

# Chapter 182-502A WAC

## PROVIDER AUDITS AND APPEALS

### WAC

182-502A-0100	Purpose.
182-502A-0200	Definitions.
182-502A-0300	Authority to audit.
182-502A-0400	Audit objectives.
182-502A-0500	Audit methods and locations.
182-502A-0600	Notification of on-site audits.
182-502A-0700	Audit overview.
182-502A-0800	Auditing process.
182-502A-0900	Audit sampling, extrapolation, and claim-by-claim review.
182-502A-1000	Provider audit—Draft report.
182-502A-1100	Provider audit—Dispute process.
182-502A-1200	Provider audit—Final report/appeal.
182-502A-1300	Audit outcomes.

### WAC 182-502A-0100 Purpose.

(1) This chapter:  
(a) Defines the department's audit and appeal process for providers; and

(b) Includes, but is not limited to, actions the department may take to ensure provider payments for covered services, supplies, or equipment:

(i) Are made in accordance with federal and state statutes and regulations; and

(ii) Comply with provider billing instructions, published memoranda, and fee schedules. For provider reimbursement rate appeals, see WAC 388-502-0220 and for hospital reports and audits, see WAC 388-550-5700.

(2) This chapter applies to all providers except:

(a) Nursing homes as described in chapters 388-96, 388-97, and 388-98 WAC; and

(b) Managed care organizations as described in chapter 388-538 WAC.

[11-14-075, recodified as § 182-502A-0100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-0100, filed 4/23/07, effective 6/1/07.]

**WAC 182-502A-0200 Definitions.** Unless otherwise specified, the following definitions and those found in WAC 388-500-0005, apply to this chapter:

**"Audit period"**—The time period the department selects to review a provider's records. This time period is indicated in the audit report.

**"Chargemaster"**—A list of all goods and services and the prices the provider charges for each of those goods and services.

**"Extrapolation"**—The methodology of estimating an unknown value by projecting, with a calculated precision (i.e., margin of error), the results of an audited sample to the universe from which the sample was drawn.

**"Medical assistance"**—For purposes of this chapter, the common phrase used to describe all medical programs available through the department.

**"Overpayment"**—Any payment or benefit to a client or to a vendor in excess of what is entitled by law, rule or contract, including amounts in dispute, as defined in RCW 43.20B.010.

**"Record"**—Documentation maintained by a health services provider to show the details of the providing of services or products to a medical assistance client. See also WAC 388-502-0020, health care record requirements.

**"Sample"**—A selection of claims reviewed under a defined audit process.

**"Universe"**—A defined population of claims submitted by a provider for payment during a specific time period.

**"Usual and customary charge"**—The rate providers must bill the department for a certain service or equipment. This rate may not exceed:

(1) The established charge billed to the general public for the same services; or

(2) If the general public is not served, the established rate normally offered to other payers for the same services.

[11-14-075, recodified as § 182-502A-0200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. 11-11-014, § 388-502A-0200, filed 5/9/11, effective 6/9/11. Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-0200, filed 4/23/07, effective 6/1/07.]

**WAC 182-502A-0300 Authority to audit.** (1) Chapter 74.09 RCW authorizes the department to conduct audits, including reaudits, and to enforce its regulations and policies for all providers.

(2) The department conducts audits on a routine basis and as necessary. Audits can be conducted prior to, or following, payment of services, supplies, or equipment.

(3) The department may also conduct an audit as a result of:

(a) Complaints/allegations;

(b) Actions taken by the Centers for Medicare and Medicaid Services or the department regarding medicare or medical assistance; or

(c) Actions taken by the department of health.

[11-14-075, recodified as § 182-502A-0300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-0300, filed 4/23/07, effective 6/1/07.]

**WAC 182-502A-0400 Audit objectives.** A department audit has the following objectives:

(1) To determine if services billed and paid under the state's medical assistance and medical care service programs were:

(a) Provided to an eligible client;

(b) Medically necessary;

(c) Provided at the appropriate level of care;

(d) Appropriately documented; and

(e) In accordance with WAC 388-502A-0100(1).

(2) To provide a systematic and uniform method of determining compliance with state and federal program rules and regulations;

(3) To provide a mechanism for data gathering which can be used to modify the state's medical assistance and medical care service programs policies and procedures;

(4) To determine if the services provided meet the community standard of care; and

(5) To determine if the provider is maintaining clinical and fiscal records which substantiate claims submitted for payment during the audit period.

[11-14-075, recodified as § 182-502A-0400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-0400, filed 4/23/07, effective 6/1/07.]

**WAC 182-502A-0500 Audit methods and locations.**

The department selects the appropriate method of conducting the audit including, but not limited to, the following:

- (1) On-site audits, conducted on the provider's premises;
- (2) Desk audits, conducted at the department's offices; or
- (3) A combination of an on-site and a desk audit.

[11-14-075, recodified as § 182-502A-0500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-0500, filed 4/23/07, effective 6/1/07.]

**WAC 182-502A-0600 Notification of on-site audits.**

(1) The department sends written notice of a scheduled on-site audit as follows:

(a) Thirty calendar days in advance for hospitals according to RCW 70.41.045; and

(b) Ten business days in advance for all other providers.

(2) Exceptions to the written notice in subsection (1) of this section include, but are not limited to:

(a) Providers who are suspected of fraudulent or abusive practices;

(b) When the department has reason to believe that a provider's action endangers the health and safety of one or more clients; or

(c) A third-party liability compliance audit.

[11-14-075, recodified as § 182-502A-0600, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-0600, filed 4/23/07, effective 6/1/07.]

**WAC 182-502A-0700 Audit overview.** (1) The following may be included in the department audit:

(a) An examination of provider medical and financial records;

(b) A draft audit report, which contains findings and directives;

(c) A dispute process as described in WAC 388-502A-1100, unless a condition in subsection (4) of this section or a condition in WAC 388-502A-1100(8) applies; and

(d) A final audit report.

(2) Providers must maintain appropriate documentation in the client's medical or health care service records to verify the level, type, and extent of services provided. Pursuant to WAC 388-502-0020, providers must:

(a) Keep legible, accurate, and complete charts and records to justify the services provided to each client;

(b) Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains; and

(c) Make charts and records available to DSHS, its contractors, and the U.S. Department of Health and Human Services upon request, for six years from the date of service or longer if required specifically by federal or state law or regu-

lation. Refer to WAC 388-502-0020 for additional provider requirements.

(3) A health care provider's bill for services, appointment books, accounting records, or other similar documents alone do not qualify as appropriate documentation for services rendered.

(4) If a provider fails to participate or comply with the department's audit process or unduly delays the department's audit process, the department considers the provider's actions or lack thereof, as abandonment of the audit.

(5) If the department suspects a provider of fraud, abusive practices, audit abandonment, or presents a risk of imminent danger to clients, the department may take one or more of the actions listed below:

(a) Immediately issue a final report;

(b) Terminate the core provider agreement;

(c) Issue a subpoena for the provider's records pursuant to RCW 43.20A.605; or

(d) Refer the provider to the appropriate prosecuting authority.

[11-14-075, recodified as § 182-502A-0700, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-0700, filed 4/23/07, effective 6/1/07.]

**WAC 182-502A-0800 Auditing process.** (1) The department inspects provider records for objective data consistent with the purpose defined under WAC 388-502A-0100(1). The department may require a provider to furnish original records for the department to review.

(2) The department may assess an overpayment for medical services and terminate the core provider agreement if a provider fails to retain adequate documentation for services billed to the department.

(3) As part of the audit:

(a) The department may examine provider financial records, client medical records, employee records, provider appointment books, and any other applicable records that are related to the services billed to the department. The examination may:

(i) Verify usual and customary charges and payables including receivable accounts;

(ii) Verify third-party liability;

(iii) Compare clinical and fiscal records to each claim; and

(iv) Compare medicaid charges to other insured or private pay patient charges to determine that the amount billed to the department is not more than the usual and customary charge documented in the provider's chargemaster.

(b) The department's procedures for auditing providers may include:

(i) Use of random sampling;

(ii) Extrapolation of principal and interest;

(iii) Conducting a claim audit;

(iv) Interviews with clients, providers, and/or their employees;

(v) Investigating complaints or allegations;

(vi) Investigating actions taken regarding medicare or medical assistance; and

(vii) Investigating actions taken by the health profession's quality assurance commissions with the department of health.

(4) Per RCW 43.20A.605, the department may issue a subpoena for records from the provider or a third party including taking depositions or testimony under oath.

(5) When possible, the department works with the provider to minimize inconvenience and disruption of health care delivery during the audit.

(6) The department does not reimburse a provider's administrative fees, such as copying fees, for records requested during an audit.

[11-14-075, recodified as § 182-502A-0800, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-0800, filed 4/23/07, effective 6/1/07.]

**WAC 182-502A-0900 Audit sampling, extrapolation, and claim-by-claim review.** (1) The department's procedures for auditing providers may include, but are not limited to, the following:

(a) The use of random sampling and extrapolation; and/or

(b) A claim-by-claim based review.

(2) The department's sample sizes are sufficient to ensure a minimum of ninety-five percent confidence level.

(a) When calculating the amount to be recovered, the department totals all overpayments and underpayments reflected in the sample and may extrapolate to the universe from which the sample was drawn.

(b) When the department uses the results of an audit sample to extrapolate the amount to be recovered, the provider may request a description of all of the following:

(i) The universe from which the department drew the sample;

(ii) The sample size and method that the department used to select the sample; and

(iii) The formulas and calculation procedures the department used to determine the amount of the overpayment.

(c) If a provider rebills a claim(s) for an adjustment and that claim(s) is part of the audit universe, the department does not remove the original paid claim(s) amount from the audit universe.

(3) When a claim-by-claim audit is conducted, specific claims are selected from the universe and audit overpayments are not extrapolated.

(4) The department recovers overpayments identified in the final audit report.

(5) The department does not consider nonbilled or zero paid services or supplies when calculating underpayments or overpayments.

(6) The department considers undocumented services to be program overpayments.

[11-14-075, recodified as § 182-502A-0900, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-0900, filed 4/23/07, effective 6/1/07.]

**WAC 182-502A-1000 Provider audit—Draft report.**

(1) Upon completion of the examination of records, the department notifies the provider of missing files or records that are necessary to complete the audit. The department allows the provider thirty calendar days from the date of notification to locate and provide those records needed to complete an audit.

(6/30/11)

(2) After the department completes its review of the provider's records, the department issues a draft report.

[11-14-075, recodified as § 182-502A-1000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-1000, filed 4/23/07, effective 6/1/07.]

**WAC 182-502A-1100 Provider audit—Dispute process.** (1) A provider may dispute the draft audit findings by submitting a written request within thirty calendar days of receipt of the draft report. The provider must:

(a) Specify which finding(s) the provider is contesting;

(b) Supply documentation to support the provider's position; and

(c) Indicate whether a dispute conference is requested.

(2) The department acknowledges and responds in writing to providers' requests for a dispute conference and to each disputed finding.

(3) In accordance with WAC 388-502A-0700 (4) and (5), the department may decline a provider's dispute request.

(4) The provider must schedule the dispute conference with the department within sixty calendar days from the day the provider receives the department's written acceptance of the request for a dispute conference.

(5) The provider requesting the dispute conference and the appropriate department representatives must attend the dispute conference.

(6) If the department and the provider reach an agreement during the dispute conference process, the department issues the final audit report.

(7) If the department and the provider cannot reach an agreement during the dispute process, and the provider has had the opportunity to raise all concerns related to the audit findings, the department closes the dispute process and issues a final audit report.

(8) In addition to the circumstances in WAC 388-502A-0600(2), the department may also issue a final audit report without the dispute process described in this section when the provider:

(a) Transfers ownership of the business;

(b) Ceases doing business in Washington;

(c) Files for bankruptcy;

(d) Transfers business or personal assets available to the audited entity at the time of the initial audit; or

(e) Abandons the dispute process by failing to participate in the process.

[11-14-075, recodified as § 182-502A-1100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-1100, filed 4/23/07, effective 6/1/07.]

**WAC 182-502A-1200 Provider audit—Final report/appeal.**

(1) After the department issues the final audit report, the provider has twenty-eight calendar days from the date of the report to appeal the overpayment. Audit appeal hearings are governed by RCW 43.20B.675.

(2) The request for an audit appeal hearing must:

(a) Be in writing;

(b) State the basis for contesting the final audit report;

(c) Include a copy of the department's final audit report;

(d) Be received by the department within twenty-eight calendar days of the provider's receipt of the notice of overpayment;

- (e) Be served on the department in a manner which provides proof of receipt as described in WAC 388-02-0050; and
- (f) Be sent to:

DSHS Office of Financial Recovery  
P.O. Box 9501  
Olympia, WA 98507-9501

(3) The burden of proving compliance with applicable federal and state statutes and regulations, provider billing instructions, published memoranda, and fee schedules rests with the provider at the audit appeal hearing.

[11-14-075, recodified as § 182-502A-1200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-1200, filed 4/23/07, effective 6/1/07.]

**WAC 182-502A-1300 Audit outcomes.** (1) Based on audit findings, the department may:

(a) Request repayment, including interest on the amount of excess benefits or payments, per RCW 43.20B.695; and

(b) Assess civil penalties per chapter 74.09 RCW. The amount of civil penalties may not exceed three times the amount of excess benefits or payments the provider received.

(2) When the department imposes a civil penalty or terminates a provider's core provider agreement the department gives written notice of the action taken to the appropriate licensing agency, disciplinary commission, or other entity requiring a report.

(3) When an audit shows that a provider has not complied with the regulations and policies of the medical assistance or the medical care service program(s), the department may refer that provider to the appropriate disciplinary commission.

(4) When the department finds evidence of or has reason to suspect fraud, the provider is referred to the appropriate prosecuting authority for possible criminal action.

[11-14-075, recodified as § 182-502A-1300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.09.200 and 74.08.090. 07-10-022, § 388-502A-1300, filed 4/23/07, effective 6/1/07.]