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**IDAPA 16  
TITLE 05  
CHAPTER 07**

**16.05.07 - THE INVESTIGATION AND ENFORCEMENT OF FRAUD, ABUSE, AND MISCONDUCT**

**000. LEGAL AUTHORITY.**

The Idaho Department of Health and Welfare has the authority to establish and enforce rules to protect the integrity of the public assistance programs against fraud, abuse, and other misconduct under Sections 56-202(b), 56-203(a) and (b), 56-209, 56-209h, 56-227, 56-227A through D, 56-1001, and 56-1003, Idaho Code, and under federal regulations. (3-30-07)

**001. TITLE, SCOPE AND POLICY.**

**01. Title.** The title of this chapter is IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." (3-30-07)

**02. Scope.** This chapter is intended to protect the integrity of the public assistance programs by identifying instances of fraud, abuse, and other misconduct by providers and their employees, participants, and by providing that appropriate action is taken to correct the problem. (3-30-07)

**03. Policy.** Action will be taken to protect both program participants and the financial resources of the public assistance programs. Where minimum federal requirements are exceeded, it is the Department's intent to provide additional protections. Nothing contained within this chapter shall be construed to limit the Department from taking any other action authorized by law, including seeking damages under Section 56-227B, Idaho Code. (3-30-07)

**002. WRITTEN INTERPRETATIONS.**

The Department has no written interpretations that apply to this chapter of rule according to Section 67-5201(19)(b)(iv), Idaho Code. (3-30-07)

**003. ADMINISTRATIVE APPEALS.**

Appeals and proceedings for any Department actions are governed by IDAPA 16.05.03, "Rules Governing Contested Case Proceedings and Declaratory Rulings." An appeal does not stay the action of the Department. (3-30-07)

**004. INCORPORATION BY REFERENCE.**

42 CFR 455-23(b) is incorporated by reference into this chapter of rules. It is available from the Centers for Medicare and Medicaid Services (CMS), 7500 Security Blvd, Baltimore, MD, 21244-1850 or on the Code of Federal Regulations internet site at <http://www.access.gpo.gov/nara/cfr/cfr-table-search.html>. (3-30-07)

**005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS -- STREET ADDRESS -- INTERNET WEBSITE.**

**01. Office Hours.** Office hours are 8 a.m. to 5 p.m., Mountain Time, Monday through Friday, except holidays designated by the state of Idaho. (3-30-07)

**02. Mailing Address.** The mailing address for the business office is Idaho Department of Health and Welfare, P.O. Box 83720, Boise, Idaho 83720-0036. (3-30-07)

**03. Street Address.** The business office of the Idaho Department of Health and Welfare is located at 450 West State Street, Boise, Idaho 83702. (3-30-07)

**04. Telephone.** (208) 334-5500. (3-30-07)

**05. Internet Website Address.** Department Internet address is: <http://www.healthandwelfare.idaho.gov>. (3-30-07)

**006. CONFIDENTIALITY OF RECORDS AND PUBLIC RECORDS REQUESTS.**

**01. Confidential Records.** Any information about an individual covered by these rules and contained in Department records must comply with IDAPA 16.05.01, "Use and Disclosure of Department Records," and federal Public Law 103-209 and 92-544. (3-30-07)

**02. Public Records.** The Department of Health and Welfare will comply with Sections 9-337 through 9-350, Idaho Code, when requests for the examination and copying of public records are made. Unless otherwise exempt, as set forth in Section 9-340, Idaho Code, and other state and federal laws and regulations, all public records in the custody of the Department of Health and Welfare are subject to disclosure. (3-30-07)

**007. -- 009. (RESERVED).**

**010. DEFINITIONS AND ABBREVIATIONS.**

For purposes of this chapter of rules, the following terms will be used as defined below. (3-30-07)

**01. Abuse or Abusive.** Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, or in physical harm, pain or mental anguish to a medical assistance recipient. It also includes recipient practices that result in unnecessary cost to the Medicaid program, or recipient utilization practices which may endanger their personal health or safety. (3-30-07)

**02. Access to Documentation and Records.** To review and copy records at the time a written request is made during normal business hours. Documentation includes all materials as described in Section 101 of these rules. (3-30-07)

**03. Claim.** Any request or demand for payment of items or services under the state's medical assistance program, whether under a contract or otherwise. (3-30-07)

**04. Conviction.** An individual or entity is considered to have been convicted of a criminal offense: (3-30-07)

**a.** When a judgment of conviction has been entered against the individual or entity by a federal, state, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged; (3-30-07)

**b.** When there has been a finding of guilt against the individual or entity by a federal, state, or local court; (3-30-07)

**c.** When a plea of guilty or nolo contendere by the individual or entity has been accepted by a federal, state, or local court; or (3-30-07)

**d.** When the individual or entity has entered into participation in a first offender, deferred adjudication, or other arrangement or program where judgment of conviction has been withheld. (3-30-07)

**05. Department.** The Idaho Department of Health and Welfare, its authorized agent or designee. (3-30-07)

**06. Exclusion.** A specific person or provider will be precluded from directly or indirectly providing services and receiving reimbursement under Medicaid. (3-30-07)

**07. Fraud or Fraudulent.** An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. (3-30-07)

**08. Knowingly, Known, or With Knowledge.** A person, with respect to information or an action, who: has actual knowledge of the information or an action; acts in deliberate ignorance of the truth or falsity of the information or the correctness or incorrectness of the action; or acts in reckless disregard of the truth or falsity of the information or the correctness or incorrectness of the action. (3-30-07)

**09. Managing Employee.** A general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency. (3-30-07)

**10. Medicaid.** Idaho's Medical Assistance Program. (3-30-07)

**11. Medical Assistance.** Payments for part or all of the cost of services funded by Titles XIX or XXI of the federal Social Security Act, as amended. (3-30-07)

**12. Ownership or Control Interest.** A person or entity that: has an ownership interest totaling twenty-five percent (25%) or more in an entity; is an officer or director of an entity that is organized as a corporation; is a partner in an entity that is organized as a partnership; or is a managing member in an entity that is organized as a limited liability company. (3-30-07)

**13. Person.** An individual, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private. (3-30-07)

**14. Program.** The Medicaid Program or any part thereof, including Idaho's State Plan. (3-30-07)

**15. Provider.** Any individual, organization or business entity furnishing medical goods or services in compliance with Department rules who has a Medicaid provider number and has entered into a written provider agreement with the Department. (3-30-07)

**16. Provider Agreement.** A written agreement between the Department and a provider or group of providers of supplies or services. This agreement contains any terms or conditions deemed appropriate by the Department. (3-30-07)

**17. Recoup and Recoupment.** The collection of funds for the purpose of recovering overpayments made to providers for items or services the Department has determined should not have been paid. The recoupment may occur through the collection of future claims paid or other means. (3-30-07)

**18. Sanction.** Any abatement or corrective action taken by the Department which is appealable under Section 003 of these rules. (3-30-07)

**19. State Plan.** The contract between the state and federal government under 42 U.S.C. section 1396a(a). (3-30-07)

**20. Title XIX.** Title XIX of the Social Security Act, known as Medicaid, is a medical benefits program jointly financed by the federal and state governments and administered by the states. This program pays for medical assistance for certain individuals and families with low income and limited resources. (3-30-07)

**21. Title XXI.** Title XXI of the Social Security Act, known as the State Children's Health Insurance Program (SCHIP). This is a program that primarily pays for medical assistance for low-income children. (3-30-07)

**011. -- 019. (RESERVED).**

**020. DEPARTMENT ACTIONS.**

When an instance of fraud, abuse, or other misconduct is identified, the Department will take action to correct the problem as provided in this section. Such corrective action may include, denial of payment, recoupment, payment suspension, provider agreement suspension, termination of provider agreement, imposition of civil monetary penalties, exclusion, recipient lock-in, referral for prosecution, or referral to state licensing boards. (3-30-07)

**021. - 099. (RESERVED).**

**100. INVESTIGATION AND AUDITS.**

Investigation and audits of provider fraud, abuse or misconduct conducted by the Department's Bureau of Audits and

Investigations or its successor are governed under this chapter of rules. (3-30-07)

**01. Investigation Methods.** Under Section 56-227(e), Idaho Code, the Department will investigate and identify potential instances of fraud, abuse, or other misconduct by any person related to involvement in the program. Methods may include: review of computerized reports, referrals to or from other agencies, health care providers or persons, or conducting audits and interviews, probability sampling and extrapolation, and issuing subpoenas to compel testimony or the production of records. Reviews may occur on either pre-payment or post-payment basis. (3-30-07)

**02. Probability Sampling.** Probability sampling shall be done in conformance with generally accepted statistical standards and procedures. "Probability sampling" means the standard statistical methodology in which a sample is selected based on the theory of probability, a mathematical theory used to study the occurrence of random events. (3-30-07)

**03. Extrapolation.** Whenever the results of a probability sample are used to extrapolate the amount to be recovered, the demand for recovery will be accompanied by a clear description of the universe from which the sample was drawn, the sample size and method used to select the sample, the formulas and calculation procedures used to determine the amount to be recovered, and the confidence level used to calculate the precision of the extrapolated overpayment. "Extrapolation" means the methodology whereby an unknown value can be estimated by projecting the results of a probability sample to the universe from which the sample was drawn with a calculated margin of error. (3-30-07)

#### **101. DOCUMENTATION OF SERVICES AND ACCESS TO RECORDS.**

**01. Documentation of Services.** Providers must generate documentation at the time of service sufficient to support each claim or service, and as required by rule, statute, or contract. Documentation must be legible and consistent with professionally recognized standards. Documentation must be retained for a period of five (5) years from the date the item or service was provided. Documentation to support claims for services includes, but is not limited to, medical records, treatment plans, medical necessity justification, assessments, appointment sheets, patient accounts, financial records or other records regardless of its form or media. (3-30-07)

**02. Immediate Access to Records.** Providers must grant to the Department and its agents, the U.S. Department of Health and Human Services and its agents, immediate access to records for review and copying during normal business hours. These records are defined in Subsection 101.01 of these rules. (3-30-07)

**03. Copying Records.** The Department and its authorized agents may copy any record as defined in Subsection 202.01 of these rules. They may request in writing to have copies of records supplied by the provider. The requested copies must be furnished within twenty (20) working days after the date of the written request, unless an extension of time is granted by the Department for good cause. Failure to timely provide requested copies will be a refusal to provide access to records. (3-30-07)

**04. Removal of Records From Provider's Premises.** The Department and its authorized agents may remove from the provider's premises copies of any records as defined in Subsection 101.01 of these rules. (3-30-07)

#### **102. -- 199. (RESERVED).**

#### **200. DENIAL OF PAYMENT.**

The following are reasons the Department may deny payment. (3-30-07)

**01. Billed Services Not Provided or Not Medically Necessary.** The Department may deny payment for any and all claims it determines are for items or services: (3-30-07)

**a.** Not provided or not found by the Department to be medically necessary. (3-30-07)

**b.** Not documented to be provided or medically necessary. (3-30-07)

**c.** Not provided in accordance with professionally recognized standards of health care. (3-30-07)

d. Provided as a result of a prohibited physician referral under 42 CFR Part 411, Subpart J. (3-30-07)

**02. Contrary to Rules or Provider Agreement.** The Department may deny payment when services billed are contrary to Department rules or the provider agreement. (3-30-07)

**03. Failure to Provide Immediate Access to Records.** The Department may deny payment when the provider does not allow immediate access to records as defined in Section 101 of these rules. (3-30-07)

**201. -- 204. (RESERVED).**

**205. RECOUPMENT.**

The Department may recoup the amount paid for items or services listed in Section 200 of these rules. If recoupment is impracticable, the Department may pursue any available legal remedies it may have. Interest shall accrue on overpayments at the statutory rate set forth in Section 28-22-104, Idaho Code, from the date of the final determination of the amount owed for items or services until the date of recovery. (3-30-07)

**206. -- 209. (RESERVED).**

**210. SUSPENSION OF PAYMENTS PENDING INVESTIGATION.**

The Department may suspend payments in whole or part in a suspected case of fraud or abuse pending investigation and conclusion of legal proceedings related to the provider's alleged fraud or abuse. When payments have been suspended under this section of rule, the Department will provide for a hearing within thirty (30) days of receipt of any timely filed notice of appeal. (3-30-07)

**01. Basis for Suspension of Payments.** When the Department through reliable evidence suspects fraud or abuse, or when a provider fails to provide immediate access to records, Medicaid payments may be withheld or suspended. (3-30-07)

**02. Notice of Suspension of Payments.** The Department may withhold payments without first notifying the provider of its intention to do so. The Department will send written notice according to 42 CFR 455-23(b) within five (5) days of taking such action. (3-30-07)

**03. Duration of Suspension of Payments.** The withholding of payment actions under this section of rule will be temporary and will not continue after: (3-30-07)

a. The Department or the prosecuting authorities determine there is insufficient evidence of fraud or willful misrepresentation by the provider; or (3-30-07)

b. Legal proceedings related to the provider's alleged fraud or abuse are completed. (3-30-07)

**211. -- 219. (RESERVED).**

**220. PROVIDER AGREEMENT SUSPENSION.**

In the event the Department identifies a suspected case of fraud or abuse, it may summarily suspend the provider agreement when such action is necessary to prevent or avoid immediate danger to the public health or safety. This provider agreement suspension temporarily bars the provider from participation in the medical assistance program, pending investigation and Department action. The Department will notify the provider of the suspension. The suspension is effective immediately upon written, electronic, or oral notification. When a provider agreement is suspended under this section of rule, the Department will provide for a hearing within thirty (30) days of receipt of any timely filed notice of appeal (3-30-07)

**221. -- 229. (RESERVED).**

**230. TERMINATION OF PROVIDER STATUS.**

Under Section 56-209h, Idaho Code, the Department may terminate the provider agreement of, or otherwise deny provider status for a period of five (5) years from the date the Department's action becomes final to, any individual or

entity who: (3-30-07)

**01. Submits an Incorrect Claim.** Submits a claim with knowledge that the claim is incorrect, including reporting costs as allowable which were known to be disallowed in a previous audit, unless the provider clearly indicates that the item is being claimed to establish the basis for an appeal and each disputed item or amount is specifically identified. (3-30-07)

**02. Fraudulent Claim.** Submits a fraudulent claim. (3-30-07)

**03. Knowingly Makes a False Statement.** Knowingly makes a false statement or representation of material fact in any document required to be maintained or submitted to the Department. (3-30-07)

**04. Medically Unnecessary.** Submits a claim for an item or service known to be medically unnecessary. (3-30-07)

**05. Immediate Access to Documentation.** Fails to provide, upon written request by the Department, immediate access to documentation required to be maintained. (3-30-07)

**06. Non-Compliance With Rules and Regulations.** Fails repeatedly or substantially to comply with the rules and regulations governing medical assistance payments. (3-30-07)

**07. Violation of Material Term or Condition.** Knowingly violates any material term or condition of its provider agreement. (3-30-07)

**08. Failure to Repay.** Has failed to repay, or was a managing employee or had an ownership or control interest in any entity that has failed to repay, any overpayments or claims previously found to have been obtained contrary to statute, rule, regulation, or provider agreement. (3-30-07)

**09. Fraudulent or Abusive Conduct.** Has been found, or was a managing employee in any entity which has been found, to have engaged in fraudulent conduct or abusive conduct in connection with the delivery of health care items or services. (3-30-07)

**10. Failure to Meet Qualifications.** Fails to meet the qualifications specifically required by rule or by any applicable licensing board. (3-30-07)

**231. -- 234. (RESERVED).**

**235. CIVIL MONETARY PENALTIES.**

Under Section 56-209h, Idaho Code, the Department may assess civil monetary penalties against a provider, any officer, director, owner, and managing employee for conduct identified in Subsections 230.01 through 230.09 of these rules. The amount of penalties may be up to one thousand dollars (\$1,000) for each item or service improperly claimed, except that in the case of multiple penalties the Department may reduce the penalties to not less than twenty-five percent (25%) of the amount of each item or service improperly claimed if an amount can be readily determined. Each line item of a claim, or cost on a cost report is considered a separate claim. These penalties are intended to be remedial, at a minimum recovering costs of investigation and administrative review, and placing the costs associated with non-compliance on the offending provider. (3-30-07)

**236. -- 239. (RESERVED).**

**240. MANDATORY EXCLUSIONS FROM THE MEDICAID PROGRAM.**

The Department will exclude from the Medicaid program any provider, entity or person that: (3-30-07)

**01. Conviction of a Criminal Offense.** Has been convicted of a criminal offense related to the delivery of an item or service under a federal or any state health care program, including the performance of management or administrative services relating to the delivery of items or services under any such program. (3-30-07)



**02. Conviction of a Criminal Offense Related to Patient Neglect or Abuse.** Has been convicted, under federal or state law, of a criminal offense related to the neglect or abuse of a patient, in connection with the delivery of a health care item or service, including any offense that the Department concludes entailed, or resulted in, neglect or abuse of patients. The conviction need not relate to a patient who is a program beneficiary. (3-30-07)

**03. Other Exclusions.** Is identified by the Centers for Medicare and Medicaid Services (CMS) as having been excluded by another state or the Office of Inspector General or any person CMS directs the Department to exclude. (3-30-07)

**241. -- 244. (RESERVED).**

**245. TERMS OF MANDATORY EXCLUSIONS FROM THE MEDICAID PROGRAM.**

Mandatory exclusions from the Medicaid program imposed under Subsections 240.01 and 240.02 of these rules, will be for not less than ten (10) years. The exclusion may exceed ten (10) years if aggravating factors are present. In the case of any mandatory exclusion of any person, if the individual has been convicted on two (2) or more previous occasions of one (1) or more offenses for which an exclusion may be effected under this section, the period of exclusion will be permanent. (3-30-07)

**246. -- 249. (RESERVED).**

**250. PERMISSIVE EXCLUSIONS FROM THE MEDICAID PROGRAM.**

The Department may exclude any person or entity from the Medicaid program for a period of not less than one (1) year: (3-30-07)

**01. Endangerment of Health or Safety of a Patient.** Where there has been a finding by a governmental agency against such person or entity of endangering the health or safety of a patient, or of patient abuse, neglect or exploitation. (3-30-07)

**02. Failure to Disclose or Make Available Records.** That has failed or refused to disclose, make available, or provide immediate access to the Department, or its authorized agent, or any licensing board, any records maintained by the provider or required of the provider to be maintained, which the Department deems relevant to determining the appropriateness of payment. (3-30-07)

**03. Other Exclusions.** For any reason for which the Secretary of Health and Human Services, or his designee, could exclude an individual or entity. (3-30-07)

**251. -- 259. (RESERVED).**

**260. AGGRAVATING FACTORS.**

For purposes of lengthening the period of mandatory exclusions and permissive exclusions from the Medicaid program, the following factors may be considered. This is not intended to be an exhaustive list of factors which may be considered: (3-30-07)

**01. Financial Loss.** The acts resulted in financial loss to the program of one thousand five hundred dollars (\$1,500) or more. The entire amount of financial loss to such program will be considered, including any amounts resulting from similar acts not adjudicated, regardless of whether full or partial restitution has been made to the program. (3-30-07)

**02. Time Acts Were Committed.** The acts were committed over a period of one (1) year or more. (3-30-07)

**03. Adverse Impact.** The acts had a significant adverse physical, mental or financial impact on one (1) or more program participants or other individuals. (3-30-07)

**04. Length of Sentence.** The length of any sentence imposed by the court related to the same act. (3-30-07)

**05. Prior Record.** The excluded person has a prior criminal, civil or administrative sanction record. (3-30-07)

**261. -- 264. (RESERVED).**

**265. REFUSAL TO ENTER INTO AN AGREEMENT.**

The Department may refuse to enter into a provider agreement for the reasons described in Subsections 265.01 through 265.05 of this rule. (3-30-07)

**01. Convicted of a Felony.** The provider has been convicted of a felony under federal or state law. (3-30-07)

**02. Committed an Offense or Act Not in Best Interest of Medicaid Participants.** The provider has committed an offense or act which the Department determines is inconsistent with the best interests of Medicaid participants. (3-30-07)

**03. Failed to Repay.** The provider has failed to repay the Department monies which had been previously determined to have been owed to the Department. (3-30-07)

**04. Investigation Pending.** The provider has a pending investigation for program fraud or abuse. (3-30-07)

**05. Terminated Provider Agreement.** The provider was the managing employee, officer, or owner of an entity whose provider agreement was terminated under Section 230 of these rules. (3-30-07)

**266. -- 269. (RESERVED).**

**270. MISCELLANEOUS CORRECTIVE ACTIONS.**

The Department may take lesser action to investigate, monitor and correct suspected instances of fraud, abuse, over utilization, and other misconduct as provided in Subsections 270.01 through 270.03 of this rule. (3-30-07)

**01. Issuance of a Warning.** Issuance of a warning letter describing the nature of suspected violations, and requesting an explanation of the problem and a warning that additional action may be taken if the action is not justified or discontinued. (3-30-07)

**02. Review.** Prepayment review of all or selected claims submitted by the provider with notice that claims failing to meet written guidelines will be denied. (3-30-07)

**03. Referral.** Referral to state licensing boards for review of quality of care and professional and ethical conduct. (3-30-07)

**271. -- 274. (RESERVED).**

**275. DISCLOSURE OF CERTAIN PERSONS.**

Prior to entering into or renewing a provider agreement, or at any time upon written request by the Department, a provider must disclose to the Department the identity of any person described at 42 CFR 1001.1001. The Department may refuse to enter into or renew an agreement with any provider associated with any person so described. The Department may also refuse to enter into, or terminate, a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under this chapter of rule. (3-30-07)

**276. -- 279. (RESERVED).**

**280. PROVIDER NOTIFICATION.**

When the Department determines actions defined in Sections 200 through 250 of these rules are appropriate, it will send written notice of the decision to the provider or person. The notice will state the basis for the action, the length of the action, the effect of the action on that person's ability to provide services under state and federal programs, and the person's appeal rights. (3-30-07)

**281. -- 284. (RESERVED).**

**285. NOTICE TO STATE LICENSING AUTHORITIES.**

The Department will promptly notify all appropriate licensing authorities having responsibility for licensing or certification of a Department action, and the facts and circumstances of that action. The Department may request certain action be taken and that the Department be informed of actions taken. (3-30-07)

**286. -- 289. (RESERVED).**

**290. PUBLIC NOTICE.**

The Department will give notice of the action taken and the effective date to the public, appropriate beneficiaries, and may give notice as appropriate to related providers, the Quality Improvement Organization (QIO), institutional providers, professional organizations, contractors, other health insurance payors, and other agencies or Departmental divisions. (3-30-07)

**291. -- 299. (RESERVED).**

**300. DEPARTMENT OF HEALTH AND HUMAN SERVICES.**

The Department will notify the Office of Inspector General within fifteen (15) days after a final action in which a person has been excluded or convicted of a criminal offense related to participation in the delivery of health care items or services under the program. (3-30-07)

**301. -- 999. (RESERVED).**

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