



Table of Contents

	<u>Page</u>
Overview	1
Service Referral and Authorization.....	1
Referral of a Client Using Form 470-3055.....	2
Intake Procedures.....	2
Referral Requirements.....	3
Documentation of Billed Services	3
Billing Procedures.....	4
Purchase of Service Provider Invoice, Form 470-0020.....	6
Instructions for Completing the Invoice.....	6
Billing for Group Care.....	8
Presence in a Facility.....	9
Billing for Reserve Bed Days.....	9
Time Limit for Submitting Invoices	10
Payment	11
Resubmittals of Rejected Claims	11
Payment Reductions or Across-the-Board Cuts.....	11
Billing Reports	12
Provider Statement.....	12
Provider Invoice Status Report	13



Overview

Payment to the provider is made when, at a minimum, all of the following conditions are met:

- ◆ An authorized service
- ◆ Is provided to an eligible client referred by DHS,
- ◆ By a provider that is in compliance with terms, conditions, and requirements of the contract,
- ◆ When the service is supported by documentation in accordance with contract requirements,
- ◆ Followed by submission of a valid claim.

This chapter addresses the service authorization, referral, and billing procedures for payment.

Service Referral and Authorization

Legal reference: 441 IAC 152.6(234) Client Eligibility and Referral

The referral worker works with the child and family to select a foster group care provider and arranges for services to be provided.

The Department determines a child's eligibility for foster group care services.

All foster group care services for children for which the Department shall make payment are referred and authorized either by the Department referral worker or by the juvenile court officer.

The Department will not make payment for foster group care services that are:

- ◆ Provided **before** the effective date of the child's eligibility determination or the effective date of the service authorization, or
- ◆ Provided **after** the service authorization expiration date or the termination date of the contract.



If a child and family have been referred to the Department and the Department has not authorized foster group care services, but the services have been ordered by the juvenile court, the Department will make payment subject to the availability of authorized funds.

The Department must authorize any change to the level of care or an increase in the number of units or duration of foster group care services.

Referral of a Client Using Form 470-3055

The referral worker will issue form 470-3055, *Referral and Authorization for Child Welfare Services*, to inform you of:

- ◆ The level of care authorized.
- ◆ The number of units of service authorized to be provided to the child.
- ◆ The duration of the authorized service.
- ◆ The effective date of service authorization and the end date of eligibility.

To view a sample of this form on line, click [here](#) for the English version and click [here](#) for the Spanish version.

Intake Procedures

Legal reference: 441 IAC 114.9(234) Intake Procedures

The group care facility shall have written intake policies. Children are to be accepted for placement only after the following criteria have been met:

- ◆ The referral worker and the staff of the facility have agreed upon an assessment of the child's need for service and supervision. The child, the child's family, and any other significant people are to be invited to participate in this process to the fullest extent possible.
- ◆ The assessment indicates that the child requires the care offered by this type of group care facility and is likely to benefit from the program the facility offers.



Referral Requirements

The following information shall be available to the facility before any decision is made regarding the acceptance of the child:

- ◆ A current social history.
- ◆ Current educational data.
- ◆ A copy of the child's physical assessment, including immunization history, completed within one year before the application, when available.
- ◆ Where indicated or when available,
 - Psychological testing completed no more than one year before referral.
 - A psychiatric report completed no more than one year before referral.
- ◆ The referring agency's case plan, which includes goals and objectives to be achieved during placement with a time frame for the achievement of these goals and objectives.
- ◆ Documentation of the legal status of the child, which includes any court orders or statements of custody and guardianship.

Documentation of Billed Services


Legal reference: 441 IAC 152.2(6) "b"

As a foster group care service provider, you are required to create and maintain documentation that accurately reflects the services provided and appropriately supports the billings submitted to the Department for payment. Details are covered in Chapter D and this chapter.

You are expected to have a quality control process that enables you to produce and maintain the required documentation with a consistently high degree of reliability.

The qualified persons who provided the service should create all of the required documentation used to substantiate your billings to the Department.

This documentation should be created contemporaneous to the service provision and must be placed in the client's individual treatment record **before** you bill for that service. Once a billing has been submitted, do not alter, change, or remove this documentation from the client's individual service record.

 Department of Human Services	Provider and Chapter Foster Group Care Services Chapter E. Billing and Payment	Page 4
		Date July 1, 2009

Do **not** bill for a service for which you do **not** have contemporaneous documentation of the provision of that service in the client’s individual service record to adequately support that billing.

After you have submitted a billing for a service, you may supplement the documentation placed in each client’s individual service record only in accordance with the identified procedures for curing documentation deficiencies as allowed. See information in Chapter D, [Supplemental Documentation](#).

This documentation is not subject to a FGCS billing review before payment for the service. However, the documentation may be reviewed for other purposes, such as licensing or contract compliance.

Maintain the documentation to substantiate your billings for not less than five years following the date of final payment, or upon completion of any required audit or review, whichever is later. If you cease providing foster group care services, contact the assigned contract monitor to discuss how these records will be made accessible for the required period.

When a FGCS billing review is to be conducted, you are required to make individual client service records, billing records, monthly census summaries, a list of all staff and supervisors providing services and their qualifications for the programs in the time period covered by the review available on the day they are requested. Failure to do so will result in overpayment findings and may also result in the application of sanctions.

For examples of certain types of service provision, billing, and documentation errors that may result in a determination that an overpayment has occurred, please see the section in Chapter F, [Overpayment Situations](#).

Billing Procedures

Payment is made after you submit a valid claim for payment for authorized services provided.

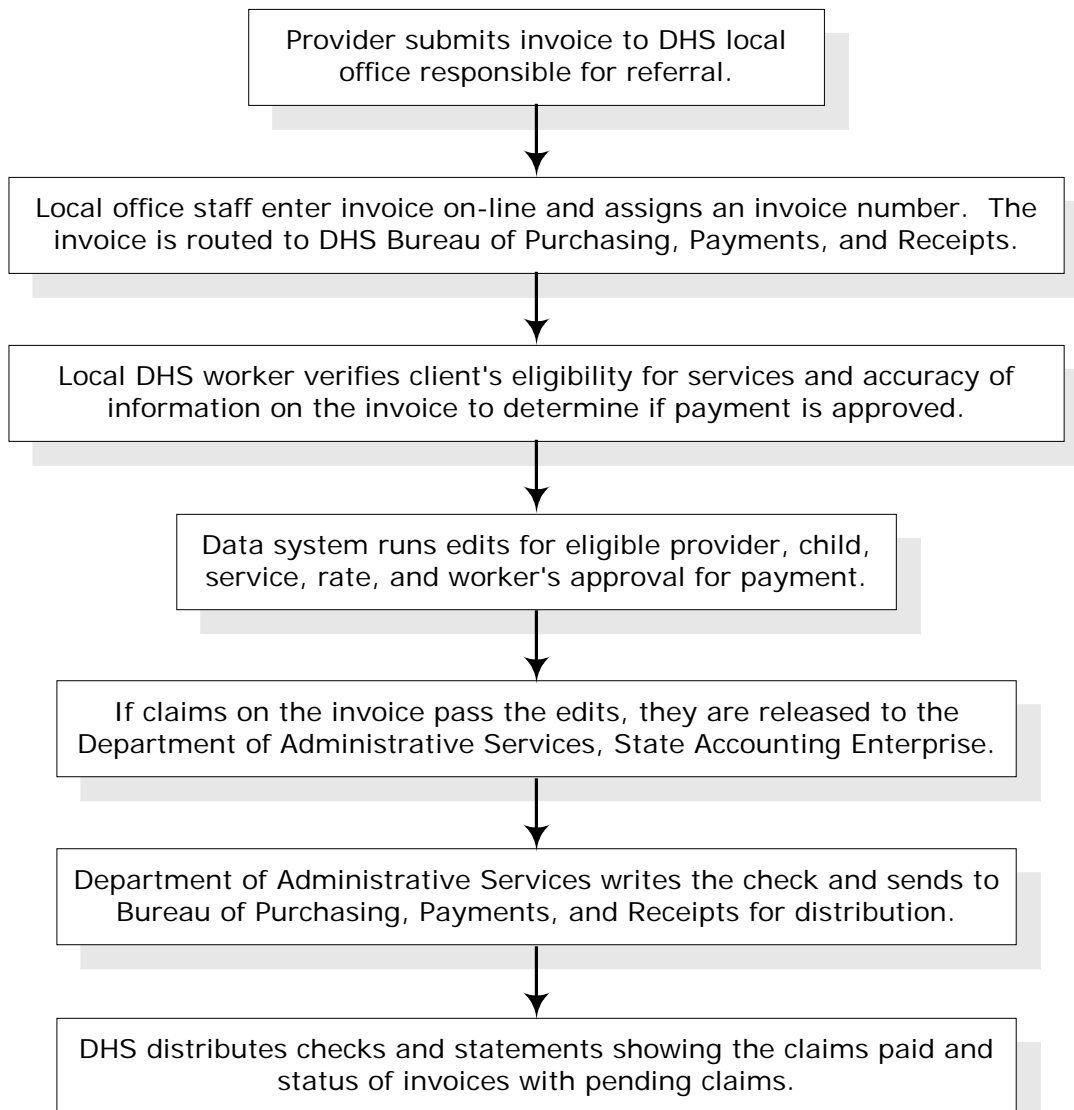
Once a billing or invoice for a service is submitted to the Department, any contractor’s clinical and fiscal records related to that service are subject to a billing review.



You may have more than one contract with the Department for purchase of services other than foster group care services. You must complete a separate invoice for each contract/contract (agreement) number.

The foster group care services contract (agreement) number will always begin with 29, e.g., 29-75-051.

The instructions that follow apply only to billing for foster group care services.



**Purchase of Service Provider Invoice, Form 470-0020**

Legal reference: 441 IAC 152.7(234) Billing Procedures

Submit claims for foster group care services on form 470-0020, *Purchase of Service Provider Invoice*, for which you have documentation of the billed per diem services as described in subrule 441 IAC 152.2(6). You may use a computer-generated version of this form with prior approval from the Department's Bureau of Purchasing, Payments, and Receipts.

Normally the billing period is from the first day of the month through the last day of the month. At the end of each month, prepare form 470-0020 for the foster group care services provided during the month.

Never bill for more than one month of service on an invoice. Submit a separate invoice for each separate month of service, even if the service span overlaps one month. Prepare separate invoices for each county from which clients are referred.

Send complete invoices to the Department office responsible for the client for approval. If the information on the invoice is not accurate and complete, claims may be rejected.

To view a sample of this form on line, click [here](#).

Instructions for Completing the Invoice

Complete the page numbers in the upper right corner of the invoice.

Enter all dates in six digits as month, day, and year (example: 12-20-08 or 12/20/08). Dollar amounts must always include the decimal point followed by two digits. (Example: \$12.50, \$5.00).

Invoice Number. Leave this space blank. This number is assigned by the Family and Children's Services (FACS) data processing system when the local Department office enters the invoice.

Billing Period. Enter the first and last dates of the billing period (usually the first and last day of the month).

State/Local. Leave blank.



County Number and Name. Enter the number and name of the county with financial responsibility for the child.

Agreement Number. Enter the seven-digit contract number from your *Foster Group Care Services Contract*, form 470-3052.

Provider Name. Enter your name as it appears on the Purchase of Service Rate List. The name on the rate list is how the name is entered onto the purchase of service payment system. The system accepts up to 24 characters. It is essential that the name entered on the invoice match the name entered on the payment system to avoid rejected claims.

Provider Address. Enter the mailing address to which the warrant is to be mailed. This address must match the mailing address specified on your contract.

Case Number. Enter the state identification number assigned to the service-billing client in the Family and Children's Service (FACS) system. This number is provided on form 470-3055, *Referral and Authorization for Child Welfare Services*.

Client's Name. Enter the service billing client's last name, first name, and middle name or initial from the *Referral and Authorization for Child Welfare Services*. The name must match the name as entered on the FACS system. The system accepts up to 16 characters for the surname and 10 characters for each of the first and middle names.

Service Beginning Date. When billing for the first month of services, enter the date that services began. When billing for months after the first month, leave blank.

Service Ending Date. Enter the service ending date only for clients who are terminating the service in the month covered by this claim. Enter the service ending date on the last billing only.

Service Code. The service code you enter must coincide with the service code in the contract and with the service code on the *Referral and Authorization for Child Welfare Services*. Remember to bill for both the service and maintenance codes.

Unit Cost. Enter the cost for one unit of service as approved by the Department.

Number of Units. Enter the number of whole units provided to each client during the billing month.



For group care maintenance and service where the unit is a day, enter the actual number of calendar days in the month for clients who received service each day in the month. A partial day counts as one unit. See [Billing for Group Care](#) below for more information on defining whether a child is present or absent, partial months of service, and reserve bed days.

Total Cost. Enter the product of the unit cost and the number of units.

Fee. Leave blank.

Credits. Leave blank.

Net Cost. Leave blank.

Totals. When all services have been entered, accumulate and enter totals by column for all pages on the last page. Totals are required for number of units. Do not total the unit cost column.

Claimant. Your signature and the date of your signature are needed on the last page only. The invoice must have an original signature. No rubber-stamped or photocopied signatures are allowed.

When you need multiple pages for one invoice, complete the 12 service lines of the form before starting on another page. On following pages, enter the contract (agreement) number and page, and then continue with the service lines. You need not repeat the remaining heading data.

Keep a copy for your records and forward the originals and one copy to the Department office in the county from which the clients were referred.

Billing for Group Care

Do not bill the group care per diem child welfare service or group care maintenance units on any given day in excess of your facility's licensed capacity.

Bill for the actual days when:

- ◆ A child was present **and**
- ◆ You have compliant documentation that the child welfare service was provided every day.



For example, bill for 31 days in March for a child who was present and received service every day.

When a child is placed in group care for a partial month, bill for child welfare service and group care maintenance for the actual number of days the child was in placement. When a child is admitted after the first day of the month, count the day the child enters the facility. Do not count the day that the child leaves if it is before the end of the month.

Presence in a Facility

Legal reference: 441 IAC 156.10(1) Group Care Facilities

For child welfare service and group care maintenance payment, a child is considered present in the facility if the child is in the facility for any portion of the day, defined as 24-hour period between midnight and midnight. Conversely, a child is considered *absent* from the facility if the child is gone from the facility for the entire day.

A child welfare service and group care maintenance payment can be made when a child is absent from the facility for family visits, hospitalization, runaway, or pre-placement visit, if the absence meets all other requirements for a reserve bed payment.

Billing for Reserve Bed Days

The Department shall provide payment for group care child welfare service and group care maintenance for family visits, hospitalization, runaways, and pre-placement visits.

The Department pays for reserve bed days only when the intent of the Department and the facility is for the child to return to the facility after the absence. If you refuse to accept the child back, you must not bill for reserve bed days or, if you did bill and were paid, you must return the reserve bed payments.

You must document the use of each reserve bed day in the child's daily log and report the number of reserve bed days claimed in the child's quarterly report. Family visits and preplacement visits to another foster care placement or an adoptive placement must be consistent with the child's case permanency plan. Your staff must be available to provide support to the child and family during visits or hospitalization.



You must notify the worker of each family visit and its planned length before the visit. Contact the worker at least 48 hours in advance of planned hospitalization and within 24 hours after an unplanned hospitalization or after the child runs away.

Payment is canceled the day after:

- ◆ You and the Department agree that the return would not be in the child's best interest, or
- ◆ The court decides not to return the child to your facility.

Following is a summary of the limits to reserve bed payments:

NUMBER OF RESERVE BED DAYS IN GROUP CARE FACILITIES		
<u>Reason</u>	<u>Worker Approval</u>	<u>Service Area Manager Approval</u>
Family visits	Up to 14 consecutive days	Up to 30 consecutive days
Hospitalization	Up to 14 consecutive days	Up to 30 consecutive days
Runaway	Up to 14 consecutive days	Up to 30 consecutive days
Preplacement visit	Up to 2 consecutive days	N/A

Time Limit for Submitting Invoices

Legal reference: 441 IAC 152.7(1) Submission of Invoices

The time limit for submission of the original invoice is 90 days from the date of service. EXCEPTION: At the end of the state fiscal year, claims for services through June 30 must be submitted by August 10.



Payment

Within 60 days of the date of receipt of a valid invoice, the Department will make payment in full of all invoices for authorized foster group care services provided to eligible clients. Invoices are subject to audit and adjustment by the Department.

All claims for the fiscal year ending June 30 must be paid within 60 days from the end of the fiscal year. Claims not paid by that time must be submitted to the State Appeal Board.

Invoices that remain unpaid 60 days after June 30 (the end of the state fiscal year) are returned to the provider unpaid. If the claim is not submitted within the required time, you may file the unpaid claim against the state by using the form, *State Appeal Board Claim Form and Affidavit*.

Instructions for completing the form are included on page two of the form. The form must be notarized. Instructions for submission of the form are given on the front of the form. The form can be obtained on the Internet at:

http://www.dom.state.ia.us/appeals/general_claims.html

Resubmittal of Rejected Claims

Legal reference: 441 IAC 152.7(2) Resubmittal of Rejected Claims

When a valid claim originally submitted within the time specified under [Time Limit for Submitting Invoices](#) is rejected because of an error, resubmit the claim as soon as corrections are made.

Be aware, however, of the time limits for payment at the end of the fiscal year. If a rejected claim is not paid within 60 days of the end of the fiscal year, you must submit the claim to the State Appeal Board, as described previously.

Payment Reductions or Across-the-Board Cuts

Legal reference: 441 IAC 152.3(5) Across-the-Board Cuts

Payment under the contract may be subject to across-the-board cuts pursuant to Iowa Code section 8.31. In the event that across-the-board cuts result in reduced payments, no contract amendment will be required.

Rates will be reduced by the amount required to meet the requirements of the budget reduction, and the chief of the Bureau of Purchased Services or designee will notify providers in writing of the method and amount of reduction.



Billing Reports

Provider Statement

You will receive a computer-generated report, *Provider Statement, S472N013*, which lists the claims paid in each check. This is the document you use to track payment of your claims. These reports are run weekly and are normally delivered to the Department's Bureau of Purchasing, Payments, and Receipts each Friday. The Bureau mails the report to you.

To view a sample of this form on line, click [here](#).

Data on the report are organized as follows:

- ◆ **Provider.** Your FGCS contract number.
- ◆ **Warrant.** The unique identifying number on the check.
- ◆ **Provider Name and Address.** The address where the check is mailed.
- ◆ **Issue Date.** The date that the check is printed. Usually, checks are mailed on the next working day after printing.
- ◆ **Amount.** The total amount of the payment included in this check.
- ◆ **Invoice Number.** The number of the invoice that contains this claim. Claims from more than one invoice can be paid with the same warrant.
- ◆ **Line Item.** The line number from this claim on the original invoice.
- ◆ **State ID.** This client's state identification number (the entry from the "Case Number" column of the invoice).
- ◆ **Name.** The name of the client for whom the claim was made.
- ◆ **Worker County.** The number of the county where the Department worker carrying the client's case is housed.
- ◆ **Service Code.**
- ◆ **Claim Month.** The month in which the claimed service was delivered.
- ◆ **Unit Rate.**
- ◆ **Amount.** The amount paid on this claim.



Provider Invoice Status Report

The *Provider Invoice Status Report*, S472N087-1, is a computer-generated report that lists the status of all of a provider's outstanding claims. This report is usually issued weekly on Friday, and is delivered to the Department's Bureau of Purchasing, Payments, and Receipts each Monday. The Bureau forwards a copy of the report both to providers and to Department local office staff.

To view a sample of this form on line, click [here](#).

Data on the report is organized as follows:

- ◆ **Invoice Number.** The invoice number is generated by the FACS system when staff in the Department's local office first enters the invoice into the system. Invoices are listed in order of entry, with the oldest first.
- ◆ **Item.** This is the line number from the original invoice. All the claims from the invoice continue to show on the report until each of the claims is paid.
- ◆ **Client Name.**
- ◆ **State ID.** This is the entry from the "Case Number" column of the invoice.
- ◆ **Service Month.**
- ◆ **Service Code.**
- ◆ **County.** This is the number of the county where the Department worker carrying the child's case is housed.
- ◆ **Worker Name.** This is the name of the Department worker carrying the child's case.
- ◆ **Status.** The five possible status entries for the payment on each claim are listed and defined on the first page of the report. "Unapproved" means that the Department worker carrying the child's case has not yet made entries on the FACS system to approve payment of the claim.
- ◆ **Status Date.** This is the date that the present claim status was achieved.
- ◆ **Amount.**
- ◆ **Warrant Number.** For payments that have been issued, the report lists the number of the warrant (check) that included the payment amount. This corresponds to the warrant number on the *Provider Statement*.