PI - Full Review/Investigation Process – FFS and MCP Claims

Purpose:

The purpose is to provide instructions for conducting a full review upon management approval of the initiation of a Fee for Service (FFS) or Managed Care Plan (MCP) provider investigation.

Identification of Roles:

RACI Definitions	
RACI - RACI charts are a type of responsibility assignment matrices in project management. These simple spreadsheets or tables highlight the different states of responsibility a stakeholder has over a particular task or deliverable and denotes it with the letters R, A, C, or I.	
(R)	Responsible
(A)	Accountable
(C)	Consulted
(I)	Informed

Iowa Medicaid PI Investigator - conducts investigations as approved and assigned by management. **(A)**

Iowa Medicaid PI Audits & Investigations Manager – approves opening of investigations and provides direction as needed by the investigator. **(R)**

Iowa Medicaid PI Data Analytics Manager – provides quality assurance oversight of Data Analyst pulls related to the investigation. **(A)**

Iowa Medicaid PI Management – Provides direction and support as needed. **(C)**

Performance Standards:

Investigations are logged in to the case management system by the Investigator within two business days of receiving the opening approval.

Path of Business Procedure:

- Conducting a FFS provider Investigation:

1) After an investigation is approved by management (refer to desk guide Opening a Full Case Review), the Investigator creates a contact log number in OnBase (refer to the OnBase – How to Create a Contact Log Number desk guide), and logs the information into the case management system. (refer to i-Sight – Opening Audit and Provider(s) on Audit desk guide).
2) All Letters are entered and tracked in the Outgoing Tracking Log. Algorithms must be designated as such in column K of the tracking log. (refer to Desk Guide for Letter Routing)
3) As possible, documentation related to the investigation is stored electronically in a folder specific to the investigation on the P: Drive. Documentation that is not scannable/electronic will be locked in a secure location throughout the duration of the investigation and maintained according to State requirements. Related correspondence that comes in or goes out via the mail should be scanned into OnBase.
4) The Investigator will discuss the investigation progress with his/her manager during matrix meetings or when a need arises. Additional meetings with State PI or other State departments will be scheduled as needed.
5) If investigation allegations or findings warrant referral to the MFCU (refer to iSight – Referral Documentation desk guide), the investigator will discuss with management and complete the necessary forms. The MCP Oversight Specialist ensures completion of the forms and will return to the reviewer if documentation is not sufficient or is incomplete. The PI Specialist will then review to determine if there is a credible allegation of fraud. Once approved, the referral is sent to the MFCU.
6) If the referral is accepted by the MFCU, the Investigator will update the case management system to show the investigation is on hold pending completion of the MFCU review. If the MFCU does not accept the referral, or if the MFCU completes its investigation and notifies Iowa Medicaid PI that administrative action may be taken, the Investigator will remove the investigation from MFCU hold in the case management system and determine if there is any recoupment or further action needed by Iowa Medicaid PI.
7) If a referral to the MFCU is not warranted, the Investigator will consider any administrative actions that may be taken, which may include education, overpayment recoupment, referral to another entity, or a combination of multiple actions. An investigation is closed if no overpayment is identified, and all other administrative actions are exhausted. If an overpayment is identified, the investigation is reassigned to the Sr. Financial Analyst for the recoupment process, with the Investigator supporting any appeal actions.

- Conducting an MCP provider Investigation:

1) PI pulls analytics/algorithms and processes tips per their established process.
2) When MCP provider outliers are identified, a 30-claim sample is pulled and verified as accurate by the Encounter data specialist.
3) After an investigation is approved by management (refer to desk guide Opening a Full
4) Case Review), the Investigator creates a contact log number in OnBase (refer to the OnBase – How to Create a Contact Log Number desk guide) and logs the information into the case management system. (refer to i-Sight – Opening Audit and Provider(s) on Audit desk guide).
5) The Investigator will complete a Documentation Request (DR) letter to gather information from the MCP concerning the subject provider and services under investigation. (Refer to DR Template). The investigator sends DR letter through the letter routing approval process. Once approved, the letter is emailed to the MCP Oversight Specialist to forward to the MCP. The MCP has 2 weeks (14 days) from the date of the DR letter to respond with requested documentation. If requested documentation is not received within 2 weeks, for each day it is late, liquidated damages will be assessed through the managed care bureau. In addition, if documentation is incomplete, liquidated damages will be assessed until complete documentation requested has been received by Iowa Medicaid.
6) If medical records/documentation are needed for review, a request is sent to the provider and a copy emailed to the MCP Oversight Specialist to forward to the MCP.
7) Documentation related to the investigation is saved to iSight. Related correspondence that comes in or goes out via the mail shall be scanned into OnBase.
8) The Investigator will discuss the investigation progress with his/her manager during matrix meetings or when a need arises. Additional meetings with State PI or other State departments will be scheduled as needed.
9) If the record review of the probe sample reflects no significant errors, the investigator initiates a Final Audit Findings (FAF) No Recoup with or without Education letter following usual PI letter development and approval routing processes. The MCP Oversight Specialist then emails the findings to the MCP.
10) If payment errors are identified from the record review, the Investigator will send a Preliminary Provider Audit Findings (PPAF) letter to the provider, with a copy emailed to the MCP Oversight Specialist to forward to the MCP, for affirmation or dispute.
11) The provider has 15 days from the date of the PPAF letter to send a written request for a reevaluation, and a total of 30 days from the date of the letter to submit any clarifying or supplemental documentation. If the provider does not elect to request a reevaluation, no further action is needed by the provider.
12) If the MCP affirms the PPAF letter findings, and a referral to the MFCU is warranted (refer to i-Sight – Referral Documentation desk guide), the investigator will discuss with

management and complete the necessary forms. The MCP Oversight Specialist ensures completion of the forms and will return to the reviewer if documentation is not sufficient or is incomplete. The PI Specialist will then review to determine if there is a credible allegation of fraud. Once approved, the referral is sent to the MFCU.

13) If a referral is accepted by the MFCU, the Investigator will update the case management system to show the investigation is on hold pending completion of the MFCU review. If the MFCU does not accept the referral, or if the MFCU completes its investigation and notifies PI that administrative action may be taken, the Investigator will remove the investigation from MFCU hold in the case management system and determine if there is any recoupment or further action needed by PI.
14) If an overpayment was identified, a Final Audit Findings (FAF) letter will be sent to the MCP identifying the overpayment amount and requesting the MCP submit the overpayment to Iowa Medicaid, or dispute the findings, within 90 days from the date of the letter.
15) Iowa Medicaid has 60 days to review the dispute and reverse or uphold the audit findings.
16) If the findings are reversed a new FAF letter will be sent out. If the findings are upheld, the overpayment amount on the original FAF letter mut be paid within 10 days from the date of Iowa Medicaid's decision.
17) The MCP is required to adjust the affected encounter claims on final overpayment decisions. Otherwise, Iowa Medicaid may offset the amount of overpayment owed by the MCP against any payments owing to the MCP.
18) An investigation is closed if no overpayment is identified, and all other administrative actions are exhausted. If an overpayment is identified, the investigation is reassigned to the Sr. Financial Analyst for the recoupment process, with the Investigator supporting any appeal actions.

Forms/Reports:

Investigation Initiation Form (IIF)

Interfaces:

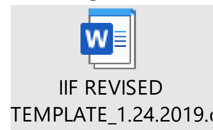
<u>FFS</u>:

State Policy
Iowa Administrative Code
Medicaid Provider Manuals
Medicaid Informational Letters
State PI & State Departments – serve as resources as needed
Medicaid Fraud Control Unit (MFCU)

MCP:
MCP Policy
MCP Provider Manuals
Iowa Administrative Code
Medicaid Informational Letters
State PI & State Departments – serve as resources as needed
Medicaid Fraud Control Unit (MFCU)

Attachments:

Investigation Initiation Form (IIF)



Desk Guides:

- Opening a Full Case Review
- Onbase – How to Create a Contact Log Number Desk Guide
- *i-Sight – Opening Audit and Provider(s) on Audit* desk guide