

## Part 2 Office and Powers

### **63A-13-201 Creation of office -- Inspector general -- Appointment -- Term.**

- (1) There is created an independent entity within the Department of Administrative Services known as the "Office of Inspector General of Medicaid Services."
- (2) The governor shall:
  - (a) appoint the inspector general of Medicaid services with the advice and consent of the Senate; and
  - (b) establish the salary for the inspector general of Medicaid services based upon a recommendation from the Department of Human Resource Management which shall be based on a market salary survey conducted by the Department of Human Resource Management.
- (3) A person appointed as the inspector general shall have the following qualifications:
  - (a) a general knowledge of the type of methodology and controls necessary to audit, investigate, and identify fraud, waste, and abuse;
  - (b) strong management skills;
  - (c) extensive knowledge of performance audit methodology;
  - (d) the ability to oversee and execute an audit; and
  - (e) strong interpersonal skills.
- (4) The inspector general of Medicaid services:
  - (a) shall serve a term of four years; and
  - (b) may be removed by the governor, for cause.
- (5) If the inspector general is removed for cause, a new inspector general shall be appointed, with the advice and consent of the Senate, to serve the remainder of the term of the inspector general of Medicaid services who was removed for cause.
- (6) The Office of Inspector General of Medicaid Services:
  - (a) is not under the supervision of, and does not take direction from, the executive director, except for administrative purposes;
  - (b) shall use the legal services of the state attorney general's office;
  - (c) shall submit a budget for the office directly to the governor;
  - (d) except as prohibited by federal law, is subject to:
    - (i) Title 51, Chapter 5, Funds Consolidation Act;
    - (ii) Title 51, Chapter 7, State Money Management Act;
    - (iii) Title 63A, Utah Administrative Services Code;
    - (iv) Title 63G, Chapter 3, Utah Administrative Rulemaking Act;
    - (v) Title 63G, Chapter 4, Administrative Procedures Act;
    - (vi) Title 63G, Chapter 6a, Utah Procurement Code;
    - (vii) Title 63J, Chapter 1, Budgetary Procedures Act;
    - (viii) Title 63J, Chapter 2, Revenue Procedures and Control Act;
    - (ix) Title 67, Chapter 19, Utah State Personnel Management Act;
    - (x) Title 67, Chapter 16, Utah Public Officers' and Employees' Ethics Act;
    - (xi) Title 52, Chapter 4, Open and Public Meetings Act;
    - (xii) Title 63G, Chapter 2, Government Records Access and Management Act; and
    - (xiii) coverage under the Risk Management Fund created under Section 63A-4-201;
  - (e) when requested, shall provide reports to the governor, the president of the Senate, or the speaker of the House; and

- (f) shall adopt administrative rules to establish policies for employees that are substantially similar to the administrative rules adopted by the Department of Human Resource Management.

Amended by Chapter 4, 2015 Special Session 1  
Renumbered and Amended by Chapter 12, 2013 General Session  
Amended by Chapter 310, 2013 General Session

**63A-13-202 Duties and powers of inspector general and office.**

- (1) The inspector general of Medicaid services shall:
  - (a) administer, direct, and manage the office;
  - (b) inspect and monitor the following in relation to the state Medicaid program:
    - (i) the use and expenditure of federal and state funds;
    - (ii) the provision of health benefits and other services;
    - (iii) implementation of, and compliance with, state and federal requirements; and
    - (iv) records and recordkeeping procedures;
  - (c) receive reports of potential fraud, waste, or abuse in the state Medicaid program;
  - (d) investigate and identify potential or actual fraud, waste, or abuse in the state Medicaid program;
  - (e) consult with the Centers for Medicaid and Medicare Services and other states to determine and implement best practices for:
    - (i) educating and communicating with health care professionals and providers about program and audit policies and procedures;
    - (ii) discovering and eliminating fraud, waste, and abuse of Medicaid funds; and
    - (iii) differentiating between honest mistakes and intentional errors, or fraud, waste, and abuse, if the office enters into settlement negotiations with the provider or health care professional;
  - (f) obtain, develop, and utilize computer algorithms to identify fraud, waste, or abuse in the state Medicaid program;
  - (g) work closely with the fraud unit to identify and recover improperly or fraudulently expended Medicaid funds;
  - (h) audit, inspect, and evaluate the functioning of the division for the purpose of making recommendations to the Legislature and the department to ensure that the state Medicaid program is managed:
    - (i) in the most efficient and cost-effective manner possible; and
    - (ii) in a manner that promotes adequate provider and health care professional participation and the provision of appropriate health benefits and services;
  - (i) regularly advise the department and the division of an action that could be taken to ensure that the state Medicaid program is managed in the most efficient and cost-effective manner possible;
  - (j) refer potential criminal conduct, relating to Medicaid funds or the state Medicaid program, to the fraud unit;
  - (k) refer potential criminal conduct, including relevant data from the controlled substance database, relating to Medicaid fraud, to law enforcement in accordance with Title 58, Chapter 37f, Controlled Substance Database Act;
  - (l) determine ways to:
    - (i) identify, prevent, and reduce fraud, waste, and abuse in the state Medicaid program; and

- (ii) balance efforts to reduce costs and avoid or minimize increased costs of the state Medicaid program with the need to encourage robust health care professional and provider participation in the state Medicaid program;
  - (m) recover improperly paid Medicaid funds;
  - (n) track recovery of Medicaid funds by the state;
  - (o) in accordance with Section 63A-13-502:
    - (i) report on the actions and findings of the inspector general; and
    - (ii) make recommendations to the Legislature and the governor;
  - (p) provide training to:
    - (i) agencies and employees on identifying potential fraud, waste, or abuse of Medicaid funds; and
    - (ii) health care professionals and providers on program and audit policies and compliance; and
  - (q) develop and implement principles and standards for the fulfillment of the duties of the inspector general, based on principles and standards used by:
    - (i) the Federal Offices of Inspector General;
    - (ii) the Association of Inspectors General; and
    - (iii) the United States Government Accountability Office.
- (2)
- (a) The office may, in fulfilling the duties under Subsection (1), conduct a performance or financial audit of:
    - (i) a state executive branch entity or a local government entity, including an entity described in Section 63A-13-301, that:
      - (A) manages or oversees a state Medicaid program; or
      - (B) manages or oversees the use or expenditure of state or federal Medicaid funds; or
    - (ii) Medicaid funds received by a person by a grant from, or under contract with, a state executive branch entity or a local government entity.
  - (b)
    - (i) The office may not, in fulfilling the duties under Subsection (1), amend the state Medicaid program or change the policies and procedures of the state Medicaid program.
    - (ii) The office shall identify conflicts between the state Medicaid plan, department administrative rules, Medicaid provider manuals, and Medicaid information bulletins and recommend that the department reconcile inconsistencies. If the department does not reconcile the inconsistencies, the office shall report the inconsistencies to the Legislature's Administrative Rules Review Committee created in Section 63G-3-501.
    - (iii) Beginning July 1, 2013, the office shall review a Medicaid provider manual and a Medicaid information bulletin in accordance with Subsection (2)(b)(ii), prior to the department making the provider manual or Medicaid information bulletin available to the public.
  - (c) Beginning July 1, 2013, the Department of Health shall submit a Medicaid provider manual and a Medicaid information bulletin to the office for the review required by Subsection (2)(b)(ii) prior to releasing the document to the public. The department and the Office of Inspector General of Medicaid Services shall enter into a memorandum of understanding regarding the timing of the review process under Subsection (2)(b)(iii).
- (3)
- (a) The office shall, in fulfilling the duties under this section to investigate, discover, and recover fraud, waste, and abuse in the Medicaid program, apply the state Medicaid plan, department administrative rules, Medicaid provider manuals, and Medicaid information bulletins in effect at the time the medical services were provided.

- (b) A health care provider may rely on the policy interpretation included in a current Medicaid provider manual or a current Medicaid information bulletin that is available to the public.
- (4) The inspector general of Medicaid services, or a designee of the inspector general of Medicaid services within the office, may take a sworn statement or administer an oath.

Renumbered and Amended by Chapter 12, 2013 General Session  
Amended by Chapter 359, 2013 General Session

**63A-13-203 Memorandum of understanding with fraud unit.**

- The inspector general shall enter into a memorandum of understanding with the fraud unit to:
- (1) formalize communication, cooperation, coordination of efforts, and the sharing of information, on a regular basis, between the office and the fraud unit;
  - (2) provide for reporting criminal activity discovered by the office to the fraud unit;
  - (3) ensure that investigations and other actions by the office and the fraud unit do not conflict; and
  - (4) provide for the sharing and classification of records between the office and the fraud unit under the Government Records Access and Management Act.

Renumbered and Amended by Chapter 12, 2013 General Session

**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 that 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:
      - (A) to the Social Services Appropriations Subcommittee; and
      - (B) as required under Section 63A-13-502; and
    - (ii) determines Subsections (3)(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 (3)(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, Chapter 4, Administrative Procedures Act, the Medicaid program and its manual or rules, or other laws or rules that may provide remedies to providers.

Amended by Chapter 222, 2016 General Session

Amended by Chapter 348, 2016 General Session

**63A-13-205 Placement of hold on claims for reimbursement -- Injunction.**

- (1) The inspector general or the inspector general's designee may, without prior notice, order a hold on the payment of a claim for reimbursement submitted by a claimant if there is reasonable cause to believe that the claim, or payment of the claim, constitutes fraud, waste, or abuse, or is otherwise inaccurate.
- (2) The office shall, within seven days after the day on which a hold described in Subsection (1) is ordered, notify the claimant that the hold has been placed.
- (3) The inspector general or the inspector general's designee may not maintain a hold longer than is necessary to determine whether the claim, or payment of the claim, constitutes fraud, waste, or abuse, or is otherwise inaccurate.
- (4) A claimant may, at any time during which a hold is in place, appeal the hold under Title 63G, Chapter 4, Administrative Procedures Act.
- (5) If a claim is approved or denied before a hearing is held under Title 63G, Chapter 4, Administrative Procedures Act, the appeal shall be dismissed as moot.
- (6) The inspector general may request that the attorney general's office seek an injunction to prevent a person from disposing of an asset that is potentially subject to recovery by the state to recover funds due to a person's fraud or abuse.
- (7) The department and the division shall fully comply with a hold ordered under this section.

Renumbered and Amended by Chapter 12, 2013 General Session

