordance with the audit findings.

185.109(10) *Liability for payment.* The department shall not be liable for payment for any programs or services prior to the contract effective date or the effective date for the rate for the program or service.

441—185.110(234) Providers under an exception to policy for establishing rates. When a provider has been granted an exception to rules 441—185.102(234) to 441—185.107(234) by the director prior to June 30, 1996, and the rate was established based on that exception by June 30, 1996, the exception shall continue in effect as written.

The rate in effect June 30, 1996, shall be frozen. The rate to be effective July 1, 1996, shall be the frozen rate plus a 2 percent index factor. If the rate based on the exception to policy was not established by June 30, 1996, the rate in effect as of June 30, 1996, shall be frozen and the rate to be effective July 1, 1996, shall be the frozen rate plus a 2 percent index factor. If the provider has a zero rate or no rate has been established for the service, the rate shall be established pursuant to subrule 185.109(1). However, for out-of-state providers with an exception to policy to establish rates based on the rates established by the state in which the provider is located, rates shall continue to be established in accordance with the existing exception to policy.

441—185.111(234) Data. The data to be used in calculating the fiscal impact of any proposed rules for a cost-based rate-setting methodology to become effective July 1, 1997, and to be used for the establishment of rates to be effective July 1, 1998, shall be the data from financial and statistical reports on which rates were established as of June 30, 1996.

These rules are intended to implement Iowa Code sections 234.6 and 234.38.

441—185.112(234) Determination of rates. Rules 441—185.102(234) to 441—185.107(234), 185.109(234) and 185.110(234) shall be held in abeyance for purposes of establishing rates effective January 1, 1998, unless otherwise provided for in these rules. Rates for a service to be effective on or after February 1, 1998, shall be established based on the payment rate negotiated between the provider and the department. This negotiated rate shall be based upon the historical and future reasonable and necessary cost of providing that service, other payment-related factors and availability of funding. Negotiated rates may be increased without negotiation if funds are appropriated for an across-the-board increase. A rate in effect as of December 31, 1997, shall continue in effect until a negotiated rate is established in accordance with the requirements of subrules 185.112(1) to 185.112(3), 185.112(6), or 185.112(12), or a rate is established in accordance with subrule 185.112(14), or until the service is terminated in accordance with subrule 185.112(4).

185.112(1) *Negotiation of rates.* Rates for services to be made effective on or after February 1, 1998, must be established in accordance with this subrule except as provided for at subrule 185.112(12) or 185.112(14).

a. On or after January 1, 1998, the department shall begin negotiating payment rates with providers of rehabilitative treatment and supportive services to be effective for services provided on or after February 1, 1998.

b. The scope of these negotiations is limited solely to the rate to be paid for each service.

(1) No other items, such as, but not limited to, changes in staff qualifications, service definition, required components, allowable costs or any licensing, certification or any contract requirement can be the subject of negotiations or used as a basis for changing rates except as provided for at subparagraph 185.112(1)*"f"*(7).

(2) The initial negotiation of rates pursuant to rule 441—185.112(234) shall encompass all of the services in the existing rehabilitative treatment and supportive services contract.

c. The service area manager of the host area is responsible for the negotiation of rates for each provider whose contract for rehabilitative treatment and supportive services is administered by the host area, regardless of where services are provided.

(1) The host area shall take into consideration the other service areas served by a provider when negotiating a rate for a service provided in multiple service areas.

(2) When a service is provided only in a nonhost area, the two service area managers shall determine which service area will negotiate the rate for that service.

d. The service area manager of the host area and the provider are mutually responsible for initiating the rate negotiation process. Negotiations should begin no later than May 1, 1998. Negotiations may be conducted in a manner acceptable to both parties but shall be conducted face to face upon the request of either party.

e. The provider must disclose any and all relevant subcontractual and related party relationships related to the provision of rehabilitative treatment or supportive services at the initiation of the rate negotiation process.

(1) This disclosure shall include all current and any proposed subcontracts that relate to the direct provision of rehabilitative treatment or supportive services for which rates are being negotiated. The provider shall make a written statement disclosing any current or proposed subcontracts that may relate to the rehabilitative treatment and supportive services for which rates are being negotiated.

(2) This disclosure shall include all transactions with related parties as defined at paragraph 185.105(11)*"c"* or 441—subrule 152.2(18) that may relate to the rehabilitative treatment and supportive services for which rates are being negotiated. The provider shall make a written statement disclosing any current related party transactions that may relate to the rehabilitative treatment and supportive services for which rates are being negotiated. This disclosure is only required when either the department or the provider seeks to establish a rate different than the rate used as the starting point for rate negotiations.

(3) Failure by a provider to comply with these requirements shall be considered a violation in accordance with subrule 185.12(6) and may result in sanctions being imposed or the withholding of payments.

f. For those services with a nonzero payment rate in effect on December 31, 1997, the rate in effect on December 31, 1997, shall be used as the starting point for rate negotiations. For rates to be effective on or after February 1, 1998, the department and the provider by mutual written agreement may either leave the rate in effect as of December 31, 1997, at its current level or they may raise or lower the rate in effect as of December 31, 1997. Adjustment of the rate in effect as of December 31, 1997, shall be based on the following factors:

(1) Changes in the Consumer Price Index for all Urban Consumers (CPI-U). Any adjustment based on changes in the CPI-U shall not exceed the amount by which the CPI-U increased during the previous calendar year.

(2) Changes in a provider's allowable costs based on current actual cost data or documented projections of cost. Allowable costs are those costs not excluded pursuant to rule 441—185.104(234).

(3) Changes in program utilization that impact the per unit cost of a program. Rates shall not be adjusted based on utilization levels that are below the minimum effective utilization of 80 percent or actual (whichever is higher) of the licensed or staffed capacity (whichever is less) of the program. If actual utilization is used as a basis for adjusting a rate, the actual effective utilization for the 12-month period immediately preceding the initiation of rate negotiations shall be used.

(4) Changes in the department's expectations of where a service must be delivered.

(5) Changes proposed by a provider and agreed to by the department of where a service must be delivered.

(6) Loss of a grant by a provider when the grant amount had previously been used to offset expenses which had resulted in a lower rate for rehabilitative treatment and supportive services.

(7) Changes in state or federal laws, rules or regulations that result in a change in the costs attributable to the services in question, including minimum wage adjustments.

(8) Competitive factors between providers.

(9) Department funding availability.

g. Existing providers who currently have a contract to provide a service where the payment rate has been established at zero prior to January 1, 1998, may use the weighted average rate established pursuant to paragraph 185.112(2)*"c"* for that service in lieu of their existing rate as the starting point for negotiations unless they have a nonzero rate for a similar service. If a provider has a nonzero rate for a similar service, the starting point for rate negotiations shall be established pursuant to paragraph 185.112(2)*"a"* or *"b."*

h. Negotiated rates are subject to the following additional limitations.

(1) For public agencies, profit or other increment above cost is not allowed (see subrule 185.112(5)). For private entities there is no provision for or prohibition of profit in these rules.

(2) Rates for cotherapy services continue to be subject to the limitations specified at subparagraph 185.106(4)*"c"*(2).

(3) Rates shall not exceed any rate ceiling established or authorized by the legislature.

(4) Rates to be paid may not exceed the limits established by 441—subrule 152.2(17).

i. The basis for any and all changes from the rate used as the starting point for negotiations shall be documented. A copy of all documentation shall be attached to the Rehabilitative Treatment and Supportive Services Negotiated Rate Establishment Amendment, Form 470-3404, when it is submitted to the bureau of purchased services for implementation.

j. Only the service area manager of the host area may approve the rates negotiated for a provider.

(1) This approval shall be based upon the historical cost basis used for establishing those rates and the documented factors justifying variation from those historical costs.

1. Payment rates in effect as of December 31, 1997, shall be considered to be sufficiently documented and no justification is required for continuing a rate in effect as of December 31, 1997.

2. Payment rates set at the weighted average rate for a service shall be considered to be sufficiently documented and no justification is required for establishing or maintaining a rate at the weighted average level.

(2) After both the provider and the service area manager of the host area have signed the Rehabilitative Treatment and Supportive Services Negotiated Rate Establishment Amendment, Form

470-3404, it shall be submitted to the bureau of purchased services along with the written disclosure required at paragraph 185.112(1)*"e"* and any necessary documentation to support changes in the rate from the historical cost base as required by paragraph 185.112(1)*"h."*

(3) The effective date of the rate for a new service shall be the effective date of a new contract or the effective date of the contract amendment adding that new service to an existing contract unless a later effective date is agreed to by both parties.

(4) The effective date of the rate for an existing service shall be the first of the month following the month in which the Rehabilitative Treatment and Supportive Services Negotiated Rate Establishment Amendment, Form 470-3404, and all necessary supportive documentation and disclosures are received by the bureau of purchased services by the fifteenth of the month.

k. Once a negotiated rate is established based on the provisions of this subrule, it shall not be changed or renegotiated during the period of this rule except in the following circumstances:

(1) By mutual consent of the provider and the service area manager of the host area based upon the factors delineated at paragraph 185.112(1)*"f,"* except that rates shall not be changed or renegotiated for the period of July 1, 2000, through June 30, 2009.

(2) In accordance with paragraph 185.112(6)*"b,"* except that rates shall not be changed or renegotiated for services not assumed by a new provider for the period of July 1, 2000, through June 30, 2009.

(3) Rates may be changed when funds are appropriated for an across-the-board increase. A 1 percent cost-of-living adjustment will be applied to those rates in effect as of June 30, 2008.

185.112(2) *New services.* When a new provider contracts to provide a rehabilitative treatment or supportive service or an existing provider adds a new rehabilitative treatment or supportive service on or after January 1, 1998, the rate for the new service shall be established based on a payment rate negotiated in accordance with subrule 185.112(1) using the weighted average rate for that service in lieu of an existing rate as the starting point for negotiations.

a. If an existing provider already has a rate for a similar service and wishes to establish a second rate for that service, the starting point for rate negotiations for the second rate shall be the starting point used in negotiations for the provider's already established rate for that similar service.

b. If an existing provider has more than one rate for a similar service and wishes to establish an additional rate for that service, the starting point for rate negotiations shall be established by the service area manager of the host area and shall be one of the following: the starting point of that provider's established rate for the similar service most closely resembling the proposed service, or the simple average of the starting points of all of the provider's established rates for similar services.

c. The weighted average rate is the weighted average rate for each service as of July 1, 1997, as previously established in accordance with subrule 185.109(1).

d. For those services where no weighted average rate has been established because there are less than four rates existing for that service or for newly developed rehabilitative treatment and supportive services, the department shall determine the cost of that service by requiring financial and statistical reports reflecting the costs for the new service to be submitted in accordance with rules 441—185.102(234) to 441—185.107(234). Initial projected rates established in accordance with this subrule shall become effective in accordance with subrule 185.107(2).

The report of actual costs pursuant to paragraph 185.103(1)*"b"* shall be used only to establish the historical costs of the new service which shall be used as the starting point in the rate negotiation process. The negotiated rate established in accordance with subrule 185.112(1) based upon the actual cost report shall become effective in accordance with paragraph 185.112(1)*"j."*

185.112(3) *Rate resolution process.* The rate resolution process may be used when the department and a provider are unable to agree upon a rate for a service within 60 days of initiating rate negotiations.

a. This process involves obtaining an independent mediator who is agreeable to both parties.

b. The cost of the mediator shall be borne equally by the provider and the department. Neither party to the mediation shall be liable for paying for more than that party's share of the cost for eight hours of mediation unless this is mutually agreed upon prior to initiation of the mediation process.

c. The rate resolution process must be concluded within 60 days of its initiation.

d. The mediator shall not make rate-setting decisions. The role of the mediator is to facilitate discussions between the parties in an effort to help the parties reach a mutual agreement.

185.112(4) *Failure to reach agreement on rates.* In the event the department and the provider are unable to reach agreement on a rate, the following procedures apply:

a. If the department and an existing provider are unable to reach agreement on a negotiated rate for an existing service with a published rate within 60 days of initiating negotiations or by June 30, 1998, whichever comes first, the rate resolution process may be used.

(1) Whether or not the rate resolution process is used, if agreement is not reached by September 30, 1998, the service shall be deleted from the provider's rehabilitative treatment and supportive services contract no later than November 30, 1998.

(2) If agreement is reached, the rate shall become effective in accordance with the provisions of paragraph 185.112(1)*"i."*

b. In the event the department and an existing provider are unable to reach agreement on a rate for a new service or an existing service without a published rate within 60 days of initiating rate negotiations, the rate resolution process may be used.

(1) If the rate resolution process is not used, and agreement is not reached within 120 days of initiating negotiations, no rate shall be established.

1. For new services, any contract amendment associated with that rate shall be denied.

2. For existing services without a rate, the contract shall be amended to delete this service from the contract.

(2) If the rate resolution process is used and no rate is agreed upon within 60 days of referral to the rate resolution process, no rate shall be established.

1. For new services, any contract amendment associated with that rate shall be denied.

2. For existing services without a rate, the contract shall be amended to delete this service from the contract.

3. If agreement is reached within the required time frames in either of the above situations, the rate shall become effective in accordance with the provisions of paragraph 185.112(1)*"i."*

c. In the event the department and a new provider are unable to reach agreement on a rate for a service within 60 days of initiating rate negotiations, the rate resolution process may be used. If no rate is agreed upon within 60 days of initiation of the rate resolution process, no rate shall be established and the services in question shall not be a part of any approved contract for rehabilitative treatment and supportive services. In the event that the department and a new provider cannot reach agreement on any rates, the contract shall be denied.

d. In all cases, a service for which a negotiated rate has not been established in accordance with subrule 185.112(1), except as provided for at subrule 185.112(12), on or before September 30, 1998, shall be terminated from the provider's contract for rehabilitative treatment and supportive services no later than November 30, 1998.

e. The department shall not be liable for payment for any rehabilitative treatment or supportive service that does not have a rate established in accordance with subrule 185.112(1), except as provided for at subrule 185.112(12), that is provided after November 30, 1998.

185.112(5) *Public agencies.* Public agencies shall be required to demonstrate their compliance with paragraph 185.106(3)*"d."*

185.112(6) *Interruptions in a program.*

a. If a provider assumes the delivery of a program from a related party provider as defined at paragraph 185.105(11)*"c"* or 441—subrule 152.2(18), the rate for the new provider shall remain the same as the rate established for the former provider. The rate for the new provider shall also remain the same as for the former provider if the difference between the former and the new provider is a change in name or a change in the legal form of ownership (i.e., a change from sole proprietorship to corporation).

b. Except as provided in paragraph *"a"* above, when a new provider assumes the delivery of a program from another provider, all rates for the services previously provided by either provider shall need to be reviewed and may be renegotiated at the request of either party.

c. If a provider ceases to contract for and provide a service or program on or after July 1, 1996, and prior to establishing a negotiated rate in accordance with subrule 185.112(1), decides to again contract for and provide that program or service, the nonzero rate in effect when the contract ceased shall be used as a starting point in negotiating a new rate in accordance with subrule 185.112(1) for that service.

d. If an existing provider ceases to contract for and provide a service or program for which a zero rate has been established, and decides to again contract for and provide that program or service, the rate shall be established in accordance with subrule 185.112(2) and the starting point for negotiations shall be the weighted average rate.

e. If a provider ceases to contract for and provide a service or program after a rate has been established in accordance with subrule 185.112(1) and decides to again contract for and provide that program or service, the rate shall be established at the rate in effect when service was interrupted.

f. Rates for services interrupted prior to July 1, 1996, shall be treated as a new service in accordance with subrule 185.112(2).

185.112(7) *Maintenance of fiscal records.* Subrules 185.102(1) to 185.102(3), rule 441—185.104(234), subrules 185.105(11) and 185.106(1), paragraph 185.106(3)*"d,"* and subrule 185.106(4) shall be used as the basis for maintenance of fiscal records.

185.112(8) *Certified audits.* Certified audits shall be conducted and the reports submitted to the department as set forth in subrule 185.102(4).

185.112(9) *Billing.* Subrule 185.106(4) remains in effect for billing purposes.

185.112(10) *Rates for services provided on or after July 1, 2000.* Rescinded IAB 12/1/99, effective 2/1/00.

185.112(11) *Liability for payment.* The department shall not be liable for payment for any programs or services prior to the contract effective date or the effective date for the rate for the program or service.

185.112(12) *Providers under an exception to policy for establishing rates.* When a provider has been granted an exception to rules 441—185.102(234) to 441—185.107(234) or 441—185.109(234) by the director of the department prior to January 1, 1998, the exception shall continue in effect as written for any provider not located in the state of Iowa and for which the exception was based upon another state's requirement that providers be paid the same rate they are paid for clients from the provider's home state. The exceptions for all other providers shall terminate and the conditions leading to the exceptions being approved shall be considered in the rate establishment negotiations.

185.112(13) *Review of rate negotiations.* Rate negotiations are considered rate determinations and shall be handled in accordance with the provisions for rate determinations at rule 441—152.3(234). Requests for review of rate determinations shall be granted only if the rate resolution process as defined at subrule 185.112(3) has been used.

185.112(14) *Establishment of statewide fixed rates.* Rescinded IAB 7/2/08, effective 7/1/08.

441—185.113 to **185.120** Reserved.

DIVISION VII
BILLING AND PAYMENT PROCEDURES

441—185.121(234) Billing procedures. At the end of each month, the provider agency shall prepare Form 470-0020, Purchase of Service Provider Invoice, for contractual services provided by the agency during the month.

Separate invoices shall be prepared for each county from which clients were referred and each program. Complete invoices shall be sent to the department county office responsible for the client for approval and forwarding for payment.

Providers shall never bill for more than one month of service. A separate invoice is required for each separate month of service, even if the service span overlaps one month.

185.121(1) *Time limit for submitting invoices.* The time limit for submission of original invoices shall be 90 days from the date of service, except at the end of the state fiscal year when claims for services through June 30 are to be submitted by August 10.

185.121(2) *Resubmittals of rejected claims.* Valid claims which were originally submitted within the time limit specified in 185.121(1) but were rejected because of an error shall be resubmitted as soon as corrections can be made.

185.121(3) *Payment.* Within 60 days of the date of receipt of a valid invoice, the department shall make payment in full of all invoices concerning rehabilitative treatment and supportive services rendered to clients, provided the invoices shall be subject to audit and adjustment by the department.

441—185.122(234) Recoupment procedures. Public agencies that are reimbursed more than their actual costs are required to refund any excess to the department within four months of the end of their fiscal year. No provision for profit or other increment above cost is intended in OMB Circular A–87 for public agencies. Those public providers subject to this provision who fail to comply with this requirement shall be considered to be in violation of 185.12(1)*"r"* and subject to sanctions. Providers who do not refund any excess payments within six months of the end of their fiscal year shall be given notice in accordance with 185.12(6) and have any and all payments suspended or withheld in accordance with 185.12(7).

441—185.123 to **185.125** Reserved.

DIVISION VIII
OVERPAYMENT PROVISIONS

441—185.126(234) Calculation of overpayments. Overpayment amounts shall be calculated by multiplying the unit rate by the number of units of the service for which the provider received payment in error.

185.126(1) *Random sampling and extrapolation.* When random sampling and extrapolation are used, the overpayment shall be calculated in accordance with paragraph 185.13(2)*"e."*

185.126(2) *Special provisions for group care.* The procedures in this subrule shall be applied to any billing audits initiated on or after December 1, 2003.

a. Determining the amount of overpayment for each child. When the department identifies an overpayment in a community, comprehensive, or enhanced group care service as a result of a provider's failure to meet the requirements for group care therapy and counseling established in subrule 185.83(5) or failure to meet the requirements for group care skill development as established in subrule 185.83(1), 185.83(2), or 185.83(3), the amount of overpayment for that service for a child during a calendar month shall be calculated as follows:

(1) Multiply the number of days for which the skill development requirement for the client was not met (deficient skill development days) by the unit rate. This is the skill development overpayment amount.

(2) Subtract the number of deficient skill development days from the number of days for which the provider received payment. The number of days remaining, if any, shall be used to determine the number of hours of acceptable therapy and counseling required pursuant to subrule 185.83(5). Any acceptable therapy and counseling provided during deficient skill development days shall be counted toward the therapy and counseling minimum requirement.

(3) Determine whether the amount of acceptable therapy and counseling provided and documented for the client during the calendar month is less than the number of hours of therapy and counseling required for the number of days of group care paid for during the calendar month that remains after adjusting for skill development deficiencies. If so, subtract the amount of acceptable therapy and counseling provided and documented for the client during the calendar month from the number of hours of therapy and counseling required for the remaining number of days of group care paid for the client during the calendar month. Divide this remainder by the required number of hours of therapy and counseling for the remaining number of days of group care paid for the client during the calendar month. The result of this division, expressed as a percentage, is the therapy and counseling deficiency percentage.

(4) Subtract the skill development overpayment amount from the total payment for this service code for this child for this month.

(5) Multiply the remaining payment, if any, by the therapy and counseling deficiency percentage. The result is the therapy and counseling overpayment amount.

(6) Add the skill development overpayment amount to the therapy and counseling overpayment amount. The result is the total overpayment amount for the child for the service code for the calendar month.

b. Determining the total overpayment amount. Add the overpayment amounts for all clients for the service code for each calendar month together to determine the total overpayment amount.

(1) If extrapolation is not used, this amount is the total overpayment amount.

(2) If random sampling and extrapolation are used, then this amount is used to calculate the sample error payment rate in accordance with subparagraph 185.13(2)*"e"*(3). The sample error payment rate is then used to calculate the extrapolated overpayment.

c. Examples. The examples set forth below are designed to address only the overpayment calculation with respect to per diem service, and do not address overpayment calculations with respect to per diem maintenance, additional services or optional service. The following examples illustrate the calculation of the overpayment amount for per diem service on rehabilitative and supportive services group foster care audits:

EXAMPLE 1. The provider furnishes comprehensive residential treatment to Child A for the month of July. Child A was discharged on July 27, so the provider may bill for only 26 days of service for July. The provider has mistakenly billed for 31 days of service for July. The provider has billed a per diem rate of $90 for each day of service, representing a total billing for July of $2,790 ($90 x 31).

Upon audit, it is determined that the provider has properly documented skill development services for each of the days the child was present in the facility and has furnished five hours of therapy and counseling to Child A during July. The overpayment calculation with respect to Child A is as follows:

The erroneous billing for five days of service during the month results in an audit adjustment of $450 ($90 x 5). The requirement for therapy and counseling for the number of days of service for which the provider may bill (26) is six hours, but only five hours of therapy and counseling were provided, resulting in an error rate of 16.67 percent ((6 - 5) ÷ 6 = 16.67 percent).

This error rate is then multiplied by the difference between the total amount the provider billed for the month ($2,790) less the overpayment for the erroneous billing ($450). There is no audit adjustment for skill development since the required skill development was properly documented. Thus, the overpayment for therapy and counseling is $390 (($2,790 - $450) x 16.67 percent = $390).

The total overpayment amount is $840, the sum of the overpayment for the erroneous billing ($450) and the overpayment for therapy and counseling ($390).

EXAMPLE 2. The provider furnishes community residential group treatment to Child B for the month of August. A provider may bill for the day of admittance to the program if service provision requirements for that day are otherwise satisfied. Since Child B was admitted to the program on August 14, Child B was present in the program for 18 days during the month. The provider has billed a per diem rate of $75 for each day of service, representing a total billing for August of $1,350 ($75 x 18).

Upon audit, it is determined that the provider failed to document the provision of skill development for two of the days during the service period during the month and that the provider has furnished 1.5 hours of therapy and counseling to Child B during August. The overpayment calculation with respect to Child B is as follows:

The failure to document the provision of skill development for two days of service during the month results in an audit adjustment for skill development of $150 ($75 x 2).

The requirement for therapy and counseling for the number of days of service for which the provider may bill (16) is two hours, but only 1.5 hours of therapy and counseling were provided, resulting in an error rate of 25 percent ((2 - 1.5) ÷ 2 = 25 percent). This error rate is then multiplied by the difference between the total amount billed by the provider for the month ($1,350) less the overpayment determined for skill development ($150). Thus, the overpayment for therapy and counseling is $300 (($1,350 - $150) x 25 percent = $300).

The total overpayment amount is $450, the sum of the overpayment for skill development ($150) and the overpayment for therapy and counseling ($300).

EXAMPLE 3. The provider furnishes enhanced residential treatment to Child C for the month of September. Child C is present in the program from the beginning of the month until discharged from the program on September 16. Since a provider may not bill for the day of discharge, the provider bills for 15 days of service for the month. The provider has billed a per diem rate of $100 for each day of service, representing a total billing for September of $1,500 ($100 x 15).

Upon audit, it is determined that the provider has documented the required skill development for the month and has furnished four hours of therapy and counseling to Child C during September. The overpayment calculation with respect to Child C is as follows:

There is no audit adjustment for skill development since the required skill development was properly documented.

The requirement for therapy and counseling for the number of days of service for which the provider may bill (15) is six hours, but only four hours of therapy and counseling were provided, resulting in an error rate of 33.33 percent ((6 - 4) ÷ 6 = 33.33 percent). This error rate is then multiplied by the difference between the total amount the provider billed for the month ($1,500) less the overpayment determined for skill development ($0). Thus, the overpayment for therapy and counseling is $500 (($1,500 - $0) x 33.33 percent = $500).

The total overpayment amount is $500, the sum of the overpayment for skill development ($0) and the overpayment for therapy and counseling ($500).

These rules are intended to implement Iowa Code sections 234.6 and 234.38.

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2 Effective date of 185.22(1)*"d,"*(2)*"d,"* and (3)*"d,"* 185.42(3), 185.62(1)*"d,"*(2)*"d,"* and (3)*"d,"* and 441—185.82(234) delayed 70 days by the Administrative Rules Review Committee at its meeting held July 11, 1995.