

Annual Medicaid Provider Audit Training 2025

Understanding Your Rights & Responsibilities During Medicaid Audits

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Disclaimer

The information provided in this educational intervention is not intended to serve as an exhaustive or detailed account of all legal requirements pertinent to compliance with Medicaid program integrity laws and regulations. The Health Care Authority (HCA) encourages all providers and entities to consult with their legal counsel, Board of Directors, or other business advisors regarding compliance with Medicaid laws and regulations.

Learning Objectives

- ▶ Understand audit procedures under RCW 74.09.195
- ▶ Know your rights as a Medicaid provider
- ▶ Learn how to respond to audit findings
- ▶ Types of Provider Audits
- ▶ Common audit findings
- ▶ Case study overview
- ▶ Areas of risk
- ▶ Access support and resources



What is RCW 74.09.195

- ▶ A Washington State law that governs Medicaid provider audits.
- ▶ Ensures fair notice, due process, and transparency.
- ▶ Applies to all providers serving Medicaid clients.



Audit Notification Requirements

- ▶ You will receive at least 30 calendar days' notice before an audit.
 - ▶ Exceptions: Suspected fraud or urgent public health risk.
- ▶ You must submit records electronically (CD, DVD, Secure File Transfer, etc.).



Audit Sampling

- ▶ HCA must make reasonable effort to avoid duplicate review of the same claims.
- ▶ Extrapolation (estimating overpayments from a sample) can be used to assess overpayments when:
 - ▶ There's a sustained high error rate, or
 - ▶ There's been prior educational intervention, and
 - ▶ The sample meets a 95% confidence level
- ▶ Focused Audit
 - ▶ Claims or transactions are selected based on certain criteria or risk factors.
 - ▶ Example: Unusual frequency of specific procedure codes, unbundling, upcoding, high volume of services compared to peers, excessive units, overlapping services, services flagged by CMS or agency partners, etc.



Audit Findings & Appeals

- ▶ You'll receive a written explanation of any adverse findings, which includes:
 - ▶ Specific audit results
 - ▶ Your appeal rights
 - ▶ Instructions for corrections or adjustments
 - ▶ **No repayment is required until all appeals are resolved**



Audit Timelines

- ▶ Preliminary audit reports must be issued within 120 days of receiving **all requested** records.
 - ▶ WAC 182-502-0020: Providers must maintain complete, legible, and accurate records for at least six years from the date of service, or longer if required by law or contract.
 - ▶ You may request an informal dispute resolution conference.
- ▶ After final findings are established and a Notice of Final Findings (or Notice of Improper Payment) is issued, you have 28 days to request a formal appeal.
- ▶ Timely reporting helps ensure closure and accountability.

Repayment Options

- ▶ You may request a repayment plan of up to 12 months.
- ▶ Plans must be documented and offered proactively.

Note: Refund via electronic transfer, such as ACH or wire transfer, is not generally accepted unless approved by HCA.

Types of Audits Performed in CY 2025

- ▶ Inpatient Hospital Services
- ▶ Outpatient Services
- ▶ Dental Services
- ▶ Provider Self-Audits (Detailed information on next slides)
 - ▶ HCA initiated
 - ▶ Provider initiated



Self-Audit Process

Provider self audits fall under the purview of WAC 182-502A-0501 Entity self audits.

Agency Initiated Provider Self Audits

- ▶ Section (1)(a) – (e)(ii) describes a provider self audit that is *initiated by the agency*.
- ▶ These are typically data driven audits that reveal a billing pattern that is prohibited by WAC or HCA's Provider Billing Instructions.
- ▶ In these instances, the agency notifies the provider with a letter describing the issue and data identifying the claims that appear to be problematic. The agency directs the provider to review the claims. Documentation is required for reversal of any of the claims to be considered.

Provider Initiated Self Audits

- ▶ Section (2)(a) – (e) describes a provider self audit that is *initiated by the provider*.
- ▶ Providers are required to self-disclose overpayments within 60 calendar days of discovery unless it is included in a program integrity activity or related to some sort of payment adjustment. The provider is required to provide the reason for the overpayment, how the overpayment was calculated and a list of claims that make up the overpayment. Key elements to include are provider number(s), claim number (TCN), client ID, client name, client DOB, procedure or revenue code, date of service, amount paid and the amount of the refund.
- ▶ Please indicate if these are fee-for-service or managed care claims. We can help process provider self audits for fee-for-service claims but an overpayment for MCO claims needs to be referred to the MCO.



Self-Audit Process (continued)

Need help to validate an overpayment?

We can provide a detailed claims report.

To get started, we'll need a few basic parameters to refine the report. At a minimum, please provide:

- 1) Dates of service
- 2) Provider's ID number (ProviderOne ID, NPI, etc.)

Additional details such as TCN (claim number) are always helpful and can enhance the report. We'll furnish the report in an Excel spreadsheet format, allowing you to easily sort, filter, and search the data according to your needs.



Self-Audit Process (continued)



Please do not submit a refund check without supporting documentation or details.

The goal for all is accurate payment. Thank you for partnering with HCA in this endeavor!

Common Audit Findings

- ▶ Inpatient Hospital
 - ▶ 14-day readmissions
 - ▶ Long LOS: admin days
 - ▶ Incorrect coding assignment
- ▶ Insufficient documentation
- ▶ Services not supported with submitted records
- ▶ Services exceeding limits
- ▶ Duplicate payment

Case Study – Example 1

(Focused audit)

Inpatient Hospital: 14-Day Readmissions Review

Index Admission: Patient #1 admitted to Hospital A on December 31st with chest pain. The patient was diagnosed with NSTEMI and underwent percutaneous coronary intervention (PCI) with stenting. Patient #1 reported some shortness of breath while walking to the bathroom, but ultimately discharged on the same day, January 4th.

Case Study – Example 1 (continued)

Inpatient Hospital: 14-Day Readmissions Review

Subsequent Admission: Patient #1 was readmitted to the same hospital, Hospital A, one day after hospital discharge, on January 5th. The patient presented with chest discomfort, dyspnea with exertion, worsening orthopnea, and generalized malaise. Patient #1 did not require revascularization nor a candidate for SNF placement. The patient discharged home after a 9-day admission.

Case Study – Example 1 (continued)

Inpatient Hospital: 14-Day Readmissions Review

Clinical Determination and Findings: Hospital A is a prospective payment hospital and reimbursed by the DRG payment methodology. Based on retrospective review of Hospital A's records, it was determined that both admissions were clinically related, the same episode of care, and the patient was discharged prematurely. The subsequent admission (Claim #2) was denied reimbursement and payment was recouped.

Case Study – Example 1 (continued)

Inpatient Hospital: 14-Day Readmissions Review

Citation Authority:

- ▶ WAC 182-550-1050 Hospital services definitions. "Hospital readmission"
- ▶ WAC 182-550-2900 Payment limits—Inpatient hospital services. (2)(f) and (g)
- ▶ WAC 182-550-3000 Payment method. (f) and (g)

Case Study – Example 1 (continued)

Inpatient Hospital: 14-Day Readmissions Review

Provider Dispute:

Generally centered around WAC 182-550-2950, Provider preventable fourteen-day readmissions.

Clarification:

WAC 182-550-2900 sets the general payment limits for inpatient hospital services, including the rule that readmissions within 14 days may not qualify for separate payment. WAC 182-550-2950 is a specialized provision that applies only to provider preventable 14-day readmissions. Both sections are complementary and -2950 does not supersede -2900. Payments can be denied under -2900, even if the admission was not preventable, if medical records clearly supports that both admissions were the same episode of care and not medically distinct.

Case Study – Example 2

(Agency initiated provider self-audit)

Dental Services: Exceeding service limits

Medicaid claims data identified that Provider D submitted and received payment for topical fluoride varnish (CDT D1206) twice within a four-day period. Claims data in ProviderOne show the service was reported for the same client at the same clinic on February 14 and again on February 18.

Case Study – Example 2 (continued)

Dental Services: Exceeding service limits

- ▶ The claims data findings prompted an agency-initiated provider self-audit.
- ▶ Provider D acknowledged the issue as a valid finding.
- ▶ Determination was made in accordance with:
 - ▶ WAC 182-535-1082(2)(c) - Covered—Preventive services.
 - ▶ HCA's Dental-Related Services Program Billing Guide

2026 Areas of Risk and Potential Focus

- ▶ Personal Care Services (PCS) – PCS is consistently flagged as high risk because services are often delivered in home settings with limited oversight.
- ▶ Non-Emergency Medical Transportation (NEMT) – Program Integrity partners, including CMS, highlight NEMT as a recurring area of abuse, including billing for rides not provided or inflating mileage.
- ▶ Behavioral Health Services – Rapid growth in behavioral health claims, especially telehealth, has created vulnerabilities.
- ▶ Pharmacy and Prescription Drugs – OIG and HFPP highlight diversion, overprescribing, and billing for drugs not dispensed. Specialty and high-cost drugs are particularly vulnerable.
- ▶ Dental Services – Overutilization of radiographs, unnecessary comprehensive exams, and billing for complex extractions.
- ▶ Expedited Prior Authorizations (EPAs) – Self-generated EPA numbers bypass manual review. Risk arises when providers misuse EPA codes without meeting criteria, leading to inappropriate billing for Medicaid covered services.



What to Expect in 2026

- ▶ HCA has contracted with Health Management Systems (HMS) as the Recovery Audit Contractor (RAC).
- ▶ Future audits will be conducted by:
 - ▶ HCA staff
 - ▶ RAC contractor (HMS)
 - ▶ UPIC contractor (Qlarent, under CMS authority)

Note: If you have concerns about the legitimacy of contractor audits, contact HCA directly for clarification.

Support & Resources



Contact Information

Fax: 360-586-0212

Email: ProgramIntegrity@hca.wa.gov



**To report fraud,
waste, or abuse:**

Phone: 360-725-1750

HotTips@hca.wa.gov

- ▶ [HCA's Program Integrity webpage](#)
- ▶ [Chapter 182-502A WAC: HCA Program Integrity regulations](#)
- ▶ Chapter 74.66 RCW: Washington State Medicaid Fraud False Claims Act
- ▶ 31 USC Sections 3729 – 3722: Federal False Claims Act
- ▶ 31 USC Sections 3801 et seq: Administrative Remedies for False Claims and Statements