Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

December 15, 2011

Michael Marshall
Secretary of State
State Capitol
LOCAL

Charlie Smithson
Chief Clerk of the House
State Capitol
LOCAL

Dear Mr. Marshall and Mr. Smithson:

The purpose of this letter is to inform the Iowa State Legislature the opportunities, costs, and barriers to implementing electronic medical records, documentation and billing system for HCBS and Mental Health providers as required by House File 649.

To date, the Department of Human Services (DHS) has been collaborating with the Iowa Association of Community Providers (IACP) to identify the types of electronic health record systems that is being utilized by other States and offered by vendors. A request for information was sent via email to the National Association of Medicaid Directors (NAMD). Most responding states indicated they did not have such systems. South Carolina has provided electronic medical records (documentation) and billing system for home and community based service providers that comply with federal and state laws and regulations. A summary of NAMD survey is enclosed.

The DHS has released a Request for Information (RFI) to explore the different vendor software products that are available. An evaluation of the information received will be conducted by DHS and IACP. A copy of the RFI is enclosed. Based on the information received, DHS and IACP will determine whether there is a viable product available that could be used in Iowa or if a product developed by the state would be advantageous. This analysis will also include the cost of purchasing or developing a system.

Sincerely,

Jennifer Davis Harbison (djj)

Jennifer Davis Harbison
Policy Advisor

JDH/djj

Enclosure

cc: Governor Terry E. Branstad
Senator Jack Hatch
Senator David Johnson
Representative David Heaton
Representative Lisa Heddens
Legislative Services Agency
Kris Bell, Senate Majority Staff
Josh Bronsink, Senate Minority Staff
Brad Trow, House Majority Staff
Zeke Furlong, House Minority Staff

NAMD
National Association of Medicaid Directors

NAMD survey summary: documentation and billing for HCBS and mental health
November 16, 2011

Thirteen states responded to NAMD's survey concerning document and billing systems for mental health and HCBS. The survey was conducted October 27, 2011, through November 15, 2011. Please contact Andrea Maresca at andrea.maresca@namd-us.org with any questions about the survey or to update this information for your state.

State respondents: Georgia, Oklahoma, Alabama, Tennessee, Colorado, Alaska, Illinois, Ohio, Kansas, Mississippi, South Carolina, Louisiana, and Arizona.

Most responding states indicated they did not have such systems. One state, South Carolina, has provided an electronic medical records (documentation) and billing system for home and community-based services providers that complies with the requirements of federal and state laws and regulations. The following is a description of the system and other key aspects of financing and governance.

System description. South Carolina Department of Health and Human Services - Division of Community Long Term Care (CLTC) uses two systems to document prior authorization for services and do billing for four of its HCBS programs. These are the programs operated and managed by CLTC. HCBS programs operated by the Department of Disabilities and Special Needs do not use these systems. First, Phoenix is used to enter assessments, service plans, service levels, and prior authorizations for service. On a nightly basis a subset of information (including by not limited to services to be render, level of service authorized, and provider) is electronically transferred from Phoenix to Care Call. Providers of HCBS services use Care Call to document service delivery by calling a toll free phone number or by documenting service delivery on the website. Personal care services performed in a person's home can only be entered by a phone call and requires a check in call and a check out call. For all services entered (web or phone), Care Call compares the amount of service documented by the provider to the prior authorization that was received from Phoenix. Care Call then prepares a claim for the amount of service delivered (up to to the amount authorized) and submits the claim to MMIS for payment.

System maintenance. Care Call is maintained by First Data Corporation. Phoenix is maintained by the State Budget and Control Board - Office of Research and Statistics.

Timelines and funding. Care Call has been in use since October 2002. The development was funded at 90/10. Due to state regulations the current contract will expire next year (2012). The state has developed an APD which has been submitted to CMS for approval. Phoenix has been in use since April 2011 and was funded 50/50.

Provider use. Medicaid providers are required to use the system. Providers may not use the system for non-Medicaid patients.

Provider satisfaction with the system. Overall providers have been satisfied with the system. They are able to use Care Call to monitor the time spent in a client's home by the aide and MMIS claim status among other things.

Governance for ongoing system modifications. Input is obtained from providers, case managers, and state staff.

HIE connection. The system is not connected to a health information exchange (HIE) and there are no plans to connect at this time.

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Iowa Department of Human Services

NOTICE TO VENDORS
REQUEST FOR INFORMATION

The Department of Human Services, Iowa Medicaid Enterprise will be receiving responses to a Request For Information (RFI) until 9:00am. (Central Time) Thursday, December 29, 2011 for:

RFI: MED-12-034 V2011.12.12

Electronic Medical Records, Documentation and Billing Systems for Home and Community Based Services and Mental Health providers

For additional information contact:

JoAnn Cowger
Contract Administration Office
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, IA 50315
jcowger@dhs.state.ia.us
(515) 256-4646

Vendors must comply with all affirmative action/equal employment opportunity provisions of State and Federal Laws.

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INFORMATION FOR VENDORS

12/2/2011

Dear Vendor:

The Department of Human Services, Iowa Medicaid Enterprise is seeking information to identify technical solutions for supporting electronic medical records, documentation and billing systems for Home and Community Based Services and Mental Health Services.

Similar information is welcomed for Substance Use Disorder Services.

Providers seek a solution that will provide documentation that will meet audit requirements, while supporting best business practices. The solution would ideally be simple and intuitive to use, allowing the direct care providers to focus the majority of their attention on meeting the needs of the Medicaid member.

Responses to this Request for Information MED-12-034 are requested on or before 9:00 am CDT on December 29, 2011.

Responses shall be sent to:

JoAnn Cowger
Contract Administration Office
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, IA 50315
jcowger@dhs.state.ia.us
(515) 256-4646

Sincerely,

Jody Holmes
CORE Unit Manager / HIT Project Director
Iowa Medicaid Enterprise

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Section 1.0 DEFINITIONS

DHS: The State of Iowa's Department of Human Services

EHR: Electronic Health Records system

RFI: A Request for Information from the Department of Human Services to ascertain the best methods, approaches, solutions, and other relevant information related to the provision of services to Iowans.

IME: Iowa Medicaid Enterprise is a collection of units, each having an area of expertise, all working together to accomplish the goals of administering the Medicaid program for the State of Iowa.

CMS: United States Department of Health and Human Services Centers for Medicare and Medicaid Services

MMIS: Medicaid Management Information Systems

Section 2.0 Request Information

2.1 Purpose for the RFI

The intended purpose of the RFI is to allow all interested vendors to present information about services they provide and suggest innovative ideas and solutions. The information will assist the DHS in understanding the functionality and pricing models currently available in the marketplace.

Background

The following legislation was enacted in HF 649, Sec. 37 in July 2011.

"11. For implementation of an electronic medical records system:

a. The implementation of an electronic medical records system shall include system purchase or development for home and community-based services providers and mental health services providers that comply with the requirements of federal and state laws and regulation by the fiscal year beginning July I, 2013.

b. The department shall analyze the costs and benefits of providing an electronic medical records and billing system for home and community-based services providers and mental health services providers that comply with the requirements of federal and state laws and regulation. The analysis shall include a review of all of the following: including the capability for an electronic medical

records and billing system within the procurement for the Medicaid management information system, developing the system, and utilizing capacity within the health information network established by the department of public health. If the analysis demonstrates that a program may be implemented in a cost-effective manner and within available funds, the department may take steps to implement such a system. The department shall report the results of the analysis, activities, and recommendations to the persons designated in this Act for submission of reports by December 15, 20.

c. Notwithstanding section 8.33, funds allocated in this subsection that remain unencumbered or unobligated at the close of the fiscal year shall not revert but shall remain available in succeeding fiscal years to be used for the purposes designated."

Further discussions with stakeholders indicated that a key component of such system must include the maintenance of records to adequately provide supporting documentation of services rendered in the event of a state or federal audit.

2.2 Expected Outcome

The RFI is expected to result in market research to inform the Iowa Legislature and provider stakeholders regarding solutions to assist in improving the current processes of service documentation and provider billing.

IME will be able to provide the following:

a. Solution options to support the maintenance of records by providers of home and community based, mental health, or substance use disorder services in compliance with all state and federal regulations.

b. System options that can support multiple providers and/or provider groups.

c. System options that meet security and privacy regulations.

d. Solution options that will meet all federal regulations and standards for enhanced federal funding, including MITA and the Seven Standards and Conditions as listed in the IT Guidance 2.0.

2.3 Information Requests

2.3.1 How does the system support the electronic medical records, service documentation, and/or billing for Medicaid Home and Community Based Services, Mental Health service providers, and Substance Use Disorder service providers? How does the system allow access from mobile/satellite locations?

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2.3.2 Does the solution provide clear documentation and instructions for usage, including training videos?

2.3.3 Could the solution integrate with a Medicaid Management Information systems for member identification, eligibility and authorization, and claims submission? Would this be done through data file exchanges, web services, etc.?

2.3.4 Could the solution integrate with the IDPH Division of Behavioral Health Central Data Repository for substance abuse disorder treatment services?

See Iowa Data Repository Vendor Submission Guide, Iowa Data Repository DB requirements at http://www.ime.state.ia.us/docs/IDPHCentralRepositoryFileFormat.pdf

2.3.5 Please describe additional programs the solution would be able to support, such as Long Term Care, etc.

2.3.6 What are the functional features of the solution?

2.3.7 What are the reporting features of the solution? What export formats are supported?

2.3.8 Is the solution fully HIPAA compliant. Is security role based? Can security rights be assigned to staff at the client level? Are audit trails captured for HIPAA reporting? Are electronic data interfaces X12 compliant?

2.3.9 Does the proposed solution meet the CMS Seven conditions and Standards listed below and ensure that the State will come into compliance with the standards and conditions pursuant to 42 CFR 433 Subpart C?

- Modularity Standard – Requires the use of a modular, flexible approach to systems development
- MITA Condition – Requires states to align to and advance increasingly in MITA maturity for business, architecture, and data; as stated above, Iowa's goal for member management is MITA Level 3
- Industry Standards Condition – States must ensure alignment with, and incorporation of, industry standards such as Health Insurance Portability and Accountability Act (HIPAA) security, privacy and transaction standards and meaningful use.
- Leverage Condition – State solutions should provide sharing, leverage, and reuse of Medicaid technologies and systems within and among states
- Business Results Condition – Systems should support accurate and timely processing of claims (including claims of eligibility), adjudications, and effective communications with providers, beneficiaries, and the public

- Reporting Condition – Solutions should produce transaction data, reports, and performance information that would contribute to program evaluation (including client outcome measures/satisfaction and follow-up capabilities), continuous improvement in business operations, and transparency and accountability
- Interoperability Condition – Systems must ensure seamless coordination and integration with the Health Insurance Exchange (whether run by the state or federal government) and allow interoperability among other state agencies and community organizations providing outreach and enrollment assistance services.

2.3.10 Is all documentation full tracked by time and authenticated user? Are changes tracked? Is there the capability for electronic signatures? Does the solution support the input and/or storing of scanned documents? Is the solution capable of e-prescribing?

2.3.11 Does the system use a business rules engine?

2.3.12 Does the solution support incident reporting?

2.3.13 Would the solution currently meet the proposed rules regarding maintenance of records? (Please see Appendix A)

2.3.14 Does the solution support provider billing to Medicaid, Medicare or other third party funding sources?

2.3.15 Can the solution support multiple provider organizations?

2.3.16 Please identify any additional features or considerations that IME should consider when drafting an RFP for these services.

Additional information may be found in:

- ✓ Appendix A: Proposed Rules regarding Maintenance of Records.
- ✓ Appendix B: Iowa Medicaid Provider Metrics

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Section 3.0 RFI RESPONSES AND QUESTION PROCESS

3.1 Content of Vendor Responses.

Vendors are requested to submit a response with enough detail for DHS to comprehend the scope, and benefits of services the Vendor is proposing to fulfill the expected outcome.

Responses should include:

- The name and principal address of the Vendor's business.
- A brief business background and experience relevant to the RFI.
- Identification of those services the Vendor believes necessary to achieve the expected outcome explained in 2.2
- An explanation of how each suggested service will fulfill or provide progress toward the expected outcome described in 2.2
- Clear suggestions and understandable ways the Vendor can show progress toward and fulfillment of the expected outcome, including possible timeframes.
- States currently contracting with the Vendor for these services.
- The anticipated total cost for all services and a description of the elements included in cost estimate.
- Name, address, e-mail address, telephone number, and fax number, of the Vendor representative to contact regarding all matters concerning this RFI;
- For clarity and consistency, all materials should reference RFI MED-12-034.

3.2 Response Submission

Please send responses in one complete, electronic copy formatted in Adobe PDF to medicaidrfp@dhs.state.ia.us. Responses should be received by 9:00 am CST on December 29, 2011.

3.3 Questions Related to this RFI

Technical questions about this RFI are to be submitted in writing by email, to medicaidrfp@dhs.state.ia.us

DHS requests that questions related to this RFI be submitted by December 16, 2011. Questions, along with the responses will be posted to the Iowa Medicaid Enterprise Website, http://www.ime.state.ia.us/Reports_Publications/index.html.

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4.0 General Terms and Conditions.

4.1 General Information and conditions

4.1.1 Information is being requested solely to ascertain possible methods, approaches, and solutions associated with this type of expected outcome.

4.1.2 The State of Iowa and the DHS will not enter into a contract with any vendor based solely on the responses provided through this RFI. Should a decision be made to pursue a contract for services related to this RFI, the Department will comply with all state competitive procurement obligations.

4.1.3 A Vendor's participation in the completion of this response will not be a factor or consideration as part of any subsequent competitive selection process.

4.1.4 Iowa Medicaid Enterprise may or may not choose to invite participating Vendor's to present additional information via webinar.

4.1.5 Vendors who were asked to submit a response to this RFI will also be notified of any subsequent bidding opportunity. Public notice requirements associated with the respective competitive process will also be completed.

4.1.6 Information submitted in response to this RFI will become the property of the DHS.

4.1.7 The DHS will not pay for any information herein requested, nor will it be liable for any other costs incurred by the Vendor.

4.1.8 The DHS reserves the right to modify this RFI at any time.

4.2 Clarification of Responses.
DHS reserves the right to contact a Vendor after the submission of responses for the purpose of clarifying a response to ensure mutual understanding.

4.3 Vendor Responses.
All RFI responses become the property of DHS. This is not a competitive process and the contents of all vendor responses will be public information.

4.4 Copyrights.
By submitting a response the Vendor agrees that the DHS may copy the response for purposes of facilitating the review or to respond to requests for public records. The Vendor consents to such copying by submitting a response and warrants that such copying will not violate the rights of any third party. The DHS will have the right to use the ideas or adaptations of ideas that are presented in the responses.

4.5 Release of Claims.
With the submission of a response, each Vendor agrees that it will not bring any claim or have any cause of action against the DHS or the State of Iowa based on any misunderstanding concerning the information provided herein or concerning

the DHS' failure, negligent, or otherwise, to provide the Vendor with pertinent information as intended by this RFI.

Responses to this Request for Information MED-12-034 be received on or before 9:00 am CDT on Thursday, December 29, 2011.

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Appendix A - Proposed Rules regarding Maintenance of Records

441—79.3(249A) Maintenance of records by providers of service. Any provider of a service that is charged to the medical assistance program shall maintain complete and legible records in English as required in this rule. These requirements apply to all providers who receive reimbursement through the medical assistance program, including home and community based services and those considered to be medical or clinical services. Failure to maintain records or failure to make records available to the department or to its authorized representative timely upon request may result in claim denial or recoupment.

79.3(1).*Documentation requirement.* A provider of service under the medical assistance program shall maintain a complete and legible member's record for each service for which a charge is made to the medical assistance program. The record shall be createdon or about the time the service is rendered Required records shall also include any records required to maintain the provider's license in good standing.
a. Definition. " "Member's Record" means a tangible history that provides evidence of:
(1) The provision of each service and each activity billed to the program; and
(2) First and last name of the member receiving the service.

b. Purpose. The member's record shall provide evidence that the service provided is:
(1) Medically necessary or meeting the department's criteria for coverage under any Medicaid program or Home and Community Based Services waiver;
(2) Consistent with the diagnosis of the member's condition;
(3) Consistent with professionally recognized standards of care;
(4) Consistent with the member's plan of care, service plan, or Consumer-Directed Attendant Care Agreement #470-3372.

c. Components.
(1) Identification. Each page or separate electronic document of the member's record shall contain the member's first and last name.

1.In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed.

2. As part of the member's record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name at least once within the permanent record.

(2) Basis for service—. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2)*"d."* The member's record shall include the following items when the

inclusion of the item is needed to support or demonstrate the need for the service. :

1. The member's complaint, symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X-ray reports.
5. Goals or needs identified in the member's plan of care or service plan.
6. Physician orders and any prior authorizations required for Medicaid payment.
7. Medication records, pharmacy records for prescriptions, or providers' orders.
8. Related professional consultation reports.
9. Progress or status notes for the services or activities provided.
10. All forms required by the department as a condition of payment for the services provided.
11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, CDAC Daily Service Record, #470-4389, CDAC Agreement #470-3372, or individualized education program.
12. The provider's assessment, clinical impression, diagnosis, or narrative, including the complete date thereof and the identity of the person performing the assessment, clinical impression, diagnosis, or narrative.
13. Any additional documentation necessary to demonstrate the necessity of the service provided or as otherwise required for Medicaid payment.

(3) Service documentation. The record for each service billed to and reimbursed by Iowa Medicaid shall include information necessary to substantiate that the service was provided. Documentation shall not be created by copying a prior service's documentation; each narrative should be distinctly different from another narrative. Service documentation shall include the following:

1. The specific procedures, services, or treatments provided.
2. The complete dates of the service, including the beginning and ending date if the service is rendered over more than one day.
3.. Services billed using time defined billing codes must have either the in and out time or the total time noted in the documentation. Services that are billed using service defined billing codes do not need either the in and out time or the total time noted in the documentation.
4. The location where the service was provided as required on the billing form or as otherwise required by the Iowa Administrative Code.
5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.
6. Any supplies dispensed as part of the service, including over the counter medications and non-prescription supplies. 7. The first and last name and professional credentials, if applicable, of the person engaged in direct service provision to the member.
8. The legible signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person's

identity. Each narrative or record must be signed even if only one person in the organization provides the service.

9. For 24-hour care, documentation for every shift of the services provided, the member's response to the services provided, and the legible signature of the person who provided each service.

(4) Outcome of service. The member's record shall indicate the member's response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

d. Basis for service requirements for specific services. The member's record for the following services must include, but is not limited to, the items specified below unless the item listed below would not support or correlate with the provided service. These items will be specified on Form 470-4479, Documentation Checklist, when the Iowa Medicaid Enterprise Program Integrity unit requests providers to submit records for review. (See paragraph 79.4(2)*"b."*)

** detail for other provider types not included here**

(35) Home- and community-based waiver services, other than case management:

1. Notice of decision for service authorization.
2. Service plan.
3. Service logs, notes, or narratives.
4. Mileage and transportation logs.
5. Log of meal delivery.
6. Invoices or receipts.
7. Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement.
8. Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record.
9. Assisted Living tenant occupancy agreement.
10. Assisted Living Facility daily census logs.

e. Corrections. Corrections made to the member's record before submitting a claim for reimbursement shall follow the guidelines listed in this section. Once records have been requested for an audit or review, no corrections or changes shall be made to those documents. If no records exist at the time of request, no records shall be created. (1) Corrections must be made or dictated by the person who provided the service and created or dictated the original documentation.

(2) A correction to a member's record must not be written over or otherwise obliterate the original entry. A single line shall be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.

(3) Any correction must indicate the person making or dictating the change , must be dated and signed by the person making or dictating the change, and must be clearly connected with the original entry in the record.

f. Corrections made to the member's record after submitting a claim for reimbursement shall follow the guidelines listed in this section. Once records have been requested for an audit or review, no corrections or changes shall be made to those documents. If no records exist at the time of request, no records shall be created.
(1) Corrections must be made or dictated by the person who provided the service and created or dictated the original documentation.
(2) A correction to a member's record must not be written over or otherwise obliterate the original entry. A single line shall be drawn through erroneous information, keeping the original entry legible. In the case of electronic records, the original information must be retained and retrievable.
(3) Any correction must indicate the person making or dictating the change, must be dated and signed by the person making or dictating the change, and must be clearly connected with the original entry in the record.
(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.
79.3(2) *Financial (fiscal) records.*
a. A provider of service shall maintain records as necessary to:
(1) Support the determination of the provider's reimbursement rate under the medical assistance program; and
(2) Support each item of service for which a charge is made to the medical assistance program. These records include financial records and other records as may be necessary for reporting and accountability.
b. A financial record does not constitute a medical record.

79.3(3) *Maintenance requirement.* The provider shall maintain records as required by this rule:
aa For a minimum of five years from the date when a claim for the service was submitted to the medical assistance program for payment, even if service provision has ended.
b. As may be required by any licensing authority or accrediting body associated with determining the provider's qualifications.

441—79.4(249A) Reviews and audits.
79.4(1) *Definitions.*
"Authorized representative," within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.
"Claim" means each claim form received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member. Providers must use the appropriate claim form as described in IAC 441-80.2(2).

"Member's record" means a legible electronic or hard-copy history that documents the criteria established for records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a member's record.
"Confidence level" means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.
"Customary and prevailing fee" means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) 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 determined by using sample data meeting the confidence level requirement.
"Fiscal record" means a legible electronic or hard-copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.
"Overpayment" means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.
"Procedure code" means the identifier that describes services performed or the service, supplies, drugs, or equipment provided.
"Random sample" means a statistically valid random sample for which the probability of selection for every item in the universe is known.
"Underpayment" means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.
"Universe" means all items or claims under review or audit during the period specified by the audit or review.

79.4(2) *Audit or review of member's 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 member and fiscal records maintained by 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 created and retained, in accordance with IAC 441-79.3, member 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 records by the Iowa Medicaid Enterprise 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:
** form not printed here**
c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

79.4(3) *Audit or review procedures.* The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider shall be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.
a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph *"b."*
b. Extension of time limit for submission
(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider's designee. The request must:
1. Establish good cause for the delay in submitting the records; and
2. Be received by the department before the date the records are due to be submitted.
(2) Under exceptional circumstances, a provider may request one additional 15-calendar-day extension. The provider or the provider's designee shall submit a written request that:
1. Establishes exceptional circumstances for the delay in submitting records; and
2. Is received by the department before the expiration of the initial 15-day extension period.
(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.
(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.
c. The department may elect to conduct announced or unannounced on-site reviews or audits. Records must be provided upon request and before the end of the on-site review or audit.
(1) For an announced on-site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.
(2) Notice is not required for unannounced on-site reviews and audits.
(3) In an on-site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.
d. Audit or review procedures may include, but are not limited to, the following:
(1) Comparing member and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.
(3) Examining third-party payment records.
(4) Comparing Medicaid charges with private-patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.
(5) Examining all documents related to the services for which Medicaid was billed.
e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.
(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.
(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.
(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.
(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

79.4(4) *Preliminary report of audit or review findings.* If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.
79.4(5) *Disagreement with audit or review findings.* If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the department and may present clarifying information and supplemental documentation.
a. Reevaluation request. A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the issues of disagreement.
(1) If the audit or review is being performed by the Iowa Medicaid Enterprise Program Integrity Unit, the request should be addressed to: IME Program Integrity Unit, P.O. Box 36390, Des Moines, Iowa 50315.
(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319-0114.

b. Additional information. A provider that has made a reevaluation request pursuant to paragraph *"a"* of this subrule may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph *"c"* of this subrule.
c. Disagreement with sampling results. When the department's audit or review findings have been generated through 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 or review of the universe of provider records used by the department in the drawing of the department's sample. Any such audit or review must:
(1) Be arranged and paid for by the provider.
(2) Be conducted by an individual or organization with expertise in coding, medical services, and Iowa Medicaid policy if the issues relate to clinical records.
(3) Be conducted by a certified public accountant if the issues relate to fiscal records.
(4) Demonstrate that bills and records that were not audited or reviewed in the department's sample are in compliance with program regulations.
(5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.
79.4(6) *Finding and order for repayment.* Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.
79.4(7) *Appeal by provider of care.* A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment. Records shall be maintained in English and must be legible and clear.

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

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.
79.9(1) Iowa Medicaid utilizes Medicare and American Medical Association (AMA) definitions and policies. If Iowa Medicaid does not publish a definition and policy for a specific code, the Medicare definition and policy shall be used.

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In the absence of a Medicare definition and policy then national coding guidelines as established by the AMA shall be used.
79.9(2) Medical Necessity is defined as the provision of medically necessary medical or allied care, services or supplies exercising reasonable and prudent clinical judgment. Reasonable and prudent clinical judgment considers whether the care, services or supplies are being provided to a patient for the purpose of evaluating, diagnosing, prevention, or treatment of an illness, injury, disease or its symptoms are in accordance with standard of good medical practice as determined by DHS or its designated representative. Medically necessary care, services or supplies shall:

a. Be consistent with the diagnosis and treatment of the patient's condition.
b. Be clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury, or disease..
c. Be in accordance with standards of good medical practice and not considered experimental or investigational. Generally accepted standards of medical practice for the purpose of determination of medical necessity considers whether the standards are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community and published professional society recommendations as determined by DHS or its designated representative
d. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.
e. Be the least costly type of service which would reasonably meet the medical need of the patient.
f. Be eligible for federal financial participation unless specifically covered by state law or rule.
g Be prescribed and /or provided within the scope of the licensure of the provider.
h. Be provided with the full knowledge and consent of the member or someone acting in the member's behalf unless otherwise required by law or court order or in emergency situations.
i. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78, 79, and 80.
79.9(3) The fact that medical or allied care, services or supplies have been prescribed or recommended does not, in and of itself, make such care or services medically necessary or guarantee Medicaid coverage. Sufficient medical documentation must be maintained to permit an independent conclusion by DHS or its designated representative that the requirements outlined above are met to determine the service provided was medically necessary and appropriate.
79.9(4) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.
79.9(5) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(6) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid. This rule is intended to implement Iowa Code section 249A.4.

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Appendix B – Iowa Provider and Member Metrics

Provider Type	Enrolled Providers	Provider Tax Entities
Rehab Agency	42	29
Home Health Agency	216	192
HABILITATION SERVICES	294	204
Community MH	39	32
Waiver	8648	8487

Program	Members
Ill and Handicapped	2916
Remedial Services	9
Childrens Mental Health	884
Physical Disability	1224
Brain Injury	1354
AIDS - HIV	43
MDSQ	73
Habilitation Services	4238
Targeted Case Management	12409
Elderly	9815
Intellectual Disability	12113