§ 108C-5. Payment suspension and audits utilizing extrapolation.

(a) The Department may suspend payments to a provider in accordance with the requirements and procedures set forth in 42 C.F.R. § 455.23.

(b) **(Effective until contingency met – see note)** In addition to the procedures for suspending payment set forth at 42 C.F.R. § 455.23, the Department may also suspend payment to any provider that (i) owes a final overpayment, assessment, or fine to the Department and has not entered into an approved payment plan with the Department or (ii) has had its participation in the Medicaid or Health Choice programs suspended or terminated by the Department. For purposes of this section, a suspension or termination of participation does not become final until all administrative appeal rights have been exhausted and shall not include any agency decision that is being contested at the Department or the Office of Administrative Hearings or in Superior Court provided that the Superior Court has entered a stay pursuant to the provisions of G.S. 150B-48.

(b) **(Effective once contingency met – see note)** In addition to the procedures for suspending payment set forth at 42 C.F.R. § 455.23, the Department may also suspend payment to any provider that (i) owes a final overpayment, assessment, or fine to the Department and has not entered into an approved payment plan with the Department or (ii) has had its participation in the Medicaid program or former NC Health Choice program suspended or terminated by the Department. For purposes of this section, a suspension or termination of participation does not become final until all administrative appeal rights have been exhausted and shall not include any agency decision that is being contested at the Department or the Office of Administrative Hearings or in Superior Court provided that the Superior Court has entered a stay pursuant to the provisions of G.S. 150B-48.

(c) For providers who owe a final overpayment, assessment, or fine to the Department, the payment suspension shall begin the thirty-first day after the overpayment, assessment, or fine becomes final. The payment suspension shall not exceed the amount owed to the Department, including any applicable penalty and interest charges.

(d) **(Effective until contingency met – see note)** Providers whose participation in the Medicaid or Health Choice programs has been suspended or terminated shall have all payments suspended beginning on the thirty-first day after the suspension or termination becomes final.

(d) **(Effective once contingency met – see note)** Providers whose participation in the Medicaid program or former NC Health Choice program has been suspended or terminated shall have all payments suspended beginning on the thirty-first day after the suspension or termination becomes final.

(e) The Department shall consult with the N.C. Departments of Treasury and Revenue and other State departments and agencies to determine if a provider owes debts or fines to the State. The Department may collect any of these debts owed to the State subsequent to consideration by the Department of the financial impact upon the provider and the impact upon access to the services provided by the provider.

(f) When issuing payment suspensions in accordance with this Chapter, the Department may suspend payment to all providers which share the same IRS Employee Identification Number or corporate parent as the provider or provider site location which owes the final overpayment, assessment, or fine. The Department shall give 30 days advance written notice to all providers which share the same IRS Employee Identification Number or corporate parent as the provider or provider site location of the intention of the Department to implement a payment suspension.

(g) The Department is authorized to approve a payment plan for a provider to pay a final overpayment, assessment, or fine including interest and any penalty. The payment plan can include a term of up to 24 months. The Department shall establish in rule the conditions of such

provider payment plans. Nothing in this subsection shall prevent the provider and the Department from mutually agreeing to modifications of a payment plan.

(h) All payments suspended in accordance with this Chapter shall be applied toward any final overpayment, assessment, or fine owed to the Department.

(i) Prior to extrapolating the results of any audits, the Department shall demonstrate and inform the provider that (i) the provider failed to substantially comply with the requirements of State or federal law or regulation or (ii) the Department has a credible allegation of fraud concerning the provider. Nothing in the subsection shall be construed to prohibit the Department from identifying the extrapolated overpayment amount in the same notice that meets the requirements of this subsection.

(j) Audits that result in the extrapolation of results must be performed and reviewed by individuals who shall be credentialed by the Department, as applicable, in the matters to be audited, including, but not limited to, coding or specific clinical issues.

(k) The Department, prior to conducting audits that result in the extrapolation of results shall identify to the provider the matters to be reviewed and specifically list the clinical, including, but not limited to, assessment of medical necessity, coding, authorization, or other matters reviewed and the time periods reviewed.

(*l*) For those matters and time periods identified in subsection (k) of this section, the provider shall not be subject to further audits by the Department, unless the Department receives a credible allegation of fraud concerning the same time period or the federal government initiates action based on allegations of fraud or other illegal activity for the same time period.

(m) The Department may specify in rules the means by which a provider may conduct voluntary self-audits upon matters subject to audit by the Department. The Department has the authority to review the self-audit for compliance with requirements of State or federal law and regulation and may reject any self-audit conducted by a provider found not in compliance. Upon the provider's payment or payment agreement for any final overpayment, assessment, or fine arising from the provider's self-audit, the provider shall not be subject to further audits by the Department of the matters and time periods subject to the provider's self-audit, except where the Department has received a credible allegation of fraud or the federal government initiates action based on allegations of fraud or other illegal activity for the same time period.

(n) The results of audits that result in the extrapolation of results may be challenged by a provider within the limited or moderate risk categories, pursuant to G.S. 108C-3.

(1) The provider shall notify the Department within 15 days of receipt of the tentative audit results of the provider's challenge of the Department's results under this subsection. The provider's notification shall select the means of challenging the error rate found by the Department.

(2) The provider may challenge the error rate found by the Department by doing one of the following:

a. Conducting a one hundred percent (100%) file review of those matters and time periods identified in subsection (k) of this section and providing the results to the Department within 60 days from the date of the receipt of the Department's notice of tentative audit results.

b. Conducting a second audit upon a sample identified and produced by the Department utilizing the same statistical and sampling methodology to produce a sample twice the size of the original sample to review those matters and time periods identified in subsection (k) of this section. The Department shall provide a new sample to the provider within 30 days from the date of receipt of a provider's request. The provider shall have 60 days from receipt of the new sample to conduct the audit and provide the results to the Department.

(3) The results of an audit conducted by the provider pursuant to this subsection shall be binding upon the provider. The Department has the authority to review the provider's audit for compliance with the requirements of State and federal law and regulation and may reject any audit conducted by a provider pursuant to this subsection found not in compliance.

(4) Nothing in this subsection shall limit a provider from challenging the accuracy of the Department's audit, the statistical methodology of the Department's original sample, or the credentials of the individuals who performed and reviewed the audit.

(o) The Department shall permit limited correction of clerical, typographical, scrivener's, and computer errors by the provider prior to final determination of any audit.

(p) The provider shall have no less than 30 days from the date of the receipt of the Department's notice of tentative audit results to provide additional documentation not provided to the Department during any audit.

(q) Except as required by federal agency, law, or regulation, or instances of credible allegation of fraud, the provider shall be subject to audits which result in the extrapolation of results for a time period of up to 36 months from date of payment of a provider's claim.

(r) At least annually, the Department shall publish notice of the intention to use audits that result in the extrapolation of results upon its Web site. Such notice shall include the services, provider types, audit elements, and the time periods subject to audit.

(s) Nothing in this Chapter shall be construed to prevent the Department from conducting unannounced or targeted audits of providers.

(t) Nothing in this Chapter shall be construed to prohibit the Department from utilizing a contractor to send notices to providers on behalf of the Department. (2011-399, s. 1; 2014-100, s. 12H.26(a), (b); 2022-74, s. 9D.15(m).)