ARC 1155C

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services amends Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," and Chapter 80, "Procedure and Method of Payment," Iowa Administrative Code.

These amendments clarify the Department's policies regarding sanctions in the Medicaid program and add detailed descriptions of actions that will cause sanctions to be imposed. The amendments also implement 2013 Iowa Acts, Senate File 357. These amendments are intended to clarify that certain Medicaid debts are nondischargeable in bankruptcy proceedings, in accordance with 11 U.S.C. § 523(a)(4). These amendments clarify when medical assistance is incorrectly paid to families caring for family members. Finally, these amendments clarify the Department's timely filing policies for claims under Chapter 80.

The Department's sanction rules are outdated and do not contain the specificity and detail to allow the Department to fully address the current climate of Medicaid provider fraud, waste, and abuse activities. The landscape of Medicaid fraud, waste and abuse has changed and continues to evolve. These amendments clarify current policy regarding certain bad debts and handling of claims at the Iowa Medicaid Enterprise (IME).

Notice of Intended Action was published in the Iowa Administrative Bulletin as **ARC 0912C** on August 7, 2013.

The Department received no comments from the public during the comment period. However, the Medical Assistance Advisory Council (MAAC) and the Iowa Hospital Association reviewed the proposed amendments and provided a number of technical wording changes, specifically in subrules 79.2(1) to 79.2(6), 79.2(10), 79.4(2), and 79.9(7), to improve the clarity and intent of the rules.

The Council on Human Services adopted these amendments on October 9, 2013.

These amendments do not provide for waivers in specified situations because all Medicaid providers are subject to the same requirements. Requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441—1.8(17A,217).

After analysis and review of this rule making, no impact on jobs has been found.

These amendments are intended to implement Iowa Code section 249A.4.

These amendments will become effective January 1, 2014.

The following amendments are adopted.

ITEM 1. Amend rule 441—79.2(249A) as follows:

441—79.2(249A) Sanctions ~~against provider of care.~~ ~~The department reserves the right to impose sanctions against any practitioner or provider of care who has violated the requirements for participation in the medical assistance program.~~

79.2(1) *Definitions.*

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

"Iowa Medicaid enterprise" means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services for the benefit of Medicaid members.

"Person" means any ~~natural person,~~ individual human being or any company, firm, association, corporation, institution, or other legal entity. "Person" includes but is not limited to a provider and any affiliate of a provider.

"Probation" means a specified period of conditional participation in the medical assistance program.

"Provider" means an individual human being, firm, corporation, association, ~~or~~ institution, or other legal entity, which is providing or has been approved to provide medical assistance to a ~~recipient~~ member pursuant to the state medical assistance program.

"Suspension from participation" means an exclusion from participation for a specified period of time.

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

"Termination from participation" means a permanent exclusion from participation in the medical assistance program.

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

79.2(2) *Grounds for ~~sanctioning providers~~ sanctions.* ~~Sanctions may be imposed by the department against a provider for any one or more of the following reasons:~~ The department may impose sanctions against any person when appropriate. Appropriate grounds for the department to impose sanctions include, but are not limited to, the following:

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

b. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the ~~provider~~ person is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.

d. ~~Failure~~ Upon lawful demand, failing to disclose or make available to the department ~~or its~~, the department's authorized agent, any law enforcement or peace officer, any agent of the department of inspections and appeals' Medicaid fraud control unit, any agent of the auditor of state, the Iowa department of justice, any false claims investigator as defined under Iowa Code chapter 685, or any other duly authorized federal or state agent or agency records of services provided to medical assistance ~~recipients and~~ members or records of payments made for those services.

e. ~~Failure~~ Failing to provide ~~and~~ or maintain ~~the~~ quality ~~of~~ services, or a requisite assurance of a framework of quality services to medical assistance recipients within accepted medical community standards as adjudged by professional peers if applicable. For purposes of this subrule, "quality services" means services provided in accordance with the applicable rules and regulations governing the services.

f. Engaging in a course of conduct or performing an act which is in violation of ~~state or federal regulations of the medical assistance program, or continuing that conduct following notification that it should cease~~ any federal, state, or local statute, rule, regulation, or ordinance, or an applicable contractual provision, that relates to, or arises out of, any publicly or privately funded health care program, including but not limited to any state medical assistance program.

g. ~~Failure to comply with the terms of the provider certification on each medical assistance check endorsement.~~ Submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or the department's representative or to any other publicly or privately funded health care program.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing ~~the recipient~~ a member to receive services or merchandise not required or requested ~~by the recipient~~.

~~*i.* Rebating or accepting a fee or portion of a fee or a charge for medical assistance patient referral.~~

~~*j.*~~ *i.* Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto, or violating any federal or state false claims Act, including but not limited to Iowa Code chapter 685.

~~*k.*~~ *j.* ~~Submission of a~~ Submitting or causing to be submitted false, intentionally misleading, or fraudulent information in an application for provider status under the medical assistance program or any quality review or other submission required to maintain good standing in the program.

~~*l.*~~ *k.* ~~Violations of any laws, regulations~~ Violating any law, regulation, or code of ethics governing the conduct of ~~occupations or professions or regulated industries~~ an occupation, profession, or other regulated business activity, when the violation relates to, or arises out of, the delivery of services under the state medical assistance program.

~~*m.*~~ *l.* ~~Conviction of a criminal offense relating to performance of a provider agreement with the state or for negligent practice resulting in death or injury to patients.~~ Breaching any settlement or similar agreement with the department.

~~*n.*~~ *m.* ~~Failure~~ Failing to meet standards required by state or federal law for participation, ~~for example,~~ including but not limited to licensure.

~~*o.*~~ *n.* Exclusion from Medicare ~~because of fraudulent or abusive practices~~ or any other state or federally funded medical assistance program.

~~*p.*~~ *o.* ~~Documented practice of~~ Except as authorized by law, charging ~~recipients~~ a person for covered services over and above ~~that paid for by~~ what the department~~, except as authorized by law~~ paid or would pay or soliciting, offering, or receiving a kickback, bribe, or rebate, or accepting or rebating a fee or a charge for medical assistance or patient referral, or a portion thereof. This ground does not include the collection of a copayment or deductible if otherwise allowed by law.

~~*q.*~~ *p.* ~~Failure~~ Failing to correct ~~deficiencies~~ a deficiency in provider operations after receiving notice of ~~these deficiencies~~ the deficiency from the department or other federal or state agency.

~~*r.*~~ *q.* Formal reprimand or censure by an association of the provider's peers ~~for unethical practices~~ or similar entity related to professional conduct.

~~*s.*~~ *r.* Suspension or termination for cause from participation in another ~~governmental medical~~ program ~~such as workers' compensation, crippled children's services, rehabilitation services or Medicare~~, including but not limited to workers' compensation or any publicly or privately funded health care program.

~~*t.*~~ *s.* Indictment or other institution of criminal charges for ~~fraudulent billing practices~~, or plea of guilty or nolo contendere to, or conviction of, any crime punishable by a term of imprisonment greater than one year, any crime of violence, any controlled substance offense, or any crime involving an allegation of dishonesty or negligent practice resulting in death or injury to ~~the~~ a provider's ~~patients~~ patient.

t. Violation of a condition of probation, suspension of payments, or other sanction.

u. Loss, restriction, or lack of hospital privileges for cause.

v. Negligent, reckless, or intentional endangerment of the health, welfare, or safety of a person.

w. Billing for services provided by an excluded, nonenrolled, sanctioned, or otherwise ineligible provider or person.

x. Failing to submit a self-assessment, corrective action plan, or other requirement for continued participation in the medical assistance program, or failing to repay an overpayment of medical assistance funds, in a timely manner, as set forth in a rule or other order.

y. Attempting, aiding or abetting, conspiring, or knowingly advising or encouraging another person in the commission of one or more of the grounds specified herein.

79.2(3) *Sanctions.* ~~The following sanctions may be imposed on providers based on the grounds specified in 79.2(2).~~

a. The department may impose any of the following sanctions on any person:

~~*a.*~~ (1) A term of probation for participation in the medical assistance program.

~~*b.*~~ (2) Termination from participation in the medical assistance program.

~~*c.*~~ (3) Suspension from participation in the medical assistance program. ~~This includes when the department is notified by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, that a practitioner has been suspended from participation under the Medicare program. These practitioners shall be suspended from participation in the medical assistance program effective on the date established by the Centers for Medicare and Medicaid Services and at least for the period of time of the Medicare suspension.~~

~~*d.*~~ (4) Suspension ~~or withholding~~ of payments ~~to provider~~ in whole or in part.

~~*e.* Referral to peer review.~~

~~*f.*~~ (5) Prior authorization of services.

~~*g.*~~ (6) ~~One hundred percent review~~ Review of ~~the provider's~~ claims prior to payment.

~~*h.* Referral to the state licensing board for investigation.~~

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

~~*j.* Providers with a total Medicaid credit balance of more than $500 for more than 60 consecutive days without repaying or reaching written agreement to repay the balance shall be charged interest at 10 percent per year on each overpayment. The interest shall begin to accrue retroactively to the first full month that the provider had a credit balance over $500.~~

~~Nursing facilities shall make repayment or reach agreement with the division of medical services. All other providers shall make repayment or reach agreement with the Iowa Medicaid enterprise.~~

b. The withholding of payments or a recoupment of medical assistance funds is not, in itself, a sanction. Overpayments and interest charged may be withheld from future payments to the provider without imposing a sanction.

c. Mandatory suspensions and terminations.

(1) Suspension or termination from participation in the medical assistance program is mandatory when a person is suspended or terminated from participation in the Medicare program, another state's medical assistance program, or by any licensing body. The suspension or termination from participation in the medical assistance program shall be retroactive to the date established by the Centers for Medicare and Medicaid Services or other state or body and, in the case of a suspension, must continue until at least such time as the Medicare or other state's or body's suspension ends.

(2) Termination is mandatory when a person pleads guilty or nolo contendere to, or is convicted of, any crime punishable by a term of imprisonment greater than five years, any crime of violence, any controlled substance offense, or any crime involving an allegation of dishonesty. Termination is also mandatory upon entry of final judgment, in the Iowa district court or a federal district court of the United States, of liability of the person in a false claims action.

(3) Suspension from participation is mandatory whenever a person, or an affiliate of the person, has an outstanding overpayment of medical assistance funds, as defined in Iowa Code chapter 249A.

d. Notwithstanding any previous successful enrollment in the medical assistance program, the person's passing of any background check by the department or any other entity, or similar prior approval for participation as a provider in the medical assistance program, in whole or in part, termination from the medical assistance program is mandatory when, in the case of a natural person, the person has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry or, in the case of a corporation or similar entity, 5 percent or more of the corporation or similar entity is owned by a person who has within the last five years been listed on any dependent adult abuse registry, child abuse registry, or sex offender registry.

79.2(4) *Imposition and extent of sanction.*

~~*a.* The decision on the sanction to be imposed shall be the commissioner's or designated representative's except in the case of a provider terminated from the Medicare program.~~

~~*b.*~~ *a.* The ~~following factors shall be considered~~ department shall consider the totality of the circumstances in determining the ~~sanction or~~ sanctions to be imposed. The factors the department may consider include, but are not limited to:

(1) Seriousness of the offense.

(2) Extent of violations.

(3) History of prior violations.

(4) Prior imposition of sanctions.

(5) Prior provision of provider education (technical assistance).

(6) Provider willingness to obey program rules.

(7) Whether a lesser sanction will be sufficient to remedy the problem.

(8) Actions taken or recommended by peer review groups or licensing boards.

b. A ground for sanction may precede enrollment in the medical assistance program, the person's passing of a background check, or similar prior approval for participation as a provider in the medical assistance program. The mere fact of an enrollment, a person's passing of a background check, or another approval is not relevant to the sanction decision.

c. Upon certification from the U.S. Department of Justice or the Iowa department of justice that a provider has failed to respond to a civil investigative demand in a timely manner as set forth in Iowa Code chapter 685 and the demand itself, the department shall immediately suspend the provider from participation for one year and suspend all payments to the provider. The suspension and payment suspension shall end upon certification that the provider has responded to the demand in full.

79.2(5) *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 facts 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.*~~ *a.* Suspension or termination from participation shall preclude the ~~provider~~ person from submitting claims for payment, whether personally or through claims submitted by any ~~clinic, group, corporation, or other association~~ other person or affiliate, for any services or supplies except for those services provided before the suspension or termination.

~~*c.*~~ *b.* No ~~clinic, group, corporation, or other association which is the provider of services shall~~ person may submit claims for payment for any services or supplies provided by a person ~~within the organization~~ or affiliate who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

~~*d.*~~ *c.* When the provisions of ~~paragraph 79.2(5)"c"~~ this subrule are violated ~~by a provider of services which is 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~~ sanction any person responsible for the violation.

79.2(6) *Notice ~~of sanction~~ to third parties.* When ~~a provider has been sanctioned~~ a sanction is imposed, the department ~~shall~~ may notify ~~as appropriate the applicable professional society, board of registration or licensure,~~ third parties of the findings made and the sanction imposed, including but not limited to law enforcement or peace officers and federal or state agencies ~~of the findings made and the sanctions imposed~~. The imposition of a sanction is not required before the department may notify third parties of a person's conduct. In accordance with 42 CFR § 1002.212, the department must notify other state agencies, applicable licensing boards, the public, and Medicaid members, as provided in 42 CFR §§ 1001.2005 and 1001.2006, whenever the department initiates an exclusion under 42 CFR § 1002.210.

79.2(7) *Notice of violation.* ~~Should the department have information that indicates that a provider may have submitted bills or has 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,~~ Any order of sanction shall be in writing and include the name of the person subject to sanction, identify the ground for the sanction and its effective date, and be sent to the person's last-known address. If the department sanctions a provider, the order of sanction shall also include the national provider identification number of the provider and be sent to the provider's last address on file within the medical assistance program.

b. ~~The known dollar value of the discrepancies or violations,~~ In the case of a currently enrolled provider otherwise in good standing with all program requirements, 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. If the provider fails to do so, the sanction shall remain effective pending any subsequent appeal under 441—Chapter 7. If the provider attempts to show cause but the department determines the sanction should remain effective pending any subsequent appeal under 441—Chapter 7, the provider may seek a temporary stay of the department's action from the director or the director's designee by filing an application for stay with the appeals section. The director or the director's designee shall consider the factors listed in Iowa Code section 17A.19(5)*"c."*

~~*c.* The method of computing the dollar value,~~

~~*d.* Notification of further actions to be taken or sanctions to be imposed by the department, and~~

~~*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.~~

79.2(8) *Suspension or withholding of payments pending a final determination.* Where the department has notified a provider of ~~a violation pursuant to 79.2(7) or an overpayment~~ any sanction, overpayment, civil monetary penalty, or other adverse action, 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. Where the department intends to withhold or suspend payments it shall notify the provider in writing.

79.2(9) *Civil monetary penalties and interest.* Civil monetary penalties and interest assessed in accordance with 2013 Iowa Acts, Senate File 357, section 5 or section 11, are not allowable costs for any aspect of determining payment to a person within the medical assistance program. Under no circumstance shall the department reimburse a person for such civil monetary penalties or interest.

79.2(10) *Report and return of identified overpayment.*

a. If a person has identified an overpayment, the person must report and return the overpayment in the form and manner set forth in this subrule.

b. A person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of the overpayment.

c. An overpayment required to be reported under 2013 Iowa Acts, Senate File 357, section 3, must be made in writing, addressed to the Program Integrity Unit of the Iowa Medicaid Enterprise, and contain all of the following:

(1) Person's name.

(2) Person's tax identification number.

(3) How the error was discovered.

(4) The reason for the overpayment.

(5) Claim number(s), as appropriate.

(6) Date(s) of service.

(7) Member identification number(s).

(8) National provider identification (NPI) number.

(9) Description of the corrective action plan to ensure the error does not occur again, if applicable.

(10) Whether the person has a corporate integrity agreement with the Office of the Inspector General (OIG) or is under the OIG Self-Disclosure Protocol or is presently under sanction by the department.

(11) The time frame and the total amount of refund for the period during which the problem existed that caused the refund.

(12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.

(13) A refund in the amount of the overpayment.

This rule is intended to implement Iowa Code section 249A.4.

ITEM 2. Amend subrule 79.4(2) as follows:

79.4(2) *Audit or review of clinical and fiscal records by the department.* Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records ~~of the provider~~ to determine whether:

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

(2) The provider has furnished the services to Medicaid members.

(3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.

(4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise ~~surveillance and utilization review services~~ program integrity unit shall include Form 470-4479, Documentation Checklist, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided

for the audit or review pursuant to paragraph 79.3(2)*"d"* to document the basis for services or activities provided~~, in the following format:~~.

~~Iowa Department of Human Services~~
~~Iowa Medicaid Enterprise Surveillance and Utilization Review Services~~
~~**Documentation Checklist**~~

~~Date of Request:~~ _____
~~Reviewer Name & Phone Number:~~ _____
~~Provider Name:~~ _____
~~Provider Number:~~ _____
~~Provider Type:~~ _____

~~Please sign this form and return it with the information requested.~~
~~Follow the checklist to ensure that all documents requested for each patient have been copied and enclosed with this request. The documentation must support the validity of the claim that was paid by the Medicaid program.~~
~~**Please send copies. Do not send original records.**~~
~~If you have any questions about this request or checklist, please contact the reviewer listed above.~~

	~~[specific documentation required]~~
	~~[specific documentation required]~~
	~~[specific documentation required]~~
	~~[specific documentation required]~~
	~~[Note: number of specific documents required varies by provider type]~~
	~~Any additional documentation that demonstrates the medical necessity of the service provided or otherwise required for Medicaid payment. List additional documentation below if needed.~~

~~The person signing this form is certifying that all documentation that supports the Medicaid billed rates, units, and services is enclosed.~~

~~Signature~~	~~Title~~	~~Telephone Number~~

~~470-4479 (4/08)~~

c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

ITEM 3. Adopt the following **new** subrule 79.9(6):

79.9(6) The acceptance of Medicaid funds by means of a prospective or interim rate creates an express trust. The Medicaid funds received constitute the trust res. The trust terminates when the rate is retrospectively adjusted or otherwise finalized and, if applicable, any Medicaid funds determined to be owed are repaid in full to the department.

ITEM 4. Adopt the following **new** subrule 79.9(7):

79.9(7) Medical assistance funds are incorrectly paid whenever a person who provided the service to the member for which the department paid was at the time service was provided the parent of a minor child, spouse, or legal representative of the member.

ITEM 5. Adopt the following **new** subrule 79.9(8):

79.9(8) The rules of the medical assistance program shall not be construed to require payment of medical assistance funds, in whole or in part, directly or indirectly, overtly or covertly, for the provision of non-Medicaid services. The rules of the medical assistance program shall be interpreted in such a manner to minimize any risk that medical assistance funds might be used to subsidize services to persons other than members of the medical assistance program.

ITEM 6. Amend rule 441—80.4(249A) as follows:

441—80.4(249A) Time limit for submission of claims and claim adjustments.

80.4(1) *Submission of claims.* Payment will not be made on any claim ~~where~~ when the amount of time that has elapsed between the date the service was rendered and the date the initial claim is received by the Iowa Medicaid enterprise exceeds 365 days. The department shall consider claims submitted beyond the 365-day limit for payment only if retroactive eligibility on newly approved cases is made that exceeds 365 days or if attempts to collect from a third-party payer delay the submission of a claim. In the case of retroactive eligibility, the claim must be received within 365 days of the first notice of eligibility by the department.

80.4(2) *Claim adjustments and resubmissions.* A provider's request for an adjustment to a paid claim or resubmission of a denied claim must be received by the Iowa Medicaid enterprise within ~~one year~~ 365 days from the date the claim was ~~paid~~ last adjudicated in order to have the adjustment or resubmission considered. In no case will a claim be paid if the claim is received beyond two years from the date of service.

80.4(3) *Definition.* For purposes of this rule, a claim is "received" when entered into the department's payment system with an action of pay, deny, or suspend. Any claim returned to the provider without such action is not "received."

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

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EDITOR'S NOTE: For replacement pages for IAC, see IAC Supplement 10/30/13.