IDAPA 16 – IDAHO DEPARTMENT OF HEALTH AND WELFARE

Division of Management Services

16.05.07 – The Investigation and Enforcement of Fraud, Abuse, and Misconduct

Who does this rule apply to?
Providers, employers and participants who commit fraud, abuse, or other misconduct in public assistance programs.

What is the purpose of this rule?
This chapter is intended to protect the integrity of the public assistance programs by identifying instances of fraud, abuse, and other misconduct by providers, their employees, participants, and by providing that appropriate action is taken to correct the problem.

What is the legal authority for the agency to promulgate this rule?
This rule implements the following statutes passed by the Idaho Legislature:

Health and Safety -
Public Assistance Law:
- Section 56-202(b), Idaho Code – Duties of Director of State Dept. of Health and Welfare
- Section 56-203(1)(2), Idaho Code – Powers of State Department
- Section 56-209, Idaho Code – Assistance to Families with Children
- Section 56-209h, Idaho Code – Administrative Remedies
- Section 56-227, Idaho Code – Fraudulent Acts – Penalty
- Section 56-227A through D, Idaho Code – Provider Fraud – Criminal Penalty

Department of Health and Welfare:
- Section 56-1001, Idaho Code – Definitions
- Section 56-1003, Idaho Code – Powers and Duties of the Director

Where can I find information on Administrative Appeals?
Administrative appeals and contested cases are governed by the provisions of IDAPA 16.05.03, "Contested Case Proceedings and Declaratory Rulings."

How do I request public records?
Unless exempted, all public records are subject to disclosure by the Department that will comply with Title 74, Chapter 1, Idaho Code, upon requests. Confidential information may be restricted by state or federal law, federal regulation, and IDAPA 16.05.01, "Use and Disclosure of Department Records."

Who do I contact for more information on this rule?

Idaho Department of Health and Welfare
Division of Management Services
Medicaid Program Integrity Unit or Welfare Fraud
450 West State Street
Boise, ID 83720-0036

Attn: Medicaid Program Integrity -OR- Unit Welfare Fraud Investigations
P.O. Box 83720
Boise, ID 83720-0036

Phones: Medicaid Fraud: (208) 334-5754, Welfare Fraud: (866) 635-7515

Faxes:
Attn: Medicaid Program Integrity (208) 334-2026
Attn: Welfare (208) 334-5694
Emails:
Medicaid - prvfraud@dhw.idaho.gov
Welfare - welfraud@dhw.idaho.gov
Webpages:
Reporting Fraud -
https://healthandwelfare.idaho.gov/AboutUs/Fraud-ReportPublicAssistanceFraud/tabid/136/Default.aspx

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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(1), 56-203(2), 56-209, 56-209h, 56-227, 56-227A through D, 56-1001, and 56-1003, Idaho Code, and under federal regulations. (7-1-21)T

001. TITLE, SCOPE AND POLICY.

01. Title. These rules are titled IDAPA 16.05.07, "The Investigation and Enforcement of Fraud, Abuse, and Misconduct." (7-1-21)T

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. (7-1-21)T

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 will limit the Department from taking any other action authorized by law, including seeking damages under Section 56-227B, Idaho Code. (7-1-21)T

002. WRITTEN INTERPRETATIONS.
This agency has written statements which pertain to the interpretation of the rules of this chapter, or to the documentation of compliance with the rules of this chapter. The document is available for public inspection and copying at cost in the main office of this agency. (7-1-21)T

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. (7-1-21)T

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 https://www.ecfr.gov/cgi-bin/text-idx?SID=70b7c477b1a5b3977331204c2ad5161e&mc=true&node=pt42.4.455&rgn=div5#se42.4.455_123. (7-1-21)T

005. -- 009. (RESERVED)

010. DEFINITIONS AND ABBREVIATIONS.
For purposes of this chapter of rules, the following terms apply. (7-1-21)T

01. Abuse or Abusive. Provider practices that are inconsistent with sound fiscal, business, child care, or medical practices, and result in an unnecessary cost to a public assistance 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. (7-1-21)T

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. (7-1-21)T

03. Claim. Any request or demand for payment, or document submitted to initiate payment, for items or services provided under a public assistance program, whether under a contract or otherwise. (7-1-21)T

04. Conviction. An individual or entity is considered to have been convicted of a criminal offense: (7-1-21)T

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; (7-1-21)T

b. When there has been a finding of guilt against the individual or entity by a federal, state, or local court; (7-1-21)T

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 (7-1-21)T

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. (7-1-21)T

05. Department. The Idaho Department of Health and Welfare, its authorized agent or designee. (7-1-21)T

06. Exclusion. A specific person or provider will be precluded from directly or indirectly providing services and receiving reimbursement under Medicaid. (7-1-21)T

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. (7-1-21)T

08. Knowingly, Known, or with Knowledge. A person, with respect to information or an action, who: (7-1-21)T

a. Has actual knowledge of the information or an action; (7-1-21)T

b. Acts in deliberate ignorance of the truth or falsity of the information or the correctness or incorrectness of the action; or (7-1-21)T

c. Acts in reckless disregard of the truth or falsity of the information or the correctness or incorrectness of the action. (7-1-21)T

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. (7-1-21)T

10. Medicaid. Idaho's Medical Assistance Program. (7-1-21)T

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. (7-1-21)T

12. Ownership or Control Interest. A person or entity that: (7-1-21)T

a. Has an ownership interest totaling five percent (5%) or more in an entity; (7-1-21)T

b. Is an officer or director of an entity that is organized as a corporation; (7-1-21)T

c. Is a partner in an entity that is organized as a partnership; or (7-1-21)T

d. Is a managing member in an entity that is organized as a limited liability company. (7-1-21)T

13. Participant. An individual or recipient who is eligible and enrolled in any public assistance program. (7-1-21)T

14. Person. An individual, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private. (7-1-21)T

15. Program. Any public assistance program, including the Medicaid program and Idaho's State Plan, or any parts thereof. (7-1-21)T

16. Provider. An individual, organization, agency, or other entity providing items or services under a public assistance program. (7-1-21)T

17. 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. (7-1-21)T

18. Public Assistance Program. Assistance for which provision is made in any federal or state law existing, or hereafter enacted, by the state of Idaho or the congress of the United States by which payments are made from the federal government to the state in aid, or in respect to payment by the state for welfare purposes to any category of needy person, and any other program of assistance for which provision for federal or state funds for aid may from time to time be made. (7-1-21)T

19. 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. (7-1-21)T

20. Sanction. Any abatement or corrective action taken by the Department which is appealable under Section 003 of these rules. (7-1-21)T

21. State Plan. The contract between the state and federal government under 42 U.S.C. section 1396a(a). (7-1-21)T

22. 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. (7-1-21)T

23. Title XXI. Title XXI of the Social Security Act, known as the Children's Health Insurance Program (CHIP). This is a program that primarily pays for medical assistance for low-income children. (7-1-21)T

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, participant lock-in, referral for prosecution, or referral to state licensing boards. (7-1-21)T

021. - 099. (RESERVED)

100. INVESTIGATION AND AUDITS.
Investigation and audits of provider fraud, abuse, or misconduct conducted by the Department's Bureau of Compliance or its successor are governed under this chapter of rules. (7-1-21)T

01. Investigation Methods. Under Section 56-227(5), Idaho Code, the Department will investigate and identify potential instances of fraud, abuse, or other misconduct by any person related to or involved in public assistance programs administered by the Department. 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. (7-1-21)T

02. Probability Sampling. Probability sampling will 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. (7-1-21)T

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. (7-1-21)T

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. (7-1-21)T

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. (7-1-21)T

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. (7-1-21)T

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. (7-1-21)T

102. -- 199. (RESERVED)

200. DENIAL OF PAYMENT.
The following are reasons the Department may deny payment. (7-1-21)T

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: (7-1-21)T

a. Not provided or not found by the Department to be medically necessary. (7-1-21)T

b. Not documented to be provided or medically necessary. (7-1-21)T

c. Not provided in accordance with professionally recognized standards of health care. (7-1-21)T

d. Provided as a result of a prohibited physician referral under 42 CFR Part 411, Subpart J. (7-1-21)T

02. Contrary to Rules or Provider Agreement. The Department may deny payment when services billed are contrary to Department rules or the provider agreement. (7-1-21)T

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. (7-1-21)T

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 will 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. (7-1-21)T

206. -- 209. (RESERVED)

210. SUSPENSION OF PAYMENTS PENDING INVESTIGATION.
The Department may suspend public-assistance 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. (7-1-21)T

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, public-assistance payments may be withheld or suspended. (7-1-21)T

02. Notice of Suspension of Payments. The Department may withhold public-assistance payments without first notifying the provider of its intention to do so when the Department is suspending payments of a Medicaid provider. The Department will send written notice within five (5) days of taking such action in accordance with 42 CFR 455.23(b). All other public assistance providers will be notified prior to the suspension of payments. (7-1-21)T

03. Duration of Suspension of Payments. The withholding of payment actions under this section of rule will be temporary and will not continue after: (7-1-21)T

a. The Department or the prosecuting authorities determine there is insufficient evidence of fraud or willful misrepresentation by the provider; or (7-1-21)T

b. Legal proceedings related to the provider's alleged fraud or abuse are completed. (7-1-21)T

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 (7-1-21)T

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: (7-1-21)T

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. (7-1-21)T

02. Fraudulent Claim. Submits a fraudulent claim. (7-1-21)T

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. (7-1-21)T

04. Medically Unnecessary. Submits a claim for an item or service known to be medically unnecessary. (7-1-21)T

05. Immediate Access to Documentation. Fails to provide, upon written request by the Department, immediate access to documentation required to be maintained. (7-1-21)T

06. Non-Compliance With Rules and Regulations. Fails repeatedly or substantially to comply with the rules and regulations governing medical assistance payments or other public assistance program payments. (7-1-21)T

07. Violation of Material Term or Condition. Knowingly violates any material term or condition of its provider agreement. (7-1-21)T

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. (7-1-21)T

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 or public assistance items or services. (7-1-21)T

10. Failure to Meet Qualifications. Fails to meet the qualifications specifically required by rule or by any applicable licensing board. (7-1-21)T

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 ten percent (10%) 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. (7-1-21)T

236. CIVIL MONETARY PENALTY PERCENTAGES.
The Department will determine the percentage of each penalty by the type of conduct, the frequency, and knowledge of the conduct. When more than one (1) type of conduct described in Section 230 of these rules is found per line item, the penalty percentage will be based on the most significant conduct. (7-1-21)T

01. Conduct Resulting in No Overpayment. The Department determines civil monetary penalties to be assessed for the following types of conduct violations that did not result in an overpayment. (7-1-21)T

a. Participant Fees. The provider collected or attempted to collect fees from participants that the provider was not entitled to collect. Violations for this type of conduct will result in a ten percent (10%) penalty. (7-1-21)T

b. Minor Rule Violations. Services were provided and properly paid but violated rule, policy, or provider agreement. Minor rule violations will result in a ten percent (10%) penalty. Minor rule violations include, but are not limited to: (7-1-21)T

i. Incorrect date spanning; (7-1-21)T

ii. Failure to list required provider credentials; or (7-1-21)T

iii. Failure to obtain required client signatures. (7-1-21)T

c. Significant Rule Violations. Services were provided but violated rule, policy, or provider agreement. Significant rule violations will result in a fifteen percent (15%) penalty. Significant rule violations

include, but are not limited to: (7-1-21)T

i. Incomplete physician referrals; or (7-1-21)T

ii. Failure to maintain documentation once valid Healthy Connections referral is obtained. (7-1-21)T

02. Conduct Resulting in Overpayment. The Department determines the civil monetary penalties to be assessed for the following types of conduct violations resulting in overpayment. Civil monetary penalties will not be assessed when a provider self-reports an overpayment and the Department receives the report prior to the initiation of a Department audit. (7-1-21)T

a. Significant Rule Violations. Services were provided but violated rule, policy, or provider agreement. Significant rule violations will result in a fifteen percent (15%) penalty. Significant rule violations include, but are not limited to: (7-1-21)T

i. Billing more services than allowed; (7-1-21)T

ii. Billing non-physician services as physician services; (7-1-21)T

iii. Billing incorrect codes (such as Physician's Current Procedural Terminology (CPT), diagnosis, revenue, etc.) or modifiers; or (7-1-21)T

iv. Inadequate documentation to support services billed. (7-1-21)T

b. Significant Rule Violations Related to Participant Care. Services were provided but violated rule, policy, or provider agreement related to participant care. Significant rule violations related to participant care will result in a twenty percent (20%) penalty. Significant rule violations include, but are not limited to: (7-1-21)T

i. Failure to obtain required Healthy Connections referrals or failure to list required core elements, such as the start and end dates on the referral; (7-1-21)T

ii. No required physician or practitioner signatures; (7-1-21)T

iii. No orders or inadequate orders, assessments, plans or evaluations prior to delivery of service or items; (7-1-21)T

iv. Services or items provided by unqualified staff; (7-1-21)T

v. Services or items provided by excluded individual; or (7-1-21)T

vi. Services or items not covered by program. (7-1-21)T

c. Significant Rule Violations for No Service or Refusal of Immediate Access to Documentation. Services were not provided, were not documented, or refusal to provide immediate access to documentation upon written request as required in Section 230.05 of these rules. Violations will result in a twenty-five percent (25%) penalty. Significant rule violations include, but are not limited to: (7-1-21)T

i. Billing and receiving payment multiple times for the same service or item; (7-1-21)T

ii. No documentation; (7-1-21)T

iii. Cloned documentation; (7-1-21)T

iv. Service not provided; (7-1-21)T

v. More units billed than provided; (7-1-21)T

vi. Billing laboratory services provided by independent laboratory, unless an exception applies, such as an independent laboratory that can bill for a reference laboratory; or (7-1-21)T

vii. Missing required pre-authorization. (7-1-21)T

03. Penalty Enhancements. (7-1-21)T

a. Error Rates. The Department determines which error rate applies by comparing the number of violations to the number of similar line items audited, or to all audited line items. Penalty percentages identified in Subsections 236.01 and 236.02 of this rule may be increased by: (7-1-21)T

i. Five percent (5%) when the error percentage of audited services is greater than twenty-five percent (25%); and (7-1-21)T

ii. Ten percent (10%) when the error percentage of audited services is greater than thirty-five percent (35%). (7-1-21)T

b. Fraudulently or Knowingly. When the Department determines the conduct was committed fraudulently or knowingly as defined in Subsections 010.07 and 010.08 of these rules, the penalty percentages may be increased by fifteen percent (15%). (7-1-21)T

237. CIVIL MONETARY PENALTIES FOR CRIMINAL HISTORY BACKGROUND CHECK VIOLATIONS.
The Department may assess civil monetary penalties against a provider, any officer, director, owner, or managing employee for failing to perform required background checks or failing to meet required time lines for completion of background checks as required by rule. The amount of the penalty is five hundred dollars ($500) for each month worked for each staff person or contractor for whom the background check was not performed or not performed timely. The maximum amount that may be assessed for criminal history background check violations is five thousand dollars ($5,000) per month. A partial month is considered a full month for purposes of determining the amount of the penalty. (7-1-21)T

238. -- 239. (RESERVED)

240. MANDATORY EXCLUSIONS FROM THE MEDICAID PROGRAM.
The Department will exclude from the Medicaid program any provider, entity or person that: (7-1-21)T

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. (7-1-21)T

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. (7-1-21)T

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. (7-1-21)T

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. (7-1-21)T

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: (7-1-21)T

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. (7-1-21)T

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. (7-1-21)T

03. Other Exclusions. For any reason for which the Secretary of Health and Human Services, or their designee, could exclude an individual or entity. (7-1-21)T

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: (7-1-21)T

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. (7-1-21)T

02. Time Acts Were Committed. The acts were committed over a period of one (1) year or more. (7-1-21)T

03. Adverse Impact. The acts had a significant adverse physical, mental, or financial impact on one (1) or more program participants or other individuals. (7-1-21)T

04. Length of Sentence. The length of any sentence imposed by the court related to the same act. (7-1-21)T

05. Prior Record. The excluded person has a prior criminal, civil, or administrative sanction record. (7-1-21)T

261. REINSTATEMENT AFTER EXCLUSION FROM MEDICAID PROGRAM.
An individual or entity who has been excluded from the Medicaid Program is not automatically reinstated at the end of the exclusion period. An individual or entity excluded by the Department must submit a written application for reinstatement to the Department. An applicant excluded by the Department must receive written notice of reinstatement from the Department before reinstatement is complete. (7-1-21)T

01. Conditions for Reinstatement. In order to be reinstated, the applicant for reinstatement must meet all criteria in Subsections 261.01.a. through 261.01.i. of this rule. The applicant must be an individual or entity: (7-1-21)T

a. Who is not currently excluded from the Medicaid program by the federal government or by any state Medicaid agency; (7-1-21)T

b. Whose Medicaid provider number is not currently terminated by any state Medicaid agency; (7-1-21)T

c. Whose debts to the Department are paid in full; (7-1-21)T

d. Who is not the subject of any civil, criminal, or state licensing authority investigation; (7-1-21)T

e. Who has not been convicted of any crime during the exclusion period; (7-1-21)T

f. Who has all the required, valid licensure and credentials necessary to provide services; (7-1-21)T

g. Who has met and continues to meet all terms and conditions of any court-ordered probation; (7-1-21)T

h. Who did not work in any capacity as an employee or contractor for any individual or entity receiving Medicaid funds during the applicant's exclusion period; and (7-1-21)T

i. Who did not submit claims or cause claims to be submitted for Medicaid reimbursement for services or supplies provided, ordered, or prescribed by an excluded individual or entity during the applicant's exclusion period. (7-1-21)T

02. Applying for Reinstatement. An individual or entity may not begin the process of reinstatement earlier than one hundred twenty (120) days before the end of the exclusion period specified in the exclusion notice. The Department will not consider a premature application. An applicant that appears on the federal or any state exclusion list may apply for reinstatement, but consideration of the application will not start until after the excluding agency has reinstated the individual or entity. (7-1-21)T

03. Request for Reinstatement. An excluded individual or entity must request an application form in writing from the Department and specifically request reinstatement. The request for reinstatement must include: (7-1-21)T

a. The applicant's name, address, and phone number; and (7-1-21)T

b. Copies of any required license, credentials, and provider number, if they exist. (7-1-21)T

04. Complete Application for Reinstatement. The applicant must complete the reinstatement application form and return the fully executed and notarized form to the Department. (7-1-21)T

05. Department Decision. The Department will issue a written decision to grant or deny a request for reinstatement. (7-1-21)T

06. Reinstatement Denied. When an application for reinstatement is denied, the applicant is ineligible to reapply for one (1) year from the date the decision of denial becomes final. (7-1-21)T

262. -- 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. (7-1-21)T

01. Convicted of a Felony. The provider has been convicted of a felony under federal or state law. (7-1-21)T

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. (7-1-21)T

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. (7-1-21)T

04. Investigation Pending. The provider has a pending investigation for program fraud or abuse. (7-1-21)T

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. (7-1-21)T

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. (7-1-21)T

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. (7-1-21)T

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. (7-1-21)T

03. Referral. Referral to state licensing boards for review of quality of care and professional and ethical conduct. (7-1-21)T

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. (7-1-21)T

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. (7-1-21)T

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. (7-1-21)T

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. (7-1-21)T

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, convicted of a criminal offense related to participation in the delivery of health care items or services under the Medicaid program, or reinstated from a prior exclusion. (7-1-21)T

301. -- 999. (RESERVED)

Subject Index