CHAPTER 73
MEDICAID FRAUD CONTROL BUREAU

[Prior to 10/7/87, 481—Chapter 6, "Medicaid Provider Audits"]

The purpose of this chapter is to define steps which may be taken by the department of inspections and appeals to ensure that provider payments for Medicaid services and supplies are made in accordance with provider manual and Medicaid rules.

481—73.1(10A) Definitions.

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

"Authorized representative" within the context of these rules means that person appointed to carry out audit or investigative procedures, including assigned auditors, investigators, or agents contracted for specific audits or investigative procedures.

"Bureau" means the Medicaid fraud control bureau.

"Claim" means a tangible and legible history which documents the criteria established for clinical records as set forth in rule 441—79.3(249A).

"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.

"Customary and prevailing" means (1) the most consistent charge by a Medicaid provider for a given service and (2) a fee within the range of usual charges for a given service billed by most providers with similar training and experience in the state of Iowa.

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

"Fiscal agent" means an organization which processes and pays claims on behalf of the department of human services.

"Fiscal record" means a tangible and legible history which documents the criteria established for fiscal records as set forth in human services rule 441—79.3(249A).

"Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some authorized benefit to the person or some other person. It includes any act that constitutes fraud under applicable federal or state law.

"Generally accepted auditing procedures" means those procedures published in Standards for Audit of Governmental Organizations, Programs, Activities & Functions, 1972 edition, by the Comptroller General of the United States.

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

"Procedure code" means the identifier which describes medical services performed or the supplies, drugs or equipment provided.

"Provider" means an individual, firm, corporation, association, or institution which provides or has been approved to provide goods or services to someone receiving state medical assistance.

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

"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 Medicaid 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.

481—73.2(10A) Complaints. Complaints are received in writing or verbally from any source. The department may acknowledge in writing receipt of a complaint.

Each complaint is recorded in a log and assigned a number. Complaints received and logged include as much of the following information as possible:

1. Case number,
2. Provider name, address, telephone and identification number,
3. Referral source,
4. Date complaint received,
5. Allegation.

481—73.3(10A) Investigative procedures. Initial complaints are reviewed and evaluated by an investigator or auditor to determine whether the provider and the recipient participate in the Medicaid program.

73.3(1) The investigator or auditor conducts a preliminary review. A written summary of the preliminary review is prepared and submitted to an evaluation team made up of:

Bureau chief,
Legal counsel,
Investigator, and
Auditor.

73.3(2) The evaluation team determines further disposition of the complaint. Options available to the bureau include, but are not limited to:

a. Referring the complaint to other affected agencies,
b. Assigning the case to an investigator or auditor, for review, audit or investigation,
c. Determining no action be taken.

481—73.4(10A) Audit of clinical and fiscal records by the department.

73.4(1) 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:

a. Claims for goods or services have been accurately paid.
b. The provider has furnished the services to Medicaid recipients.
c. The provider has retained clinical and fiscal records which substantiate claims submitted for payment during the audit period.

73.4(2) Records generated and maintained by the department of human services, its fiscal agent, or by the department of inspections and appeals may be used by auditors or investigators and in all proceedings relative to audits or investigations conducted.

481—73.5(10A) Who shall be reviewed, audited, or investigated. Any Medicaid provider may be reviewed, audited, or investigated at any time at the discretion of the department.

481—73.6(10A) Auditing and investigative procedures. The department will select the appropriate method of conducting an audit or investigation and will protect the confidential nature of the records being reviewed. The provider may be required, by administrative subpoena, to furnish records to the department. The provider may select the method of delivering any requested records to the department.

73.6(1) Audit or investigative procedures may include, but are not limited to, the following:

a. Comparing clinical and fiscal records with each claim.
b. Interviewing recipients of services, and employees of providers.
c. Examining third party payment records.
d. Comparing Medicaid charges with private patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee. Records of privately paying patients will be requested by subpoena.

73.6(2) Use of statistical sampling techniques. The department's procedures for auditing Medicaid providers may include the use of random sampling and extrapolation. When this procedure is 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.

a. The audit or investigative findings generated through the audit or investigative procedures shall constitute prima facie evidence in all department proceedings of the number and amount of requests for payment as submitted by the provider.

b. When the department's audit or investigative 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. Any such audit must:

(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, and

(4) Be submitted to the department with all supporting documentation.

481—73.7(10A) Actions based on audit or investigative findings.

73.7(1) The department shall report the results of an audit or investigation of provider records to concerned parties consistent with applicable rules.

73.7(2) When fraud is found, the department shall refer to an agency empowered to prosecute as provided for in Iowa Code sections 10A.402(7) and 249A.5.

73.7(3) When error or abuse is found the department will refer to DHS.

481—73.8(10A) Confidentiality. All material and information compiled during the audit or investigative procedure is confidential in accordance with Iowa Code section 10A.105.

481—73.9(10A) Appeal by provider of care. Collection decisions are made by DHS. Providers may appeal decisions of the department according to rules in human services 441—Chapter 7.

These rules are intended to implement Iowa Code sections 10A.105, 10A.402(7), and 249A.5.

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