Washington State Health Care Authority

Program Integrity (PI)

Frequently asked questions (FAQs)

Where can I find PI definitions?

PI definitions can be found in WAC 182-502A-0201.

What types of PI activities are conducted by the HCA?

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

What type of federally mandated PI audits or reviews can a provider or entity expect?

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

What is the HCA's authority to conduct PI activities of Washington Apple Health providers and entities, and recover improper payments?

Visit the Resources page of the HCA PI website.

How will a provider or entity know if they are being audited or reviewed by the HCA?

- A provider or entity will typically receive written notification by certified mail from HCA Section of Program Integrity.
- A provider or entity 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, encounters or contract deliverables for PI activities?

- Algorithms
- Risk assessments of paid claims or encounters
- 100 percent review of paid claims or encounters for a specific period
- Random stratified or non-stratified sample of claims or encounters for a specific time period
- Criteria-driven selection of specific claims or encounters for a specific time period

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

Information and records requested may include but may not be limited to:

- Appointment books/patient sign-in sheets.
- Billing or payment system screen prints.
- 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/ledgers/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.
- Training, credentialing or education records.
- Transfer records/referral documents.
- Treatment records.

How long must a provider or entity keep records for a PI activity?

Providers must maintain appropriate documentation to support the payment received for 6 years.

Entities must maintain appropriate documentation to support the benefits administered, payment issued and payment received for 10 years.

Please see WAC 182-502-0020 (providers) and 42 CFR 438.3(h) (entities).

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

HCA staff will either make copies (if onsite) or request copies be made of original records and/or information.

Is a provider or entity reimbursed for costs incurred during an audit?

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

How does a provider or entity 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), professional healthcare licenses, and pertinent training/education records of all pertinent staff available for the auditors.

How much time does a provider or entity have to dispute or appeal PI activity findings?

- A provider or entity 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 or entity 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 or entity 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 or entity may contact the auditor to request an extension.
- If the provider or entity 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
- Office of Attorney General (ATG)
- ATG Medicaid Fraud Control Division
- Other stakeholders as appropriate
- WAC 182-502A-0701 allows referral for disciplinary or criminal action if warranted