

**191—15.33(507B) Audit procedures for medical claims.**

**15.33(1) Prohibitions.** This rule applies to all claims paid on or after January 1, 2002:

*a.* Absent a reasonable basis to suspect fraud, an insurer may not audit a claim more than two years after the submission of the claim to the insurer. Nothing in this rule prohibits an insurer from requesting all records associated with the claim.

*b.* Absent a reasonable basis to suspect fraud, an insurer may not audit a claim with a billed charge of less than \$25.

**15.33(2) Standards.**

*a.* In auditing a claim, the insurer must make a reasonable effort to ensure that the audit is performed by a person or persons with appropriate qualifications for the type of audit being performed.

*b.* In auditing a claim, the auditor must use the coding guidelines and instructions that were in effect on the date the medical service was provided.

**15.33(3) Contents of audit request.** All correspondence regarding the audit of a claim must include the following information:

*a.* The name, address, telephone number and contact person of the insurer conducting the audit,

*b.* The name of the entity performing the audit if not the insurer,

*c.* The purpose of the audit, and

*d.* If included in the audit, the specific coding or billing procedure that is under review.

This rule is intended to implement Iowa Code section 507B.4(3) “j”(15).

[ARC 7734C, IAB 3/20/24, effective 4/24/24]