HOUSE OF REPRESENTATIVES - FLOOR VERSION

STATE OF OKLAHOMA

2nd Session of the 60th Legislature (2026)

HOUSE BILL 3342 By: Williams of the House

and

Woods of the Senate

AS INTRODUCED

An Act relating to Medicaid audits; creating the Oklahoma Medicaid Audit Bill of Rights Act; defining terms; providing certain protections for health care providers; providing for advance notice; providing for specialty appropriate audit; limiting scope of audits; directing for no allowance of extrapolation; providing for appeals process; providing for noncodification; providing for codification; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law not to be codified in the Oklahoma Statutes reads as follows:

This act shall be known and may be cited as the "Oklahoma Medicaid Audit Bill of Rights Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5029.10 of Title 63, unless there is created a duplication in numbering, reads as follows:

As used in this act:

1. "Audit" means an investigation or review of a claim submitted by a health care provider if the investigation or review:

a. is conducted by an auditor, and

b. involves records, documents, or information other than the filed claim;

2. "Auditor" means

a. an insurance company,

b. a third-party payor,

c. the Oklahoma Health Care Authority, or

d. an entity that represents a responsible party, including a company or group that administers claims services;

3. "Clerical or recordkeeping error" means a mistake in the filed claim regarding a required document or record, including, but not limited to:

a. a typographical error,

b. a scrivener's error, or

c. a computer error; and

4. "Health care provider" means a person who is licensed, certified, or otherwise authorized by the laws of this state to administer health care services to Medicaid patients.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5029.11 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. Notwithstanding any other law, when an audit is conducted by an auditor, the audit shall be conducted according to the following bill of rights:

1. An auditor conducting the initial audit shall give the health care provider notice of the audit at least one (1) week before conducting the initial audit for each audit cycle;

2. An audit that involves the application of clinical or professional judgment shall be conducted by or in consultation with a health care provider of the same specialty as the health care provider being audited;

3. A clerical or recordkeeping error shall not:

a. constitute fraud, or

b. be subject to criminal penalties without proof of intent to commit fraud.

A claim arising pursuant to paragraph 3 of this subsection may be subject to recoupment;

4. A finding of an overpayment or underpayment of a filed claim may be a projection based on the number of patients served by the health care provider having a similar diagnosis.

Recoupment of claims pursuant to this paragraph shall be based on the actual overpayment unless the projection for overpayment or underpayment is part of a settlement by the health care provider;

5. When an audit is for a specifically identified problem that has been disclosed to the health care provider, the audit shall be limited to a claim that is identified by a claim number;

6. For an audit other than that described in paragraph 5 of this subsection, the audit shall be limited to the greater of:

a. fifty claims, or

b. twenty-five one-hundredths of one percent (0.25%) of the number of claims billed by the health care provider to the auditor in the previous calendar year;

7. If an audit reveals the necessity for a review of additional claims, the audit shall be conducted by one of the following methods at the discretion of the health care provider:

a. on-site,

b. electronically, or

c. by the same method as the initial audit;

8. Except for an audit initiated pursuant to paragraph 5 of this subsection, an auditor shall not initiate an audit of a health care provider more than two times in a calendar year;

9. A recoupment shall not be based on:

a. documentation requirements in addition to the requirements for creating or maintaining documentation

prescribed by state law, rule, federal law or regulation, or

b. a requirement that a health care provider perform professional duties prescribed by state law, rule, federal law, or regulation;

10. Recoupment shall only occur following the correction of a claim and shall be limited to amounts paid in excess of amounts payable under the corrected claim.

An auditor may recoup the entire overpaid claim if payment is issued for the corrected claim on the same date.

Following a notice of overpayment, a health care provider shall have at least sixty (60) days to file a corrected claim;

11. Approval of a health care service, health care provider, or patient eligibility upon adjudication of a claim shall not be reversed unless the health care provider obtained the adjudication by fraud or misrepresentation of claim elements;

12. Each health care provider shall be audited under the same standards and parameters as other similarly situated health care providers audited by the auditor;

13. A health care provider shall be allowed at least sixty (60) days following receipt of the preliminary audit report in which to produce documentation to address any discrepancy found during the audit;

14. The period covered by an audit shall not exceed twenty-four (24) months from the date the claim was submitted to or adjudicated by an auditor;

15. The preliminary audit report pursuant to paragraph 13 of this subsection shall be delivered to a health care provider within one hundred twenty (120) days after the conclusion of the audit.

A final audit report shall be delivered to the health care provider within six (6) months after the receipt of the preliminary audit report or receipt of the final appeal as provided for in this subsection, whichever is later; and

16. Notwithstanding any other provision in this section, the auditor conducting the audit shall not use the accounting practice of extrapolation in calculating recoupments or penalties for audits.

B. A recoupment of any disputed funds shall only occur after final internal disposition of the audit, including the appeals process as described in subsection C of this section.

C. 1. An auditor that conducts an audit shall:

a. establish an appeals process under which a health care provider may appeal an unfavorable preliminary audit report to the auditor, and

b. provide a copy of the final audit report to the health benefit plan sponsor after the completion of any review process.

2. If following the appeal pursuant to subparagraph a of paragraph 1 of this subsection the auditor finds that an unfavorable audit report or any portion of the unfavorable audit report is unsubstantiated, the auditor shall dismiss the audit report or the unsubstantiated portion of the audit report without any further proceedings.

D. The total amount of any recoupment on an audit shall be refunded to the party responsible for payment of the claim.

SECTION 4. This act shall become effective November 1, 2026.

COMMITTEE REPORT BY: COMMITTEE ON HEALTH AND HUMAN SERVICES OVERSIGHT, dated 02/25/2026 - DO PASS, As Coauthored.