Program Integrity Reporting Guide

Overview

This manual provides information for the program integrity (PI) reporting requirements required by the Department of Health and Human Services (HHS), Iowa Medicaid managed care plans (MCPs). Each Managed Care Plan (MCP), medical and dental, is required to adhere to reporting requirements in the contract. ***All submitted reports must be specific to the Iowa Medicaid program only and must meet the Performance Targets and Reporting Requirements.***

NOTICE: Submitting questions related to reporting does not preclude a report from being due on the associated due date. All parties will work together to ensure that all questions are answered but, to the extent that there are outstanding questions as of the due date of required reports, it is the expectation that the MCPs document assumptions made and submit the report by the communicated due date. Iowa Medicaid suggests asking questions with adequate time before the due date of the report.

Unless otherwise noted, the MCPs must submit all reports using the formats specified by Iowa Medicaid. If Iowa Medicaid changes the reporting templates, formats, or definitions, Iowa Medicaid will provide the MCPs with new electronic versions with these updates.

MCP – Submitted Reports

*Iowa Medicaid-Prescribed Templates*

For the Iowa Medicaid prescribed templates, the MCP must adhere to the following guidelines:

* Iowa Medicaid requires that the MCPs submit data in these templates without changing the template format.
* Iowa Medicaid will supply templates electronically to the MCOs and dental plans. If the MCPs submits data with incorrect file or worksheet names, or in formats that have been altered in any other way except to provide the performance data for the current reporting period, Iowa Medicaid will require the MCP to re-submit the data under correct file or worksheet names and in correct formats.
* MCPs should only enter data in the identified cells. Do not insert new worksheets, columns or rows, except where instructed.
* In text fields where there is no data to report, please indicate N/A or a sentence expressing that there is no information to report. N/A can only be used if the MCP has reached that section of the report. If the section has not been reached, then leave it blank. An example is if an investigation is being conducted and the error report has not been calculated, leave it blank.
	+ If there is a tab or worksheet that does not have data to input yet, please leave that blank. For example, until D7 has a recovery to add, it should be left blank.
* In numeric fields where there is no data to report, please indicate “0.” Iowa Medicaid understands that with the “Accounting” setting for number formats this will populate as $, “-“ which is acceptable as well.

Filename

The MCP must submit reports using Iowa Medicaid-prescribed naming conventions for all reports uploaded to the Iowa Medicaid Portal Access (IMPA). The MCP will include the MCP name, report name, reporting period, and date of upload for all reports.

Examples:

[MCO] [Report Name] [Report Period] [MM.DD.YY]

AGP Program Integrity Activity June 2019 07.30.19

Overall General Guidance

The purpose of this section will be utilized to provide guidance for items that are consistent throughout all Program Integrity (PI) templates.

Overall Guidance

* ONLY Iowa Medicaid PI exposure should be reported on the PI templates.
* MCPs must report the PI activities of their subcontractors on the PI templates.
* Each State Fiscal Year (SFY), MCPs will start with a blank template and carryover all open items from the previous SFY to continue tracking in the current SFY.
* Removal of closed cases
	+ Any cases that are closed; and closed is defined as an investigation that closes without recoupment, or the date that the final recoupment has been collected form the provider; can be removed from the report with the start of the new SFY.

Definitions Tabs

Each definitions tab refers to the most current version of the PI Reporting Guide, creating one true source of guidance throughout the reporting process.

Drop Down (DO NOT EDIT)

This section on each report shows what drop downs are provided for each drop-down section of the report. This is not an all-encompassing list but covers most of the situations. The option for other may be used. With each new version of the template, Iowa Medicaid reviews these lists and makes appropriate updates. Iowa Medicaid welcomes suggestions for drop downs throughout in between template updates as well.

Reporting Calendar and Frequency

Monthly Reporting

Monthly reporting is due on the 30th of the month after the close of the reporting month. For example, to report for July, the July monthly report would be due on August 30th. For February, monthly reporting is still due thirty (30) days after the close of the month. This means that the report will be due March 1st or 2nd depending on the year.

Quarterly Reporting

The quarterly report is due on the 30th of the month after the close of the reporting quarter. For example, to report for the first quarter (July – September), the report would be due on October 30th.

Annual Reporting

The annual report is due on the 30th of the month after the close of the reporting year. For example, for SFY2022 (July 2021 – June 2022), the report would be due on July 30th, 2022.

Monthly reporting

The purpose of monthly reporting is to provide Iowa Medicaid PI with a snapshot of all activities that occurred in a particular month. The monthly reporting shows the investigative activities, provider notices, recoveries, CAFs, Iowa Medicaid provider actions, MCP provider actions, and requests for information. Through the information submitted, Iowa Medicaid can review the progress of the MCP SIU and PI activities.

Report Template Filename

The template file name for the monthly report is below:

[MCO] PI1-PI7\_Program Integrity Activity\_V14 [Reporting Month] [MM.DD.YY]

[MCO] PI14\_Total Non-PI Recoveries\_V2 [Reporting Month] [MM.DD.YY]

Description

PI1\_Investigative Activities

This tab is utilized for tracking the progress of tips, investigations and providing next steps once an investigation is closed. If the tip progresses to requesting records, this tip is moved to the investigation phase for the purposes of this report as described below.

* **Date Report Submitted:** Enter the date MCPs submit the report.
* **Internal Case Number/ Tracking Number:** This is an optional field for the MCPs to insert their tracking or case number.
* **Provider Information:** Enter the following information:
	+ Provider NPI (if the provider does not have an NPI, list the atypical number as applicable);
	+ Last name, first name, or organization name; and
	+ Provider type (drop down list).
* **Review Type:** This section is a drop down to select whether the investigation is internal or external (UPIC, Iowa Medicaid). If the investigation is external, the cell will turn red.
* **FWA TIP Information:** This section is filled out to describe the information received in the allegation. The tip information section is meant to address factual information used to track, trend and understand the sources providing tips.
* **Date Received Tip:** Enter the date that the tip was received
* **Source Category [Drop Down List]:** This field shows where the tip originated. There are several drop down options of potential sources; however, if the source is not present then select “Other.” It should be noted that the MCPs are to use best judgment when selecting a drop down. For example, if there is a tip found due to a story in the media, select “Public” not “Other.” There is a new drop down stating “External Investigation – UPIC, Iowa Medicaid” which shall be used external investigations when your MCP is involved.
* **If “Other”, Name Source of Tip:** Since there are some circumstances were using “other” might be necessary, enter the source of the tip.
* **TIP Allegation Category [Drop Down List]:** Enter the category that best fits the tip allegation from the drop-down list. If there are multiple allegations, select the main category and then add the rest in the brief description of tip allegation. There is an option for “other” if there are no other categories that suffice.
* **If “Other,” Name TIP Allegation Category:** Enter the tip allegation only if “other” is selected in the TIP Allegation Category field.
* **Brief Description of TIP Allegation:** Summarize the tip allegation with enough factual information to understand what will be reviewed.
* **TIP Vetting Status [Drop Down List]:** This field has a drop down to select the status. The options for the drop downs are to be utilized as stated below:
	+ Open – This should be used if the tip is open and remains as a preliminary investigation
	+ Closed, Moved to Investigation – Use this drop down if the tip has been corroborated and requires a full investigation. If this is selected, the Investigation section should have at a minimum the Date Investigation Started, Type of Investigation, and Potential Overpayment Identified Related to MCP Iowa Medicaid Services must be populated.
	+ Closed, Combined with Existing Case – This drop down is selected if the same provider is being investigated under similar circumstances on another investigation or tip. If this drop down is selected, please note the case number of the case that it is combined with in the “Investigation Summary” section.
	+ Closed, No Findings – This should be used when the tip has unfounded allegations. When using this drop down, add a note to the “Brief Description of Tip Allegation” summarizing why the tip was unfounded. Leave the allegation in the field as well.
	+ Sent to MFCU – Use this drop down when the allegation warrants a direct referral to MFCU.
	+ Re-Opened – This drop down should be used when the tip was closed, but later re-opened. For example: There is an allegation for a provider for one date of service. There is no date of service billed so the tip is closed. The provider then bills for that service, so the tip is re-opened
* **Summary of Closed, No Findings:** This field has been added to Version 13 and future versions of the reporting template. This filed will take the place of the previous step of adding the summary to the “Brief Description of Tip Allegation.” The purpose of this field is to describe why the tip was unfounded.
* **Investigation Activity:** This section describes the information pertinent to the investigation. Updating this section provides a snapshot of the status of the investigation for the reporting period.
* **Date Investigation Started:** Enter the date that the investigation began. This date coincides with the date that the potential overpayment for Iowa Medicaid dollars is calculated. Iowa Medicaid considers interaction with the provider as being an investigation, such as requesting medical records.
* **Type of Investigation [Drop Down List]:** Select the type of investigation. The selection will either be desk, onsite or desk and onsite for investigations conducted by your MCP. Desk audits are those performed at the MCP on a provider’s claims and/or medical documentation. Onsite would be selected if the SIU went to the provider’s office and conducted the review onsite. Desk and onsite is used when the investigation have both activities. If the investigation is from an external source (UPIC, Iowa Medicaid), use the External Investigation drop down.
* **Potential Overpayments Identified Related to MCP Iowa Medicaid Services:** This is the sum of potential MCP overpayments that are identified related to the MCP Iowa Medicaid services. This is considered the universe that is the potential exposure. If there is no way to calculate the potential overpayment and medical records are being requested, use the dollar amount for the services paid that are being requested as the potential overpayment amount. For example, the MCP is requesting 30 records that paid $15,872 for services. The $15,872 would be used only if the potential overpayment amount universe cannot be calculated prior to opening the investigation.
* **Investigation Status [Drop Down List]:** Select the corresponding status from the drop-down list. The options are listed below:
	+ New – This would be used for anything that is new for the reporting period.
	+ Open – Used for anything that is in an active investigation.
	+ Closed – Select when the investigation has reached conclusion. The investigation is complete and is unfounded or founded and moved to recovery. **If the investigation is closed, a closed date must be present.**
	+ Referred – This is for investigations that have been referred to Iowa Medicaid/MFCU.
* **Investigation Summary:** Provide a narrative description of the investigation findings or status update, including, but not limited to, documents audited, anomalies found, reviews taken place, among other updates. This should be a detailed description of factual information with the date that the event occurred. New information is added to the top or the bottom, if it is in sequential order. Please ensure that you are adding descriptive notes as to why there will be no referral to MFCU, or provider notices submitted. Add the specific outcomes and determining factors against submitting a referral. This format will be continued until the close of the case. The MCP can add notes to the case after it has closed; however, many times this will not be necessary as the case has already had a determination.
	+ Example of Findings Format:

10/18/2019: Data for upcoding was reviewed and potential OP amount was found. 10/19/2019: 30 medical records were requested from the provider. Records are due 11/19/2019.

11/4/2019: Medical records were received and were sent to the coding auditor to review.

11/14/2019: Coding auditor completed review. 18/30 (60% error rate) records were found to be upcoded. MFCU referral drafted

* + Example for not submitting MFCU Referral or Provider Notice: this note may read “MCP will not be submitting a provider notice or referral to MFCU due to members confirming that the services took place. The issues were due to record keeping and MCP is moving forward with an administrative recovery currently. The provider will be reviewed again in 6 months.”
* **Payment Error Rate:** The Error rate can be calculated by using the following process:
	+ Determine what the subject of the investigation will be prior to the medical record request. This subject(s) will be the reason that you are doing the investigation on to determine if the provider is billing correctly. Example: based on data mining, you suspect the provider is unbundling. You would then request at least 30 records or a SVRS of claims involving unbundling.
	+ A review of medical records/claims involving unbundling is completed. The 30 medical records/claims involving that were reviewed and 15 of those records were denied because the provider unbundled.
	+ All 30 records were reviewed and 15 were incorrect/denied. The error rate is 50%. Half of the records were denied so that is the error rate.
	+ If there were other findings on the claim that were not the focus of the investigation, add the payment error rate to this column and explain what caused the error rate in the summary.
* **Date Investigation Closed:** Enter the date that investigation is complete for both founded and unfounded cases. Keep in mind that for cases that are founded and require recovery the process does not stop. The MCP will need to either reach out to the IMEPI inbox to request permission to recover OR wait until the provider falls off the provider alert list. The provider will fall off the provider alert list once the provider is listed as closed. For example, if the provider is listed as closed when the report is received 10/30/2020, then the provider alert list that comes out on or before 11/15/2020 will not have that provider present. Once the case is closed, the case should be grayed out.
* **Case Closure Disposition [Drop Down List]:** Select the action(s) taken by the MCP. The options are as follows:
	+ Educate
	+ Educate & Pre-pay
	+ Educate & Prepay & Recover
	+ Educate & Recovery
	+ No Further Action
	+ Pre-pay Review
	+ Recovery
* **Auto calculations**
	+ **Amount of Time (Days) Case has Been Open:** This is an auto calculation based on when the investigation was opened and the date the report is submitted. It is calculating the current amount of time the investigation has been open.
	+ **Total Time (Days) Case Open:** This is an auto calculation based on when the investigation started and when the investigation closed. It is calculating the total time from open to close it took for the investigation.

PI2\_FWA Provider Notices

The provider Notice tab is a way to track FWA provider notices submitted, supplemental information provided to MFCU without provocation, overpayment letters sent to providers and/or education letters sent to providers. This tab is to be used only for cases that were submitted as a provider notice. If no provider notice was sent, and an education or overpayment letter was sent, this information will be present on the PI1 and PI3 tabs.

* **Internal Case Number/ Tracking Number:** This is an optional field for the MCP to insert their tracking or case number.
* **Provider Information:** Enter the following information:
	+ Provider NPI (if no NPI, list the atypical number if applicable);
	+ Last name, first name, or organizational name; and
	+ Provider Type [Drop Down List]
* **Findings:**  Provide a summary of the narrative description of the investigative summary from the PI1\_Investigative Activities tab. Keep the summary brief and factual of the reasons for the MFCU referral. If the MCP is providing supplemental information, provide a note in this field that states: “Providing supplemental information to current MFCU investigation and pending all further action.” The rest of the fields will not need to be populated for supplemental information, so leave them blank. The MCP does not need to create a tip for this provider. A tip will be created once MFCU has closed their investigation and then the MCP is able to start the investigation process per MCP policy.
* **Notices:** This is the information about the procedure from the submission of the FWA provider notice to the closure and whether administrative recovery was pursued.
* **Date FWA Provider Notice Sent:** Enter the date the Notice of Suspected Fraud, Waste, and Abuse (FWA) form was sent to Iowa Medicaid/MFCU. If this form requires correction, the MCP will be notified. Once the corrected form is resubmitted, that date will be the date of notice used. For example, MCP 1 sends in a provider notice for Dr. X with an incorrect NPI and non-factual information on 11/1/2019. This request gets rejected and sent back to MCP 1. MCP 1 corrects the NPI and resubmits with factual information on 11/4/2019. The date used in the associated field on the monthly report is 11/4/2019.
* **MFCU Disposition [Drop Down List]:** Select from the following options:
	+ Pending: Choose this selection if the provider notice has been submitted to Iowa Medicaid or MFCU and a determination has not been communicated.
	+ Not Credible – Iowa Medicaid: Use this option when the response that Iowa Medicaid has rejected the referral due to not being credible.
	+ Accepted – MFCU: This response is used when the MCP receives communication that the MFCU as accepted the referral.
	+ Declined – MFCU: Use this response when MFCU declination is communicated back to the MCP.
* **MFCU Disposition Date:** Enter the date the MFCU made their decision on the provider submitted on the FWA provider notice. The date is listed on the bottom portion of the documentation returned filled out by the MFCU director.
* **MFCU Closure Date:** Enter the date that MFCU closed the case. The document that is sent with the closure notification has the date listed.
* **Pursue Administrative Recovery [Y/N]:** Enter “Y” for Yest or “N” for No in this field. This will show whether the MCP decided to recover. If the Y is selected, Iowa Medicaid will expect to see a corresponding line on the Recovery tab for this provider. Make sure that the provider is not on the provider alert list OR that permission has been requested and received from Iowa Medicaid.
* **Education & Overpayment Letters:** This section highlights what was found in the PI1\_PI Activities Tab for Case Closure Disposition. This section is only to be used when there is a provider notice submitted. There is no need to add every education and overpayment letter sent.
* **Education/Overpayment Letter Sent [Drop Down List]:** Enter whether the Education Letter, Overpayment Letter, or Both were sent to the provider.
* **Date Letter Sent to Provider:** Provide the date the letter was sent to the provider. If both letters were sent, but on different days, add both dates. An example would be 12/4/2019 (E); 12/5/2019 (OP).

PI3\_Recovery

The Recovery tab is used to track the amount and number of recoupments made throughout the reporting timeframe.

* **Internal Case Number/ Tracking Number:** This is an optional field for the MCP to insert their tracking or case number.
* **Provider Information:** Enter the following information:
	+ Provider NPI (If provider does not have NPI, list the atypical provider number);
	+ Last name, first name, or organization name; and
	+ Provider type [Drop Down List]
* **PI-Related Overpayment Recovery:** This section relates to any overpayments that the MCPs recover with details. This section details the overpayments recouped and the process for recovery with tracking.
* **Date overpayment Letter was Sent to Provider:** Please add the date that the overpayment letter was sent to the provider.
* **Actual Overpayment Amount to be Recovered:** This is the amount of monies that will be recovered. With any recoupment, there may be a rebuttal period in which the amount of overpayment changes. This specific field is used to identify the amount that the MCPs will receive back due to PI reasons.
* **Overpayment Recovery Method [Drop Down]**: Populate the field with the route that the recovery will be conducted. The drop-down selections include offset, repayment plan, claims adjustment, check, collections, external review, electronic funds transfer, decided not to pursue, and write-off. The first five options are to be used when a recovery is being conducted. A write-off may be used for situations where the provider will not submit the monies, will not respond to contact attempts, and Iowa Medicaid does not believe a referral for sanction is appropriate.
* **Overpayment Recovery Progress Notes**: This field is used to detail the progress made on the recovery. Previously, the Terms of Repayment Plan was being used as a status update as well as the actual terms of the repayment plan. Separating out these fields allows for each MCP to add the progress notes to this section.
	+ An example of using this field can be if the provider submits additional records and the actual overpayment amount changes, the MCP can place a dated note with that information such as: “10/31/2019 – Provider submitted rebuttal records supporting procedure codes #### changing the actual OP amount from $5,450 to $4,200.”
	+ Additionally, if the provider is not following the terms of the repayment plan, then make an update to the notes here. From the example in the section below, if the provider missed a payment, the MCP should add a note such as:
		- “2/2020 – Provider X missed the February 2020 payment. The investigator is reaching out to the office to verify whether or not this payment will be received and inform them that the payments will not extend to September 2021.”
* **Terms of Repayment Plan:** The terms of repayment plan section are used to describe the repayment plan process, updates. An example is: “Provider X will be paying $150 for the next 20 months to reach the total overpayment amount of $3,000. Payments will start January 2020 and end August 2021.”
* **Payment Received this Month:** This column is used to show the dollar amount received **during the reporting month.** Anything that has been recovered during September 2019 will show up on the September 2019 report. This column is to be cleared monthly and only reflect recoveries for the reporting month.
* **Total Payment Received to Date:** Enter the total amount received from the provider to the end date of the reporting month. If at the reporting month, the MCP has received three $600 payments for the repayment plan, the Total Payment Received to Date column should reflect $1800 paid to date. Once the total monies have been collected, this number should not change.
* **Date of Final Recovery Payment:** When all monies have been collected from the associated provider, add the date that the last transaction occurred.
* **Referred for Sanctioning [drop down]:** Indicate whether the provider was referred by the MCP for sanctioning.
* **Type of Investigation [drop down]:** Indicate whether the recoupment was due to an internal or external investigation. If external, the cell will change to red.
* **Encounter Claims Updated [drop down]:** Indicate “yes” or “no” in the cell for verification if the encounter claims have been updated.

PI4\_Credible Allegation of Fraud (CAF)

This tab is to detail the CAFs that each MCP has in place.

* **Internal Case Number/ Tracking Number:** This is an optional filed for the MCP to insert their tracking or case number.
* **Provider Information:** Enter the following:
	+ Provider NPI (if the provider does not have an NPI, list the Atypical Provider number);
	+ Last Name, First name, or Organization Name; and
	+ Provider Type (drop down list).
* **Credible Allegation of Fraud (CAF) Payment Suspensions:** This section covers the details of the CAF suspensions from the date the CAF was received until the lift and details in between.
	+ **Date CAF Letter Email Received:** Enter the date that the CAF letter was sent from Iowa Medicaid via email.
	+ **Date on CAF Letter from State:** Enter the date on the CAF letter attached from the email received from Iowa Medicaid.
	+ **Type of Suspension [drop down]:** Indicate whether the suspension is partial or whole.
	+ **Date Notified Subcontractors:** Indicate whether the appropriate subcontractors have been notified.
	+ **Date of Provider Suspension in Systems (Including Subcontractor Systems):** Enter the date that the suspension went into place in the MCP and subcontractor systems.
	+ **Compliance with 1 Day to Suspend (Autocalc):** This field automatically populates based on the dates input from the CAF letter and date the suspension went into place.
	+ **Date of State Notice to Lift Suspension:** Provide the date that the State gave notice to lift the suspension for that provider.
	+ **Date Notified Subcontractors of Suspension Lift:** Indicate whether the appropriate subcontractors have been notified.
	+ **Amount Held in Suspense:** Use this field to populate the amount of money that has been held in suspense since the beginning of the CAF. The amount of monies paid to provider and amount of monies kept due to administrative recovery will add together to make this amount or less, depending on whether the provider or organization is placed on the CAF.
	+ **Amount Held in Suspense by Subcontractor:** The amount of money held in suspense by the subcontractors since the beginning of the CAF.
	+ **CAF Lifted, Amount Paid to Provider:** Enter the dollar amount paid to the provider once the CAF is lifted. This dollar amount is based on the monies held in suspense.
	+ **CAF Lifted, Date Paid to Provider:** Provide the date that the monies were paid to the provider.
	+ **CAF Lifted, Amount Paid to Provider by Subcontractor:** Enter the dollar amount paid to the provider by the subcontractor once the CAF is lifted. This dollar amount is based on the monies held in suspense by the subcontractor.
	+ **CAF Lifted, Date Subcontractor Paid Provider:** Provide the date that the monies were paid to the provider by the subcontractor.
	+ **CAF Lifted, Amount Kept due to Administrative Recovery:** Enter the dollar amount kept at the MCP once the CAF is lifted. This dollar amount is based on the monies held in suspense by the MCPs and their subcontractors.

PI5\_Iowa Medicaid Provider Action

This section describes the actions that Iowa Medicaid has taken against a provider that the MCPs implement.

* **Internal Case Number/ Tracking Number:** This is an optional field for the MCP to insert their tracking or case number.
* **Provider Information:** Enter the following information:
	+ Provider NPI (If the provider does not have an NPI, list the Atypical Number);
	+ Last name, first name, or Organization name; and
	+ Provider type [drop down]
* **Iowa Medicaid Provider Actions:** These actions are submitted from Iowa Medicaid to the MCP for probation, withholding of payments, suspension, and termination.
* **Date of State Notification:** Enter the date the state notification of the provider action is received.
* **Iowa Medicaid Provider Action Taken [drop down]:** Select the drop down for with the provider action was taken. The provider action types include probation, withholding of payments, suspension from participation, and termination from participation.
* **Reason for Provider Action [drop down]:** select the drop down for the reason the provider action was taken.
* **If other, explain:** Explain the reason for the provider action if not included in the drop-down selections.
* **Date MCOs Take Action:** Enter the date that the action was put into place.
* **Action Taken by MCO:** Provide the action that was taken by the MCP.
* **Date Notified Subcontractor:** Enter the date that the subcontractor was notified about the provider action based on the communication from Iowa Medicaid. If no subcontractor is notified, leave blank.
* **Date Action Lifted:** Enter the date that the action was lifted by Iowa Medicaid.
* **MCO/Dental Plan Actions:** These are actions taken by the MCP in association with the state action.
* **Amount held in suspense:** Enter the amount held in suspense for the State Action. This is the amount that would be paid, not the amount billed.
* **Amount Paid to Provider when Action Lifted:** Enter amount paid to the provider once the State Action was lifted.

PI6\_MCO Provider Action

This section highlights actions that the MCPs have taken against a provider for program integrity reasons.

* **Internal Case Number/ Tracking Number:** This is an optional field for the MCP to insert their tracking or case number.
* **Provider Information:** Enter the following information:
	+ Provider NPI (If the provider does not have an NPI, list the Atypical Provider Number);
	+ Tax Identification Number (TIN); and
	+ Last name, first name, or organization name.
* **Provider Action:** The information provided in this section will provide Iowa Medicaid a clear picture of the reason that the MCP thought a provider action was necessary. This information is reviewed internally to determine if further action is necessary at the State of Iowa Level.
* **Date of Action:** Enter the date the MCP took action.
* **MCO Action [drop down list]:** Choose from the drop-down list of the action that was taken place by the MCP.
* **Explain “Other” if selected in MCO Action:** This field provides the option to explain if the MCP took action against a provider for a reason that is not listed as a drop down in the MCO Action field.
* **Reason for Action [drop down]:** Select the drop down that accounts for the reason for the action from excluded by LEIE, DMF, SAM, other; license expired; license suspended; provider deceased; other; PI concern; denied by credentialing department; denied by credentialing committee; and license voluntarily surrendered.
* **Explain if Reason for Action is “other”:** This field provides the option to explain the reason for the action if not provided in the drop downs.
* **Date Notified Iowa Medicaid/MFCU:** Enter the date that Iowa Medicaid or MFCU was notified about the action. This is the only spot where the MCO or dental plan will technically be reporting ahead. For example, if the report is submitted 10/30/2019, then that is the day that Iowa Medicaid/MFCU is notified. This will most likely only be the date that Iowa Medicaid is notified; however, there may be extenuating circumstances where MFCU will need to be notified. Additionally, Iowa Medicaid requests that the MCO or dental plan consider written email notification if the provider action is an action that Iowa Medicaid also needs to take, such as exclusion, that has not been communicated by Iowa Medicaid. For items such as pre-payment review, the date that the report is submitted may be used for date notified.
* **Date of Notice to State Licensing Board:** Enter the date the MCP sent the notice to the State Licensing Board for the action.
* **Notified Subcontractor [drop down]:** Select “yes” if the subcontractor was notified and “no” if the subcontractor was not notified. There is also a drop down for “no subcontractor” if the MCP does not have subcontractors. Be able to justify why a subcontractor was not notified about the provider action.
* **Date Action Lifted:** Enter the date that the action was lifted by the MCP.

PI7\_Requests for PI Information

This section is to provide Iowa Medicaid with information that has been requested from the MCP relevant to program integrity. Additionally, this tab is being used to account for the monthly database checks.

* **Internal Case Number/ Tracking Number:** This is an optional field for the MCP to insert their tracking or case number.
* **Requestor [drop down]:** Select the group requesting the PI specific information from the MCP. For database checks, the selection would be Iowa Medicaid.
* **Date Request Received:** Enter the date that the request was received from the requestor. The date utilized for database checks is the date that each database check was started.
* **Request details:** Provide information about the request so that Iowa Medicaid is able to read this information and understand what was asked without knowing the background information. For instance, taking the request from above, if this request was to determine if the MCOs or dental plans were running a particular report a particular CPT code, the request details should describe that information. In this section, add the individual’s name that completed the request as well. Additionally, provide the department of this individual completing the request. The database checks request details will list out the requirement and the action taken.
* **Date Request Completed:** Enter the date that the request was completed and sent back to the requestor. If the request is completed on 10/1/2019, but not sent to Iowa Medicaid until 10/8/2019, the date should be 10/8/2019. As with the date request received for the database checks, this is the date that it is completed.

PI14\_Total Non-PI Recoveries

This report shows the amount of money recovered due to a variety of non-program integrity related reasons. Although this section shows non-PI recoveries, these recoveries may show trends that do involve PI in the future.

* **Claim ID:** Enter the MCP claim identification number.
* **Encounter Claim ID:** Enter the encounter claim number that is sent to Iowa Medicaid.
* **Member ID:** Enter the member’s identification number that had the service provided.
* **Provider TIN:** Enter the provider tax identification number.
* **Provider NPI:** Add the provider’s National Provider Identification number.
* **Last Name, First Name, or Organization:** Input the last name and first name of the provider or the organization where the claim was billed. This should match the provider TIN and NPI.
* **Original Claim Paid Date:** Enter the date that the original claim was paid.
* **Amount of Claim:** Input the total dollar amount of the claim that was submitted and paid.
* **Date of Service:** List the date that the service was completed.
* **Overpayment Recovery Reason [drop down]:** Select the overpayment recovery reason from the list of drop downs that most closely match the reason for the recovery. Third Party Liability is no longer reported on this template.
* **Amount Recovered:** This field is for the amount that has been recovered from the paid amount.
* **Date Recovered:** Input the date that the dollars were recovered.
* **Medical Category [drop down]:** Select the category for the dollars recovered.
* **Recovery Method [drop down]:** Select the drop down that best describes the method that the overpayment was recovered.
* **Comments:** Insert any comments that are necessary to the claim recovery.

Quarterly Reporting

The purpose of Quarterly Reporting is to provide the actions that each MCP is actively taking to prevent fraud, waste, and abuse (FWA). Quarterly Reporting allows each MCPs to teach Iowa Medicaid about the activities that are being utilized to combat FWA. This report also provides an amount associated with monies avoided or saved throughout the quarter.

There is a quarterly report for single case agreements. Iowa Medicaid can provide oversight and be aware of providers that are obtaining the single case agreements versus becoming an in-network provider.

Quarterly reporting is used to support the annual work plan as well. To report for the first quarter from July to September, the report would be due on October 30th.

Report Filename

The template file name for the quarterly report is below:

[MCO] PI8-PI10\_Program Integrity Cumulative-Quarterly Update and Reporting\_V4 [Reporting Period][MM.DD.YY]

[MCO] PI11\_Single Case Agreement Quarterly Report\_V1 [Reporting Period][MM.DD.YY]

Description

PI8\_Cost Avoidance Cost Savings

This section shows the amount of money saved as cost avoidances or cost savings. At the top of this report, there is a spot to update the MCP name and add the SFY. For this section, the categories are broken down into Data Mining, Payment Policies, Internal Policy and Rule Changes and Proprietary Payment Edits (Non-CCI). There is a spot for categories listed below for categories not covered in those listed. Examples are SIU Pre-Payment Review and Audit Services, among other avoidance and saving techniques. For any categories added to this spreadsheet, make sure that the corresponding savings type is also input.

PI9\_PI Activity

This portion of the template shows activities completed surrounding member outreach, provider outreach, education, and prevention. At the top of this report, there is a spot to update the MCP name and add the SFY.

* **Total number of EOBs sent:** Enter the number of EOBs that were sent to Iowa Medicaid members for the quarter specified.
* **Total Number of EOBs Responded to:** Enter the number of EOBs that had a member response.
* **Total Number of EOBs turned into TIPs:** Enter the number of responses received from EOBs that turned into a TIP/ Allegation.
* **Total Number of TIPS listed on the monthly report:** From the EOB responses turned into a TIP/ Allegation, list the total reported on the monthly report. Iowa Medicaid may follow up and ask which ones were and were not reported, so be prepared to answer that question.
* **Total Number of Medical Records Reviewed for Prepay:** Enter the total number of medical records that were reviewed received from providers that are on pre-payment review.
* **Total Number of Members Referred to Lock-in [RX, Medical, or Both]:** Enter the total number of members that were referred for RX, Medical, or Both lock-in programs. **Note: Not applicable to dental plans.**
* **Education Activities/Prevention Activities/Training Activities:** List the education activities/ prevention activities/ training activities that were performed for the reporting period. This list should include education that is internal and external. Iowa Medicaid may ask to review these activities on an ad hoc basis. When filling out this information, make sure that there is enough description that Iowa Medicaid will understand the activity that took place. Examples of these activities are new hire training, on-line seminars, and in-person conferences, fax blasts, newsletters, among other activities.
* **Activity Type [drop down]:** Select the type of activity that was completed from the following:
	+ Education – an example of education is a fax blast to providers that encourages correct coding, with educational references from CPT or other coding references.
	+ Prevention – An example of prevention is a campaign to decrease opioid overutilization.
	+ Provider FWA Training – An example of provider FWA training is annual training that providers are required to complete.
	+ Internal FWA Training – An example of internal FWA training is on-boarding FWA training for new employees

Iowa Medicaid may ask for a list of attendees at the training, list of providers sent education or prevention, or other information ad hoc. The Iowa Medicaid will give the MCP notice and a due date for this request.

* **Date Completed:** Enter the date that the associated activity was completed.

PI10\_Algorithms

This section highlights each algorithm run by the MCP. There must be enough information reported to understand what was reviewed. At the top of this report, there is a spot to update the MCP name and add the SFY. The definition that Iowa Medicaid is using for algorithms is as follows: Running data and identifying a pattern in your data that shows a potential program integrity concern. These are not to be confused with system edits.

* **Algorithm Category/Topic:** Provide the name or shorthand of the algorithm category/topic for this column. Examples of acceptable algorithms are “unbundling lab codes” and “Upcoding E/M Visits”. Examples of unacceptable algorithm categories are “EM99214” and “CPT96110.” Adding easy to understand names assists in the review process.
* **# Of Providers:** Enter the number of providers that are identified by the algorithm.
* **Amount Identified:** Enter the total universe of dollars identified from the algorithm. Iowa Medicaid understands that this number is an estimate.
* **Date Completed:** Enter the date that the algorithm was completed. Keep the previous reporting in this section and clear out only at the beginning of the next SFY. If a continuous algorithm is run, the MCP is able to list the quarter that the algorithm is ran.
* **Tips Open from Algorithm:** This section has a “Yes” or “No” drop down selection. If there is a tip or tips opened from this algorithm, then select yes.

PI11\_Single Case Agreement Quarterly Report

This excel spreadsheet is used to document all the single case agreements that the MCP had during the previous quarter.

* **Medicaid ID #:** Enter the number for the Medicaid member receiving the services from the single case agreement. This number is the state Medicaid ID number, NOT the MCP ID number.
* **Provider Last Name:** Enter the last name of the provider.
* **Provider First Name:** Enter the first name of the provider.
* **Organization Name:** If the provider is an organization, leave the first name and last name fields blank. The organization name will be provided in this field instead.
* **Provider NPI:** Enter the provider NPI. Note that this number should be associated with the provider or organization name added to the previous fields.
* **DOS Start Date:** Enter the date that the single case agreement started per the contract.
* **DOS End Date:** Enter the date that the single case agreement ended per the contract.
* **SCA Extended [drop down]:** Select from Yes or No as to whether the SCA was extended.
* **Date SCA Extension Ends:** If the SCA extension is granted, then the new date the SCA ends will be present here. If the SCA is not extended, leave this field blank.
* **Date SCA Expires:** Enter the expiration date for the SCA. There may not always be an expiration date. This situation would be used when there may be the need to extend services, but not past this certain expiration date.
* **Date Referred to Medicaid to Enroll:** Provide the date the provider was referred to Medicaid to enroll. If the provider was not referred to Medicaid to enroll, leave this field blank.
* **Date Referred to Credentialing:** Provide the date that the provider was referred to the MCP credentialing department to become an in-network provider. If the provider was not referred to credentialing, leave this field blank.
* **Payment Terms:** Provide the payment terms for the single case agreement. An example of what is expected for this field is the amount that will be paid for the name of the service provided per time that the service is billed for the length of the SCA. If other details are necessary, or more than one service is on the SCA, add that information as well.
* **Auth #:** Enter the number associated with the SCA.
* **Date of Last Paid Claim:** Enter the date of the last paid claim to the NPI on the SCA for the member associated.
* **Claim #:** Enter the claim number associated with the date of the last paid claim.
* **$ Amount Paid (YTD):** Provide the amount that the MCP has paid that NPI for the SFY to date for the SCA only.

Annual Reporting

The purpose of the Compliance and Annual Work Plans are different. These plans are to be Iowa Medicaid specific. The Compliance Plan is a way to show Iowa Medicaid how the MCO or dental plan works. The plan describes the scope, mission statement, definitions, overview, communications, activities, detection and investigation overview, movement of cases, campaigns/projects, analytics, explanation of benefits, on-sites, partnership and collaboration, education and training program, and mitigation and risk identification, all supported by the attached appendices.

The Annual Work Plan shows the plan moving forward into the next SFY. This report will be utilized to track that the future reports support what this plan had reflected.

There is a quarterly report for single case agreements and member lock-ins. Member lock-ins tracking will help to assist in understanding the number of members locked in and the rationale.

Report Template Filename

These reports should be named as follows:

[MCO] PI12\_Program Integrity Annual Work Plan\_V1 [Reporting Period][MM.DD.YY]

[MCO] PI13\_Program Integrity Compliance Plan\_V2 [Reporting Period][MM.DD.YY]

[MCO] PI15\_Annual Member Lock-In Report\_V1 [Reporting Period][MM.DD.YY]

Description

PI12\_Program Integrity Annual Work Plan

This template is in Excel and should be a brief plan to show what activities the MCP will complete throughout the year.

* **MCO or Dental Plan Information:** There are fields to insert the MCP name, the date, the section of the contract and the compliance plan section.
* **Topics:** The topics are broken down into prevention activities, verification of services, onsite, and mitigation plan for any risks identified for upcoming years. These topics parallel what is described in the Compliance Plan; however, it creates a simplified plan that can be easily used for Iowa Medicaid to track whether the plan is being followed.
* **Quarter:** Each topic is to be broken down by quarter. This will provide the MCPs the opportunity to select the potential frequency of the activity.
* **Focus Area/Topic/Category/Activity:** From the broad topics in Column A, this field allows for further breakdown of what will be completed from this broad topic. For example, the prevention activity could have the focus area of prescription opioid epidemic.
* **Description/ Methodology:** Please provide a brief description of what is being completed and how it is being completed. For example, if the MCP is providing lunch and learns, the “description/methodology” would be [MCP] providing training to mid-level providers in person over lunch, or something to that effect.

PI13\_Program Integrity Compliance Plan

This form is a word document that allows for an explanation for each section in each MCP compliance plan.

* **Cover Page:** The cover page allows fore each MCP to add their name and the date the compliance plan was submitted.
* **Contents:** The table of contents is set up to be easily updated once the compliance plan is complete. This way, each MCP is able to create additional subheadings as necessary to keep their document organized.
* **Scope:** Enter the goals and objectives for the MCP, along with how to plan with contractual requirements that are consistent with State and Federal Regulations. Describe the safeguards in place to ensure payments for services are appropriate.
* **Mission Statement:** Provide the Iowa Medicaid specific mission.
* **Definitions:** Define any acronyms or terms used in the document that need to be defined.
* **MCP Overview:** Provide the MCP organizational structure for Iowa Program Integrity, including the SIU unit. Name key personnel, management, and investigations and provide job descriptions and duties for the named individuals. Include education and experience requirements for the named personnel.
* **Communications:** Outline the MCP communication plan for Iowa Program Integrity, SIU Manager, and Compliance Officer. This would include the communication process workflow for program integrity activities. For example, a TIP comes in and it is communicated to X, then X communicates to Y, etc.
* **Program Integrity Activities**
	+ **Detection and Investigation Overview:** Describe the end-to-end process on how the MCP detects and investigates all Iowa tips and referrals received by the various sources. Include the overpayment recovery process (high-level business flow).
	+ **Movement of Cases:** Provide an overview of moving cases after MFCU has declined and/or closed the case and sent it back for recovery.
	+ **Campaigns/Projects:** Identify goals for preventing FWA in Iowa Medicaid. Describe the campaigns and projects to prevent FWA. Identify any focused reviews to be performed as a result of FWA prevention activities. Identify activities and safeguards to ensure services were rendered.
	+ **Analytics:** Describe the analytics plan used for preventing FWA.
	+ **Explanation of Benefits (EOBs):** Describe the process for sending out EOBs to members and ensuring services paid for were provided to the member.
	+ **Onsite:** Describe methodology when conducting onsite audit with providers in regard to Iowa FWA.
* **Other Program Integrity Activities**
	+ **Partnership and Collaboration:** Identify collaboration activities with external partners such as subcontractors combating FWA.
	+ **Education and Training Program:** Describe the education and training program for internal staff, providers, members, subcontractors regarding program integrity. Include the type of education and training, frequency, and the audience. Proof of training should be available upon request.
* **Mitigation Plan and Risk Identification:** Describe methodology for identifying and addressing vulnerabilities in your program integrity processes.
* **Appendices:** Attach a list of pertinent health care fraud laws and state and federal regulations. Provide policies and procedures pertaining to Iowa Program Integrity activities.

PI15\_Annual Member Lock-In Report

This form is an Excel document that captures the members that have been locked throughout the previous State Fiscal Year. **NOTE: This report is not applicable to dental plans.**

* **Member ID:** This field is to add the member’s State Identification number. The MCP may have an alternate ID number used at the MCP; however, this field is specific to the State ID.
* **Member Last Name:** Input the member’s last name.
* **Member First Name:** Input the member’s first name.
* **Date of Lock-In:** Add the date of lock-in for the member to the pharmacy, provider, or both.
* **Pharmacy Locked into:** This filed will be used to fill out the name of the locked pharmacy. If the pharmacy changes, please note the date of the change and the new pharmacy as well. This is an example of the format:

7/6/2020 – Pharmacy A 8/29/2020 – Pharmacy B

* **Pharmacy NPI:** Insert the pharmacy NPI that is being used for the member lock-in.
* **Primary Care Physician/Prescriber Locked Into:** The MCP may lock the member to a prescriber or utilize a PCP, depending on the language in the contract. Add that prescribers name in the format of last name, first name.
* **PCP/Prescriber NPI:** Add the associated provider or prescriber NPI that is being used for the lock-in
* **Number of Prescribers:** This field will be used to add the number of prescribers that the member was using prior to the lock-in. If the member saw 12 providers, but only 11 were prescribers, then the number of 11 should be utilized in this field.
* **Case or Care Management:** For this field, input the date that case or care management started regardless of whether it is internal or external for the member that is locked in. Any end date should be listed as necessary. If there is no case or care management, leave this field blank. This field should be filled out in the following format: MM/DD/YYYY (-MM/DD/YYY or present), (Case or Care) Management.
* **Date Lock-In Removed:** Input the date the lock-in was removed. If the lock-in has not been removed, this field should be left blank.
* **Reason for Removal:** This field will be left as a free-form field. This field must indicate the reason(s) that the removal occurred. Again, if the lock-in has not been removed, the field should be left blank.