section;

(b) ensure that the office, or any entity that contracts with the office to conduct audits, has on staff a medical or dental professional who is experienced in the treatment, billing, and coding procedures used by the type of provider being audited;

(c) ensure that a finding of overpayment or underpayment to a provider is not based on extrapolation, unless:

(i) there is a determination of sustained or high level of payment error involving the provider;

(ii) documented education intervention has failed to correct the level of payment error;

Ŝ→ [~~or~~] and ←Ŝ

(iii) the value of the claims for the provider, in aggregate, exceeds $200,000 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.

Section 5. Section **63A-13-102** is amended to read:

63A-13-102. Definitions.

As used in this chapter:

(1) "Abuse" means:

(a) an action or practice that:

(i) is inconsistent with sound fiscal, business, or medical practices; and

(ii) results, or may result, in unnecessary Medicaid related costs; or

(b) reckless or negligent upcoding.

(2) "Claimant" means a person that:

(a) provides a service; and

(b) submits a claim for Medicaid reimbursement for the service.

(3) "Department" means the Department of Health, created in Section 26-1-4.

(4) "Division" means the Division of Health Care Financing, created in Section 26-18-2.1.

(5) "Extrapolation" means a method of using a mathematical formula that takes the audit results from a small sample of Medicaid claims and projects those results over a much

Ŝ→ [~~or~~] and ←Ŝ

(iii) the value of the claims for the provider, in aggregate, exceeds $200,000 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.

Section 7. Section **63A-13-502** is amended to read:

63A-13-502. Report and recommendations to governor and Executive Appropriations Committee.

(1) The inspector general of Medicaid services shall, on an annual basis, prepare a written report on the activities of the office for the preceding fiscal year.

(2) The report shall include:

(a) non-identifying information, including statistical information, on:

(i) the items described in Subsection 63A-13-202(1)(b) and [~~Section 63A-13-204~~] Subsections 63A-13-204(1) through (3)(a);

(ii) action taken by the office and the result of that action;

(iii) fraud, waste, and abuse in the state Medicaid program;

(iv) the recovery of fraudulent or improper use of state and federal Medicaid funds;

(v) measures taken by the state to discover and reduce fraud, waste, and abuse in the state Medicaid program;

(vi) audits conducted by the office;

(vii) investigations conducted by the office and the results of those investigations; and

(viii) administrative and educational efforts made by the office and the division to improve compliance with Medicaid program policies and requirements;

(b) recommendations on action that should be taken by the Legislature or the governor to:

(i) improve the discovery and reduction of fraud, waste, and abuse in the state Medicaid program;

(ii) improve the recovery of fraudulently or improperly used Medicaid funds; and

(iii) reduce costs and avoid or minimize increased costs in the state Medicaid program;

(c) recommendations relating to rules, policies, or procedures of a state or local