

**Effective 5/12/2015**

**Superseded 5/10/2016**

**63A-13-204 Selection and review of claims.**

- (1)
  - (a) The office shall periodically select and review a representative sample of claims submitted for reimbursement under the state Medicaid program to determine whether fraud, waste, or abuse occurred.
  - (b) The office shall limit its review for waste and abuse under Subsection (1)(a) to 36 months prior to the date of the inception of the investigation or 72 months if there is a credible allegation of fraud. In the event the office or the fraud unit determines that there is fraud as defined in Section 63A-13-102, then the statute of limitations defined in Subsection 26-20-15(1) shall apply.
- (2) The office may directly contact the recipient of record for a Medicaid reimbursed service to determine whether the service for which reimbursement was claimed was actually provided to the recipient of record.
- (3) The office shall:
  - (a) generate statistics from the sample described in Subsection (1) to determine the type of fraud, waste, or abuse that is most advantageous to focus on in future audits or investigations;
  - (b) ensure that the office, or any entity that contracts with the office to conduct audits:
    - (i) has on staff or contracts with a medical or dental professional who is experienced in the treatment, billing, and coding procedures used by the type of provider being audited; and
    - (ii) uses the services of the appropriate professional described in Subsection (3)(b)(i) if the provider who is the subject of the audit disputes the findings of the audit;
  - (c) ensure that a finding of overpayment or underpayment to a provider is not based on extrapolation, unless:
    - (i) there is a determination that the level of payment error involving the provider exceeds a 10% error rate:
      - (A) for a sample of claims for a particular service code; and
      - (B) over a three year period of time;
    - (ii) documented education intervention has failed to correct the level of payment error; and
    - (iii) the value of the claims for the provider, in aggregate, exceeds \$200,000 in reimbursement for a particular service code on an annual basis; and
  - (d) require that any entity with which the office contracts, for the purpose of conducting an audit of a service provider, shall be paid on a flat fee basis for identifying both overpayments and underpayments.
- (4)
  - (a) If the office, or a contractor on behalf of the department:
    - (i) intends to implement the use of extrapolation as a method of auditing claims, the department shall, prior to adopting the extrapolation method of auditing, report its intent to use extrapolation to:
      - (A) the Social Services Appropriations Subcommittee; and
      - (B) the Executive Appropriations Committee pursuant to Section 63A-13-502; and
    - (ii) determines Subsections (2)(c)(i) through (iii) are applicable to a provider, the office or the contractor may use extrapolation only for the service code associated with the findings under Subsections (2)(c)(i) through (iii).
  - (b)
    - (i) If extrapolation is used under this section, a provider may, at the provider's option, appeal the results of the audit based on:

- (A) each individual claim; or
  - (B) the extrapolation sample.
- (ii) Nothing in this section limits a provider's right to appeal the audit under Title 63G, Administrative Code, Title 63G, Chapter 4, Administrative Procedures Act, the Medicaid program and its manual or rules, or other laws or rules that may provide remedies to providers.