

Effective 5/12/2015

26-18-20 Review of claims -- Audit and investigation procedures.

- (1)
 - (a) The department shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and in consultation with providers and health care professionals subject to audit and investigation under the state Medicaid program, to establish procedures for audits and investigations that are fair and consistent with the duties of the department as the single state agency responsible for the administration of the Medicaid program under Section 26-18-3 and Title XIX of the Social Security Act.
 - (b) If the providers and health care professionals do not agree with the rules proposed or adopted by the department under Subsection (1)(a), the providers or health care professionals may:
 - (i) request a hearing for the proposed administrative rule or seek any other remedies under the provisions of Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and
 - (ii) request a review of the rule by the Legislature's Administrative Rules Review Committee created in Section 63G-3-501.
- (2) The department shall:
 - (a) notify and educate providers and health care professionals subject to audit and investigation under the Medicaid program of the providers' and health care professionals' responsibilities and rights under the administrative rules adopted by the department under the provisions of this section;
 - (b) ensure that the department, or any entity that contracts with the department 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, as defined in Section 63A-13-102, 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.
- (3)
 - (a) If the department, 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 the Social Services Appropriations Subcommittee; and
 - (ii) determines Subsections (2)(c)(i) through (iii) are applicable to a provider, the department 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, General Government, 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.

Enacted by Chapter 135, 2015 General Session