Washington State Health Care Authority

# Frequently asked questions (FAQ)

## What types of program integrity activities are conducted by the HCA?

- Desk audits and reviews
- Onsite audits
- Data mining
- Algorithms
- Site visits

## What type of federally mandated program integrity audits or reviews can a provider expect?

- CMS Medicaid Integrity Contractor (MIC) audits
- CMS Payment Error Rate Measurement (PERM) audits
- Health & Human Services (HHS) Office of Inspector General (OIG) audits
- Medicaid Recovery Audit Contractor (RAC) audits

## What is the HCA's authority to conduct program integrity activities of Washington Apple Health providers and recover improper payments?

Visit related laws and rules.

## How will providers know if they are being audited or reviewed by the HCA?

- Providers will typically receive written notification by certified mail from the Section of Program Integrity (PI).
- Providers may receive an overpayment notice if an algorithm or data review identifies overpayments.
- As authorized by WAC 182-502A, unannounced visits may occur.

## What methods are used to select claims for program integrity activities?

- Algorithms
- 100 percent review of a provider's claims for a specific period
- Random stratified or non-stratified sample of claims for a specific time period
- Criteria-driven selection of specific claims for a specific time period

## What types of records and information will the HCA request during an audit or review?

Providers must retain documentation that supports the services billed to the HCA. PI may request the following types of information and records; please note that this is not an all-inclusive listing:

- Appointment books/patient sign-in sheets.
- Coding summary.
- Complete hospital medical records.
- Core Provider Agreement.
- Credit balance reports.
- Dental x-ray films.
- Diagnostic test results (e.g. lab reports, radiology/nuclear medicine reports, etc.).
- Durable & non-durable medical equipment/product delivery documents.
- Financial reports/accounting/billing records, charge masters, service level descriptions.
- Invoices.
- Medication administration records/sheets.
- Office/facility policies/employment records.
- Office visit/hospital visit notes.
- Ownership agreement/business licenses and professional staff licenses/certificates.
- Patient care plans.
- Physician/practitioner orders.
- Prescription records.

- Proof of delivery documents.
- Surgical, recovery and anesthesia records.
- Transfer records/referral documents.
- Treatment records.

### How long must a provider keep records for a program integrity activity?

Providers must maintain appropriate documentation in the client's medical or health care service records for 6 years.

Please see WAC 182-502-0020.

### Will original records be removed from a provider's office / facility?

Audit staff will either make copies or request copies be made of original provider records and/or information.

### Are provider reimbursed for costs incurred during an audit?

No, WAC 182-502A-0401(11) states, "The agency does not reimburse the costs an entity incurs complying with program integrity activities.

### How does a provider prepare for an onsite audit?

- Provide a workspace or room, with table and chairs and adequate electrical outlets for audit equipment.
- Have key office staff available during the audit for the audit team to interview.
- If medical records are requested in advance, please have records in alphabetical order placed in the designated workspace for the auditors.
- Have copies of current business license(s) and professional healthcare licenses of all pertinent staff available for the auditors.

### How much time does a provider have to dispute or appeal program integrity activity findings?

- A provider may informally dispute a draft audit report or preliminary review notice within 30 days from receipt of the report or notice. See WAC 182-502A-0801.
- A provider may request an administrative hearing to formally appeal a final audit report or notice of improper payment within 28 days from receipt of the report or notice. See WAC 182-502A-0901 and RCW 41.05A.170.
- A provider may informally dispute and formally appeal an algorithm overpayment notice. To formally appeal, a provider must request an administrative hearing within 28 days from receipt of overpayment notice. There is not a separate time period to submit an informal dispute. Therefore it must also be received within 28 days of receipt of an algorithm overpayment notice. See WAC 182-502-0230 and RCW 41.05A.170.

### Can an extension be requested for a dispute or an appeal?

- When an audit or review is in the draft or preliminary state, a provider may contact the auditor to request an extension.
- If the provider has received a final audit report, notice of improper payment or overpayment notice, no extension is allowed. See RCW 41.05A.170.

### Who might receive a copy of the audit / review report?

- Department of Social and Health Services (DSHS) Office of Financial Recovery
- Department of Health
- Attorney General's Office
- Medicaid Fraud Control Unit
- Other stakeholders as appropriate
- WAC 182-502A-0701 allows referral for disciplinary or criminal action if warranted