**ARC 6566B**

HUMAN SERVICES DEPARTMENT [441]

**Adopted and Filed**

Pursuant to the authority of Iowa Code section 249A.4, the Department of Human Services amends Chapter 7, "Appeals and Hearings," and Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," and rescinds Chapter 87, "Medicaid Provider Audits," Iowa Administrative Code.

These amendments address documentation requirements for Medicaid providers. The proposed amendments:

- Clarify documentation requirements for all Medicaid providers, including specific lists of documentation required for each type of service;
- Explain what is acceptable when making a correction to a medical record;
- Update and move rules formerly in Chapter 87 to rule 441—79.4(249A);
- Set deadlines for the submission of records in response to an audit or review request;
- Clarify the statistical sampling techniques that may be used for audits or reviews and the requirements for challenging the Department's sampling results;
- Add a reevaluation process which affords a provider that has received a preliminary overpayment finding an opportunity to submit clarifying information and supplemental documentation to justify the provider's charges; and

These amendments are intended to help providers understand what documentation is required to support charges to the Medicaid program in an effort to streamline review processes

and eliminate unnecessary appeals. Current rules on documentation are directed primarily to providers of nontraditional Medicaid services. The amendments clarify requirements for all provider groups. The Iowa Medicaid Enterprise Surveillance and Utilization Review Services Unit will attach a checklist of the documentation required by these rules to all records requests.

These amendments provide that maintenance and submission of a particular item of documentation that is normally required may be waived if the item:

- Is not routinely received or created in connection with a particular service or activity, and
- Is not required in order to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity.

Requests for the waiver of any rule may be submitted under the Department's general rule on exceptions at 441— 1.8(17A,217).

Notice of Intended Action on these amendments was published in the Iowa Administrative Bulletin on November 7, 2007, as **ARC 6391B**. The Department received comments on the Notice of Intended Action from 15 persons or organizations. In response to these comments, the Department has made the following changes to amendments published under Notice of Intended Action:

- In subparagraph 79.3(2)"c"(3), added limitations to the requirements relating to documentation of service date, time and location; medications and supplies dispensed; and the credentials of the person performing the service billed to Medicaid.
- In subparagraph 79.3(2)"d"(33), clarified that the specified authorization form is required only for services authorized before May 1, 2007, and clarified that all case management

services are addressed, including those delivered under a home-and community-based services waiver.

- Amended proposed paragraph 79.3(2)“e” to allow the person who provided the service to authorize another person to make changes in a record, to remove the requirements that the original information show on an electronic record and that the change entry indicate the reason for the change, and to allow changes to be made after billing provided that the service is rebilled if the change affects the accuracy or validity of the claim.

- In subrule 79.4(7), omitted the sentence “Documentation not received by the department pursuant to the requirements in paragraph 79.4(3)“a,” paragraph 79.4(3)“b,” or subrule 79.4(5) shall not be considered on appeal.” On an appeal of a review or audit finding, the issue is whether the finding was correct based on the information provided. Any new evidence submitted at the hearing is irrelevant to that issue, and under the current rules, administrative law judges have generally excluded such evidence on that basis.

The Council on Human Services adopted these amendments on January 9, 2008.

These amendments are intended to implement Iowa Code section 249A.4.

These amendments shall become effective on April 1, 2008.

The following amendments are adopted.

ITEM 1. Amend rule **441—7.1(17A)**, definition of “aggrieved person,” numbered paragraph **“7,”** as follows:

7. For providers, a person or entity:

- Whose license, certification, registration, approval, or accreditation has been denied or revoked or has not been acted on in a timely manner.

- Whose claim for payment ~~as a provider~~ or ~~whose~~ request for prior authorization of

payment has been denied in whole or in part and who states that the denial was not made according to department policy. Providers of Medicaid services must accept reimbursement based on the department's methodology.

- Whose contract as a Medicaid patient manager has been terminated.
- ~~That has been notified that an~~ Who has been subject to the withholding of a payment to recover a prior overpayment ~~has been established and repayment is requested.~~ or who has received an order to repay an overpayment pursuant to 441—paragraph 79.4(4)"c."
- ~~That~~ Who has been notified that the managed care reconsideration process has been exhausted and ~~that~~ who remains dissatisfied with the outcome.
- ~~Whose claim for payment was not paid according to department policy. Providers of Medicaid services must accept reimbursement based on the department's methodology without making any additional charges to the recipient.~~
- Whose application for child care quality rating has not been acted upon in a timely fashion, who disagrees with the department's quality rating decision, or whose certificate of quality rating has been revoked.

ITEM 2. Amend subrule **79.2(2)** by rescinding paragraph **"u."**

ITEM 3. Amend subrule **79.3(2)** as follows:

Amend the introductory paragraph as follows:

**79.3(2)** Medical (clinical) records. A provider of service shall maintain complete and legible medical records for each service for which a charge is made to the medical assistance program. ~~, except as provided in paragraph 79.3(2)"d."~~ Required records shall include any records required to maintain the provider's license in good standing.

Amend paragraph **"c"** as follows:

Rescind subparagraph **(1)** and adopt the following **new** subparagraph in lieu thereof:

(1) Identification. Each page or separate electronic document of the medical record shall contain the member's first and last name. In the case of electronic documents, the member's first and last name must appear on each screen when viewed electronically and on each page when printed. As part of the medical record, the medical assistance identification number and the date of birth must also be identified and associated with the member's first and last name.

Amend subparagraph **(2)** as follows:

(2) Basis for service—general rule. General requirements for all services are listed herein. For the application of these requirements to specific services, see paragraph 79.3(2)"d." The medical record shall reflect the reason for performing the service or activity, substantiate medical necessity, and demonstrate the level of care associated with the service. ~~Documentation may~~ The medical record shall include ~~one or more of~~ the ~~following, as applicable to the service being provided~~ items specified below, unless the listed item is not routinely received or created in connection with a particular service or activity and is not required to document the reason for performing the service or activity, the medical necessity of the service or activity, or the level of care associated with the service or activity:

1. The member's complaint, ~~or~~ symptoms, and diagnosis.
2. The member's medical or social history.
3. Examination findings.
4. Diagnostic test reports, laboratory test results, or X–ray reports.
5. Goals or needs identified in the member's plan of care.
6. Physician orders and any prior authorizations required for Medicaid payment.

7. Medication records, pharmacy records for prescriptions, or providers' orders.

8. Related professional consultation reports.

9. Progress or status notes for the services or activities provided.

10. All forms required by the department as a condition of payment for the services provided.

11. Any treatment plan, care plan, service plan, individual health plan, behavioral intervention plan, or individualized education program.

~~6~~ 12. The ~~observer's~~ provider's assessment, clinical impression, ~~or~~ diagnosis, or narrative, including the complete date of the observation thereof and the identity of the ~~observer~~ person performing the assessment, clinical impression, diagnosis, or narrative.

13. Any additional documentation necessary to demonstrate the medical necessity of the service provided or otherwise required for Medicaid payment.

Amend subparagraph **(3)** as follows:

(3) Service documentation. The record for each service ~~encounter~~ provided shall include information necessary to ~~support each item of~~ substantiate that the service ~~reported on the medical assistance claim form. The documentation~~ was provided and shall ~~identify~~ include the following:

1. The specific procedures or treatments performed.

2. The complete date ~~and~~ of the service, including the beginning and ending ~~time when the service was provided~~ date if the service is rendered over more than one day.

3. The complete time of the service, including the beginning and ending time if the service is billed on a time-related basis.

4. The location where the service was provided if otherwise required on the billing form or in 441—paragraph 77.30(5)"c" or "d," 441—paragraph 77.33(6)"d," 441—paragraph

77.34(5)“d,” 441—paragraph 77.37(15)“d,” 441—paragraph 77.39(13)“e,” 441—paragraph 77.39(14)“d,” or 441—paragraph 77.46(5)“i,” or 441--subparagraph 78.9(10)“a”(1).

~~4~~ 5. The name, dosage, and route of administration of any medication dispensed or administered as part of the service.

~~5~~ 6. ~~Medications or other~~ Any supplies dispensed as part of the service.

~~6~~ 7. The first and last name and ~~title~~ professional credentials, if any, of the person providing the service.

~~7~~ 8. The signature of the person providing the service, or the initials of the person providing the service if a signature log indicates the person’s identity.

9. For 24–hour care, documentation for every shift of the services provided, the member’s response to the services provided, and the person who provided the services.

Rescind paragraphs **“d”** and **“e”** and adopt the following **new** paragraphs in lieu thereof:

d. Basis for service requirements for specific services. The medical record for the following services must include, but is not limited to, the items specified below (unless the listed item is not routinely received or created in connection with the particular service or activity and is not required to document the reason for performing the service or activity, its medical necessity, or the level of care associated with it). These items will be specified on Form 470–4479, Documentation Checklist, when the Iowa Medicaid enterprise surveillance and utilization review services unit requests providers to submit records for review. (See paragraph 79.4(2)“b.”)

(1) Physician (MD and DO) services:

1. Service or office notes or narratives.

2. Procedure, laboratory, or test orders and results.

(2) Pharmacy services:

1. Prescriptions.

2. Nursing facility physician order.

3. Telephone order.

4. Pharmacy notes.

5. Prior authorization documentation.

(3) Dentist services:

1. Treatment notes.

2. Anesthesia notes and records.

3. Prescriptions.

(4) Podiatrist services:

1. Service or office notes or narratives.

2. Certifying physician statement.

3. Prescription or order form.

(5) Certified registered nurse anesthetist services:

1. Service notes or narratives.

2. Preanesthesia physical examination report.

3. Operative report.

4. Anesthesia record.

5. Prescriptions.

(6) Other advanced registered nurse practitioner services:

1. Service or office notes or narratives.

2. Procedure, laboratory, or test orders and results.

(7) Optometrist and optician services:

1. Notes or narratives supporting eye examinations, medical services, and auxiliary procedures.

2. Original prescription or updated prescriptions for corrective lenses or contact lenses.

3. Prior authorization documentation.

(8) Psychologist services:

1. Service or office psychotherapy notes or narratives.

2. Psychological examination report and notes.

(9) Clinic services:

1. Service or office notes or narratives.

2. Procedure, laboratory, or test orders and results.

3. Nurses' notes.

4. Prescriptions.

5. Medication administration records.

(10) Services provided by rural health clinics or federally qualified health centers:

1. Service or office notes or narratives.

2. Form 470–2942, Prenatal Risk Assessment.

3. Procedure, laboratory, or test orders and results.

4. Immunization records.

(11) Services provided by community mental health centers:

1. Service referral documentation.

2. Initial evaluation.

3. Individual treatment plan.

4. Service or office notes or narratives.

5. Narratives related to the peer review process and peer review activities related to a member's treatment.

6. Written plan for accessing emergency services.

(12) Screening center services:

1. Service or office notes or narratives.

2. Immunization records.

3. Laboratory reports.

4. Results of health, vision, or hearing screenings.

(13) Family planning services:

1. Service or office notes or narratives.

2. Procedure, laboratory, or test orders and results.

3. Nurses' notes.

4. Immunization records.

5. Consent forms.

6. Prescriptions.

7. Medication administration records.

(14) Maternal health center services:

1. Service or office notes or narratives.

2. Procedure, laboratory, or test orders and results.

3. Form 470–2942, Prenatal Risk Assessment.

(15) Birthing center services:

1. Service or office notes or narratives.

2. Form 470–2942, Prenatal Risk Assessment.

(16) Ambulatory surgical center services:

1. Service notes or narratives (history and physical, consultation, operative report, discharge summary).

2. Physician orders.

3. Consent forms.

4. Anesthesia records.

5. Pathology reports.

6. Laboratory and X–ray reports.

(17) Hospital services:

1. Physician orders.

2. Service notes or narratives (history and physical, consultation, operative report, discharge summary).

3. Progress or status notes.

4. Diagnostic procedures, including laboratory and X–ray reports.

5. Pathology reports.

6. Anesthesia records.

7. Medication administration records.

(18) State mental hospital services:

1. Service referral documentation.

2. Resident assessment and initial evaluation.

3. Individual comprehensive treatment plan.

4. Service notes or narratives (history and physical, therapy records, discharge summary).

5. Form 470–0042, Case Activity Report.

6. Medication administration records.

(19) Services provided by skilled nursing facilities, nursing facilities, and nursing facilities for persons with mental illness:

1. Physician orders.

2. Progress or status notes.

3. Service notes or narratives.

4. Procedure, laboratory, or test orders and results.

5. Nurses' notes.

6. Physical therapy, occupational therapy, and speech therapy notes.

7. Medication administration records.

8. Form 470–0042, Case Activity Report.

(20) Services provided by intermediate care facilities for persons with mental retardation:

1. Physician orders.

2. Progress or status notes.

3. Preliminary evaluation

4. Comprehensive functional assessment

5. Individual program plan

6. Form 470-0374, Resident Care Agreement

7. Program documentation

8. Medication administration records.

9. Nurses' notes.

10. Form 470–0042, Case Activity Report.

(21) Services provided by psychiatric medical institutions for children:

1. Physician orders or court orders.

2. Independent assessment.

3. Individual treatment plan.

4. Service notes or narratives (history and physical, therapy records, discharge summary).

5. Form 470–0042, Case Activity Report.

6. Medication administration records.

(22) Hospice services:

1. Physician certifications for hospice care.

2. Form 470–2618, Election of Medicaid Hospice Benefit.

3. Form 470–2619, Revocation of Medicaid Hospice Benefit.

4. Plan of care.

5. Physician orders.

6. Progress or status notes.

7. Service notes or narratives.

8. Medication administration records.

9. Prescriptions.

(23) Services provided by rehabilitation agencies:

1. Physician orders.

2. Initial certification, recertifications, and treatment plans.

3. Narratives from treatment sessions.

4. Treatment and daily progress or status notes and forms.

(24) Home– and community–based habilitation services:

1. Notice of decision for service authorization.

2. Service plan (initial and subsequent).

3. Service notes or narratives.

(25) Remedial services and rehabilitation services for adults with a chronic mental illness:

1. Order for services.

2. Comprehensive treatment or service plan (initial and subsequent).

3. Service notes or narratives.

(26) Services provided by area education agencies and local education agencies:

1. Service notes or narratives.

2. Individualized education program (IEP).

3. Individual health plan (IHP).

4. Behavioral intervention plan.

(27) Home health agency services:

1. Plan of care or plan of treatment.

2. Certifications and recertifications.

3. Service notes or narratives.

4. Physician orders or medical orders.

(28) Services provided by independent laboratories:

1. Laboratory reports.

2. Physician order for each laboratory test.

(29) Ambulance services:

1. Documentation on the claim or run report supporting medical necessity of the

transport.

2. Documentation supporting mileage billed.

(30) Services of lead investigation agencies:

1. Service notes or narratives.

2. Child’s lead level logs (including laboratory results).

3. Written investigation reports to family, owner of building, child’s medical provider, and local childhood lead poisoning prevention program.

4. Health education notes, including follow–up notes.

(31) Medical supplies:

1. Prescriptions.

2. Certificate of medical necessity.

3. Prior authorization documentation.

4. Medical equipment invoice or receipt.

(32) Orthopedic shoe dealer services:

1. Service notes or narratives.

2. Prescriptions.

3. Certifying physician’s statement.

(33) Case management services, including HCBS case management services:

1. Form 470–3956, MR/CMI/DD Case Management Service Authorization Request, for services authorized before May 1, 2007.

2. Notice of decision for service authorization.

3. Service notes or narratives.

4. Social history.

5. Individual treatment plan.

6. Reassessment of member needs.

(34) Early access service coordinator services:

1. Individualized family service plan (IFSP).

2. Service notes or narratives.

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

1. Notice of decision for service authorization.

2. Service plan.

3. Service logs, notes, or narratives.

4. Mileage and transportation logs.

5. Log of meal delivery.

6. Invoices or receipts.

7. Forms 470–3372, HCBS Consumer–Directed Attendant Care Agreement, and 470–4389, Consumer–Directed Attendant Care (CDAC) Service Record.

e. Corrections. A provider may correct the medical record before submitting a claim for reimbursement.

(1) Corrections must be made or authorized by the person who provided the service or by a person who has first–hand knowledge of the service.

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

(3) Any correction must indicate the person making the change and any other person

authorizing the change, must be dated and signed by the person making the change, and must be clearly connected with the original entry in the record.

(4) If a correction made after a claim has been submitted affects the accuracy or validity of the claim, an amended claim must be submitted.

ITEM 4. Rescind and reserve subrule **79.3(4)**.

ITEM 5. Rescind rule 441—79.4(249A) and adopt the following **new** rule in lieu thereof:

**441—79.4(249A) Reviews and audits.**

**79.4(1)** Definitions.

"Authorized representative," within the context of this rule, means the person appointed to carry out audit or review procedures, including assigned auditors, reviewers or agents contracted for specific audits, reviews, or audit or review procedures.

"Claim" means each record received by the department or the Iowa Medicaid enterprise that states the amount of requested payment and the service rendered by a specific and particular Medicaid provider to an eligible member.

"Clinical record" means a legible electronic or hard–copy history that documents the criteria established for medical records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a clinical record.

"Confidence level" means the statistical reliability of the sampling parameters used to estimate the proportion of payment errors (overpayment and underpayment) in the universe under review.

"Customary and prevailing fee" means a fee that is both (1) the most consistent charge by a Medicaid provider for a given service and (2) within the range of usual charges for a given service

billed by most providers with similar training and experience in the state of Iowa.

"Extrapolation" means that the total amount of overpayment or underpayment will be determined by using sample data meeting the confidence level requirement.

"Fiscal record" means a legible electronic or hard–copy history that documents the criteria established for fiscal records as set forth in rule 441—79.3(249A). A claim form or billing statement does not constitute a fiscal record.

"Overpayment" means any payment or portion of a payment made to a provider that is incorrect according to the laws and rules applicable to the Medicaid program and that results in a payment greater than that to which the provider is entitled.

"Procedure code" means the identifier that describes medical or remedial services performed or the supplies, drugs, or equipment provided.

"Random sample" means a statistically valid random sample for which the probability of selection for every item in the universe is known.

"Underpayment" means any payment or portion of a payment not made to a provider for services delivered to eligible members according to the laws and rules applicable to the Medicaid program and to which the provider is entitled.

"Universe" means all items or claims under review or audit during the period specified by the audit or review.

**79.4(2)** Audit or review of clinical and fiscal records by the department. Any Medicaid provider may be audited or reviewed at any time at the discretion of the department.

a. Authorized representatives of the department shall have the right, upon proper identification, to audit or review the clinical and fiscal records of the provider to determine whether:

(1) The department has correctly paid claims for goods or services.

(2) The provider has furnished the services to Medicaid members.

(3) The provider has retained clinical and fiscal records that substantiate claims submitted for payment.

(4) The goods or services provided were in accordance with Iowa Medicaid policy.

b. Requests for provider records by the Iowa Medicaid enterprise surveillance and utilization review services unit shall include Form 470–4479, Documentation Check–list, which is available at www.ime.state.ia.us/Providers/Forms.html, listing the specific records that must be provided for the audit or review pursuant to paragraph 79.3(2)"d" to document the basis for services or activities provided, in the following format:

Iowa Department of Human Services

Iowa Medicaid Enterprise Surveillance and Utilization Review Services

**Documentation Checklist**

Date of Request:

Reviewer Name & Phone Number:

Provider Name:

Provider Number:

Provider Type:

Please sign this form and return it with the information requested.

Follow the checklist to ensure that all documents requested for each patient have been copied and enclosed with this request. The documentation must support the validity of the claim that was paid by the Medicaid program.

**Please send copies. Do not send original records.**

If you have any questions about this request or checklist, please contact the reviewer listed above.

| | |
|---|---|
| | [specific documentation required] |

| | |
|---|---|
| | [specific documentation required] |
| | [specific documentation required] |
| | [specific documentation required] |
| | [Note: number of specific documents required varies by provider type] |
| | Any additional documentation that demonstrates the medical necessity of the service provided or otherwise required for Medicaid payment. List additional documentation below if needed. |

The person signing this form is certifying that all documentation that supports the Medicaid billed rates, units, and services is enclosed.

| Signature | Title | Telephone Number |
|---|---|---|

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c. Records generated and maintained by the department may be used by auditors or reviewers and in all proceedings of the department.

**79.4(3)** Audit or review procedures. The department will select the method of conducting an audit or review and will protect the confidential nature of the records being audited or reviewed. The provider may be required to furnish records to the department. Unless the department specifies otherwise, the provider may select the method of delivering any requested records to the department.

a. Upon a written request for records, the provider must submit all responsive records to the department or its authorized agent within 30 calendar days of the mailing date of the request, except as provided in paragraph "b."

b. Extension of time limit for submission.

(1) The department may grant an extension to the required submission date of up to 15 calendar days upon written request from the provider or the provider's designee. The request must:

1. Establish good cause for the delay in submitting the records; and

2. Be received by the department before the date the records are due to be submitted.

(2) Under exceptional circumstances, a provider may request one additional 15–calendar–day extension. The provider or the provider's designee shall submit a written request that:

1. Establishes exceptional circumstances for the delay in submitting records; and

2. Is received by the department before the expiration of the initial 15–day extension period.

(3) The department may grant a request for an extension of the time limit for submitting records at its discretion. The department shall issue a written notice of its decision.

(4) The provider may appeal the department's denial of a request to extend the time limit for submission of requested records according to the procedures in 441—Chapter 7.

c. The department may elect to conduct announced or unannounced on–site reviews or audits. Records must be provided upon request and before the end of the on–site review or audit.

(1) For an announced on–site review or audit, the department's employee or authorized agent may give as little as one day's advance notice of the review or audit and the records and supporting documentation to be reviewed.

(2) Notice is not required for unannounced on–site reviews and audits.

(3) In an on–site review or audit, the conclusion of that review or audit shall be considered the end of the period within which to produce records.

d. Audit or review procedures may include, but are not limited to, the following:

(1) Comparing clinical and fiscal records with each claim.

(2) Interviewing members who received goods or services and employees of providers.

(3) Examining third–party payment records.

(4) Comparing Medicaid charges with private–patient charges to determine that the charge to Medicaid is not more than the customary and prevailing fee.

(5) Examining all documents related to the services for which Medicaid was billed.

e. Use of statistical sampling techniques. The department's procedures for auditing or reviewing Medicaid providers may include the use of random sampling and extrapolation.

(1) A statistically valid random sample will be selected from the universe of records to be audited or reviewed. The sample size shall be selected using accepted sample size estimation methods. The confidence level of the sample size calculation shall not be less than 95 percent.

(2) Following the sample audit or review, the statistical margin of error of the sample will be computed, and a confidence interval will be determined. The estimated error rate will be extrapolated to the universe from which the sample was drawn within the computed margin of error of the sampling process.

(3) Commonly accepted statistical analysis programs may be used to estimate the sample size and calculate the confidence interval, consistent with the sampling parameters.

(4) The audit or review findings generated through statistical sampling procedures shall constitute prima facie evidence in all department proceedings regarding the number and amount of overpayments or underpayments received by the provider.

**79.4(4)** Preliminary report of audit or review findings. If the department concludes from an audit or review that an overpayment has occurred, the department will issue a preliminary finding of a tentative overpayment and inform the provider of the opportunity to request a reevaluation.

**79.4(5)** Disagreement with audit or review findings. If a provider disagrees with the preliminary finding of a tentative overpayment, the provider may request a reevaluation by the

department and may present clarifying information and supplemental documentation.

a. Reevaluation request. A request for reevaluation must be submitted in writing within 15 calendar days of the date of the notice of the preliminary finding of a tentative overpayment. The request must specify the reason or the specific issues of disagreement.

(1) If the audit or review is being performed by the Iowa Medicaid enterprise surveillance and utilization review services unit, the request should be addressed to: IME SURS Unit, P.O. Box 36390, Des Moines, Iowa 50315.

(2) If the audit or review is being performed by any other departmental entity, the request should be addressed to: Iowa Department of Human Services, Attention: Fiscal Management Division, Hoover State Office Building, 1305 E. Walnut Street, Des Moines, Iowa 50319–0114.

b. Additional information. A provider that has made a reevaluation request pursuant to paragraph "a" of this subrule may submit clarifying information or supplemental documentation that was not previously provided. This information must be received at the applicable address within 30 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider, except as provided in paragraph "c" of this subrule.

c. Disagreement with sampling results. When the department's audit or review findings have been generated through sampling and extrapolation and the provider disagrees with the findings, the burden of proof of compliance rests with the provider. The provider may present evidence to show that the sample was invalid. The evidence may include a 100 percent audit or review of the universe of provider records used by the department in the drawing of the department's sample. Any such audit or review must:

(1) Be arranged and paid for by the provider.

(2) Be conducted by an individual or organization with expertise in coding, medical

services, and Iowa Medicaid policy if the issues relate to clinical records.

(3) Be conducted by a certified public accountant if the issues relate to fiscal records.

(4) Demonstrate that bills and records that were not audited or reviewed in the department's sample are in compliance with program regulations.

(5) Be submitted to the department with all supporting documentation within 60 calendar days of the mailing of the preliminary finding of a tentative overpayment to the provider.

**79.4(6)** Finding and order for repayment. Upon completion of a requested reevaluation or upon expiration of the time to request reevaluation, the department shall issue a finding and order for repayment of any overpayment and may immediately begin withholding payments on other claims to recover any overpayment.

**79.4(7)** Appeal by provider of care. A provider may appeal the finding and order of repayment and withholding of payments pursuant to 441—Chapter 7. However, an appeal shall not stay the withholding of payments or other action to collect the overpayment.

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

ITEM 6. Rescind and reserve **441—Chapter 87**.