WAC 182-502A-0701 Agency outcomes. (1) Following the medicaid agency's evaluation of an entity's records including, but not limited to, claims, encounter data, or payments, the agency may do any combination of the following:

(a) Deny a claim or claim line.

(b) Recover an improperly paid claim.

(c) Instruct the entity to submit:

(i) Additional documentation; or

(ii) A new claim. If the entity fails to submit a new claim within sixty calendar days, the agency denies the new claim as untimely.

(d) Request a refund of an improper payment to the agency by check.

(e) Refer an overpayment to the office of financial recovery for collection.

(f) Issue a preliminary finding, which the entity may dispute under WAC 182-502A-0801.

(i) If an entity agrees with the preliminary finding before the deadline stated in the notice, the entity must notify the agency in writing. The agency then issues a final notice.

(ii) If an entity does not respond by the agency's deadline, the agency issues a final notice.

(g) Issue an overpayment notice or final notice, which the entity may appeal under WAC 182-502A-0901.

(i) The final notice includes:

(A) The asserted overpayment or improper payment amount;

(B) The reason for an adverse determination;

(C) The specific criteria and citation of legal authority used to make the adverse determination;

(D) An explanation of the entity's appeal rights;

(E) The appropriate procedure to submit a claims adjustment, if applicable; and

(F) One or more of the following:

(I) Directives;

(II) Educational intervention; or

(III) A program integrity compliance plan.

(ii) Upon request, the agency allows an entity with an adverse determination the option of repaying the amount owed according to a negotiated repayment plan of up to twelve months. Interest may be calculated and charged on the remaining balance each month.

(h) Recover interest under RCW 41.05A.220.

(i) Impose civil penalties under RCW 74.09.210.

(j) Refer the entity to appropriate licensing authorities for disciplinary action.

(k) Refer the entity to the agency's medical dental advisory committee for review and potential termination of the contract or core provider agreement.

(l) Determine it has sufficient evidence to make a credible allegation of fraud. The agency then:

(i) Refers the case to the medicaid fraud control division and any other appropriate prosecuting authority for further action; and

(ii) Suspends some or all Washington apple health payments to the entity unless the agency determines there is good cause not to suspend payments under 42 C.F.R. 455.23.

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

(3) At any time during a program integrity activity, the agency may issue a final notice if the entity:

(a) Stops doing business with the agency;

(b) Transfers control of the business;

(c) Makes a suspicious asset transfer;

(d) Files for bankruptcy; or

(e) Fails to comply with program integrity activities.

(4) The entity must repay any overpayment identified by the agency within sixty calendar days of being notified of the overpayment, except when a repayment plan is negotiated with the agency under subsection (1)(g)(ii) of this section.

[Statutory Authority: RCW 41.05.021, 41.05.160, and C.F.R. Sections 438.608 through 438.610. WSR 20-02-100, § 182-502A-0701, filed 12/31/19, effective 1/31/20. Statutory Authority: RCW 41.05.021, 41.05.160, 2017 c 242. WSR 18-07-050, § 182-502A-0701, filed 3/14/18, effective 4/14/18. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-01-129, § 182-502A-0701, filed 12/19/14, effective 1/19/15.]