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PROVIDER TYPES

NEW SECTION

WAC 388-502-0002 Eligible provider types [formerly 388-502-0010(3)]

The following healthcare practitioners are eligible to request enrollment with the Washington state department of social and health services to provide medical assistance to department clients.

- (1) Professionals:
 - (a) Advanced registered nurse practitioners;
 - (b) Anesthesiologists;
 - (c) Audiologists;
 - (d) Chemical dependency professionals
 - (i) Mental health care providers; and
 - (ii) Peer counselors.
 - (e) Chiropractors;
 - (f) Dentists;
 - (g) Dental hygienists;
 - (h) Denturists;
 - (i) Dietitians or nutritionists;
 - (j) Hearing aid fitters/dispensers;
 - (k) Marriage and family therapists, only as provided in WAC 388-531-1400;
 - (l) Mental health counselors, only as provided in WAC 388-531-1400;
 - (m) Mental health care providers;
 - (n) Midwives;
 - (o) Nurse anesthetist;
 - (p) Occupational therapists;
 - (q) Ophthalmologists
 - (r) Opticians;
 - (s) Optometrists;
 - (t) Orthodontists;
 - (u) Orthotist;
 - (v) Osteopathic physicians;
 - (w) Osteopathic physician assistants;
 - (x) Peer counselors;
 - (y) Podiatric physicians;
 - (z) Pharmacists;
 - (aa) Physicians;
 - (bb) Physician Assistants;
 - (cc) Physical therapists;
 - (dd) Prosthetist;
 - (ee) Psychiatrists;
 - (ff) Psychologists;

- (gg) Radiologists;
 - (hh) Registered nurse delegators;
 - (ii) Registered nurse first assistants;
 - (jj) Respiratory therapists;
 - (kk) Social workers, only as provided in WAC 388-531-1400; and
 - (ll) Speech/language pathologists.
- (2) Agencies, centers and facilities:
- (a) Adult day health centers;
 - (b) Ambulance services (ground and air);
 - (c) Ambulatory surgery centers (Medicare-certified);
 - (d) Birthing centers (licensed by the department of health);
 - (e) Blood banks;
 - (f) Cardiac diagnostic centers;
 - (g) Case management agencies;
 - (h) Chemical dependency treatment facilities certified by the department of social and health services (DSHS) division of alcohol and substance abuse (DASA), and contracted through either:
 - (i) A county under chapter 388-810 WAC; or
 - (ii) DASA to provide chemical dependency treatment services.
 - (i) Centers for the detoxification of acute alcohol or other drug intoxication conditions (certified by DASA);
 - (j) Community AIDS services alternative agencies;
 - (k) Community mental health centers;
 - (l) Diagnostic centers;
 - (m) Early and periodic screening, diagnosis, and treatment (EPSDT) clinics
 - (n) Family planning clinics;
 - (o) Federally qualified health centers (designated by the federal Department of Health and Human Services);
 - (p) Genetic counseling agencies;
 - (q) Health departments;
 - (r) Health maintenance organization (HMO)/managed care organization (MCO);
 - (s) HIV/AIDS case management;
 - (t) Home health agencies;
 - (u) Hospice agencies;
 - (v) Hospitals;
 - (w) Indian Health Service facilities/Tribal 638 Facilities;
 - (x) Tribal or urban Indian clinics;
 - (y) Inpatient psychiatric facilities;
 - (z) Intermediate care facilities for the mentally retarded (ICF-MR);
 - (aa) Kidney centers;
 - (bb) Laboratories (CLIA certified);

- (cc) Maternity support services agencies; maternity case managers; infant case management, first steps providers
 - (dd) Neuromuscular and neurodevelopmental centers;
 - (ee) Nurse services/delegation;
 - (ff) Nursing facilities (approved by the DSHS Aging and Disability Services Administration);
 - (gg) Pathology laboratories;
 - (hh) Pharmacies;
 - (ii) Private duty nursing agencies;
 - (jj) Radiology – stand alone clinics;
 - (kk) Rural health clinics (Medicare-certified);
 - (ll) School-based healthcare services;
 - (mm) Sleep study centers; and
 - (nn) Washington state school districts and educational service districts.
- (3) Suppliers of:
- (a) Durable and nondurable medical equipment and supplies;
 - (b) Infusion therapy equipment and supplies;
 - (c) Prosthetics/orthotics;
 - (d) Hearing aids; and
 - (e) Oxygen equipment and supplies.
- (4) Contractors:
- (a) Transportation brokers;
 - (b) Spoken language interpreter services agencies;
 - (c) Independent sign language interpreters; and
 - (d) Eyeglass and contact lens providers

NEW SECTION

WAC 388-502-0003 Noneligible provider types [formerly WAC 388-502-0010(5)]

The department does not enroll licensed or unlicensed healthcare practitioners not specifically listed in WAC 388-502-0002, including, but not limited to:

- (1) Acupuncturists;
- (2) Counselors, except as provided in WAC 388-531-1400;
- (3) Sanipractors;
- (4) Naturopaths;
- (5) Homeopaths;
- (6) Herbalists;
- (7) Massage therapists;
- (8) Social workers, except as provided in WAC 388-531-1400 and WAC 388-537-0350;
- (9) Christian Science practitioners, theological healers, and spiritual healers;
- (10) Chemical dependency professional trainee (CDPT); and
- (11) Mental health trainee (MHT).

ENROLLMENT

NEW SECTION

WAC 388-502-0005 Core Provider Agreement (CPA)

- (1) All healthcare practitioners must have an approved Core Provider Agreement (CPA) or be enrolled as a performing provider on an approved CPA to provide services to a medical assistance client; otherwise any request for payment will be denied. [formerly 388-502-0010(2)]
- (2) For services provided out-of-state refer to WAC 388-501-0180, WAC 388-501-0182, and WAC 388-501-0184.
- (3) All performing providers of services to a medical assistance client must be enrolled under the billing provider's CPA.
- (4) The department does not pay for services provided to clients during the CPA application process, regardless of whether the CPA is later approved or denied.
- (5) When the department approves a CPA, the effective date of the CPA is the date of approval. This also applies to healthcare practitioners who join an established group or clinic as a performing provider, when the established group or clinic has an existing CPA.

NEW SECTION

WAC 388-502-0010 When the department enrolls

- (1) Nothing in this chapter obligates the department to enroll any eligible healthcare practitioner who requests enrollment. [formerly 388-502-0010(4)]
- (2) To enroll as a provider with the department, a healthcare practitioner must, on the date of application: [formerly 388-502-0010(2)]
 - (a) Be currently licensed, certified, accredited, or registered according to Washington state laws and rules. Persons or entities outside of Washington state, see WAC 388-502-0120; [formerly WAC 388-502-0010(1)(a)]
 - (b) Have current professional liability coverage, individually or as a member of a group, through a commercial carrier;
 - (c) Have a current federal Drug Enforcement Agency (DEA) certificate, if applicable to the profession's scope of practice;
 - (d) Meet the conditions in this chapter and other chapters regulating the specific type of healthcare practitioner; [formerly WAC 388-502-0010(1)(b)]
 - (e) Sign, without modification, a core provider agreement (CPA) and Debarment form (DSHS 09-048) or a contract with the department. (Note: Section 13 of the CPA, DSHS 09-048 (REV. 08/2005), is hereby rescinded. The department and each provider signing a core provider agreement will hold each other harmless from a legal action based on the negligent actions or omissions of either party under the terms of the agreement.); [formerly WAC 388-502-0010(3)(f)]
 - (g) Agree to accept the payment from the department as payment in full; [formerly 388-502-0020(1)(e)]
 - (h) Fully disclose ownership and control information requested by the department. [formerly WAC 388-502-0020(2)] If payment for services is to be made to a group practice, partnership, or corporation, the group, partnership, or corporation must enroll and obtain a CPA number to be used for submitting claims as the billing provider. All owners must be identified and fully disclosed in the application; and
 - (i) Have screened employees and contractors with whom they do business prior to hiring or contracting, and on a monthly ongoing basis thereafter, to assure that employees and contractors are not excluded from receiving federal funds as required by 42 U.S.C. 1320a-7 and 42 U.S.C. 1320c-5.

NEW SECTION

WAC 388-502-0012 When the department does not enroll

- (1) The department does not enroll a healthcare practitioner for reasons which include, but are not limited to, the following: [formerly WAC 388-502-0030(2)]
 - (a) The department determines that:
 - (i) There is a quality of care issue with significant risk factors that may endanger client health and/or safety (see WAC 388-502-0030(1)(a); or [partially from WAC 388-502-0030(2)]
 - (ii) There are risk factors that affect the credibility, honesty, or veracity of the healthcare practitioner (WAC 388-502-0030(1)(b)).
 - (b) The healthcare practitioner: [formerly WAC 388-502-0030(2)]
 - (i) Is excluded from participation in Medicare, Medicaid or any other federally-funded healthcare program;
 - (ii) Has a current formal or informal pending disciplinary action, Statement of Charges, or the equivalent from any state or federal professional disciplinary body at the time of initial application;
 - (iii) Has been disciplined based upon allegations of sexual misconduct or admitted to sexual misconduct;
 - (iv) Has a suspended, terminated, revoked, or surrendered professional license as defined under RCW 18.130;
 - (v) Has a restricted, suspended, terminated, revoked, or surrendered professional license in any state;
 - (vi) Is noncompliant with the department of health's or other state health care agency's Stipulation to Informal Disposition, Agreed Order, Final Order, or other similar licensure restriction;
 - (vii) Is suspended or terminated by any agency within the state of Washington that arranges for the provision of healthcare;
 - (viii) Fails a background check performed by the department. See WAC 388-502-0014 and WAC 388-502-0016; or
 - (ix) Does not have sufficient liability insurance according to WAC 388-502-0016 for the scope of practice.
- (2) The department may not pay for any healthcare service, drug, supply, or equipment prescribed or ordered by a healthcare practitioner whose application for a core provider agreement (CPA) has been denied or terminated.
- (3) The department may not pay for any healthcare service, drug, supply, or equipment prescribed or ordered by a healthcare practitioner who does not have a current CPA with the department when the department determines there is a potential danger to a client's health and/or safety.

- (4) Nothing in this chapter precludes the department from entering into other forms of written agreements with a healthcare professional, healthcare entity, supplier or contractor of service. [formerly WAC 388-502-0010(4)]
- (5) If the department denies an enrollment application, the applicant does not have any dispute rights within the department.

NEW SECTION

WAC 388-502-0014 Review and consideration of an applicant's history

- (1) The department may consider enrolling a healthcare practitioner for reasons which include, but are not limited to, the following:
 - (a) The department determines that:
 - (i) There is not a quality of care issue with significant risk factors that endanger client health and/or safety;
 - (ii) There are not risk factors that affect the credibility, honesty, or veracity of the applicant; and
 - (iii) The applicant is not likely to repeat the violation that led to a restriction or sanction; and
 - (b) The healthcare practitioner has:
 - (i) Been excluded from participation in Medicare, Medicaid, or any other federally funded healthcare program but is not currently excluded; or
 - (ii) A history of probation, suspension, termination, revocation, or a surrendered professional license, certification, accreditation, or registration as defined under RCW 18.130 but currently has an active license, certification, accreditation, or registration; or
 - (iii) A restricted or limited professional license, certification, accreditation, or registration as defined under RCW 18.130.160; or
 - (iv) A history of denial, limitation, suspension or termination of participation or privileges by any healthcare institution, plan, facility, clinic, or state agency for quality of care issues or inappropriate billing practices and the quality of care issue or inappropriate billing practices have been corrected to the department's satisfaction.
- (2) The department may conduct a background check on any applicant applying for a core provider agreement (CPA).

- (3) The department's response to a review of a request for enrollment is based on the information available to the department at the time of application.

PROVIDER REQUIREMENTS

NEW SECTION

WAC 388-502-0016 Continuing requirements

- (1) To continue to provide services for eligible clients and be paid for those services, a provider must:
- (a) Provide all services without discriminating on the grounds of race, creed, color, age, sex, sexual orientation, religion, national origin, marital status, the presence of any sensory, mental or physical handicap, or the use of a trained dog guide or service animal by a person with a disability;
[formerly WAC 388-502-0020(1)(h)]
 - (b) Provide all services according to federal and state laws and rules, department billing instructions, numbered memoranda issued by the department, and other written directives from the department;
[formerly WAC 388-502-0020(1)(i)]
 - (c) Inform the department of any changes to the provider's application or contract, including but not limited to, changes in:
 - (i) Ownership (see WAC 388-502-0018);
 - (ii) Address or telephone number;
 - (iii) Professional practicing under the billing provider number; or
 - (iv) Business name.
 - (d) Retain a current professional State license, registration, certification and/or applicable business license for the service being provided, and update the department of all changes;
 - (e) Inform the department in writing within seven calendar days of changes applicable to the provider's clinical privileges;
 - (f) Inform the department in writing within seven business days of receiving any informal or formal disciplinary order, decision, disciplinary action or other action(s), including, but not limited to, restrictions, limitations, conditions and suspensions resulting from the practitioner's acts, omissions, or conduct against the provider's license, registration, or certification in any State;

- (g) Report immediately to the department any information discovered regarding an employee's or contractor's exclusion from receiving federal funds in accordance with 42 U.S.C. 1320a-7 and 42 U.S.C. 1320c-5. See WAC 388-502-0010(2)(j))
 - (h) Pass a background check, when the department requires such information to fully evaluate a provider;
 - (i) Maintain professional and general liability coverage requirements, if not covered under agency, center or facility, in the amounts identified by the department;
 - (j) Not surrender, voluntarily or involuntarily, his or her professional State license, registration, or certification in any State while under investigation by that State or due to findings by that State resulting from the practitioner's acts, omissions, or conduct; and
 - (k) Furnish documentation or other assurances as determined by the department in cases where a provider has an alcohol or chemical dependency problem, to adequately safeguard the health and safety of medical assistance clients that the provider:
 - (i) Is complying with all conditions, limitations, or restrictions to the provider's practice both public and private; and
 - (ii) Is receiving treatment adequate to ensure that the dependency problem will not affect the quality of the provider's practice.
- (2) A provider may contact the department with questions regarding its programs. However, the department's response is based solely on the information provided to the department's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern the department's programs. [formerly WAC 388-502-0020(2)]
- (3) The department may refer the provider to the appropriate state health professions quality assurance commission. [formerly WAC 388-502-0230(2)]

NEW SECTION

WAC 388-502-0018 Change of Ownership

- (1) A provider must notify the department in writing within seven calendar days of ownership or control changes of any kind. An entity is considered to have an ownership or control interest in an another entity if it has direct or indirect ownership of five percent or more, or is a managing employee (e.g. a general manager, business manager, administrator, or director) who exercises operational or managerial control over the entity or who directly or indirectly conducts day-to-day operations of the entity. The department determines whether a new core provider agreement (CPA) must be completed for the new entity.
- (2) When a provider obtains a new federal tax identification (ID) following a change of ownership, the department terminates the provider's CPA as of the date of the change in federal tax ID. The provider may reapply for a new CPA; **[formerly WAC 388-502-0030(5)(d)]**
- (3) All new ownership enrollments are subject to the requirements in WAC 388-502-0010. In addition to those requirements, the applicant must:
 - (a) Complete a change of ownership form;
 - (b) Provide the department with a copy of the contract of sale identifying previous and current owners; and
 - (c) Provide the department with a list of all provider numbers affected by the change of ownership.

AMENDED SECTION

WAC 388-502-0020 General requirements for providers Healthcare record requirements

This section applies to providers, as defined under WAC 388-500-0005 and under WAC 388-538-050. Providers must:

- (1) ~~Enrolled providers must: Maintain appropriate documentation in the client's medical or healthcare records to verify the level, type, and extent of services provided to each client to fully justify the services and billing, including, but not limited to:~~
 - (a) ~~Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to: Client's name and date of birth;~~
 - (b) ~~Dates of services;~~
 - (c) ~~Name and title of person performing the service, if other than the billing practitioner;~~

- (d) Chief complaint or reason for each visit;
 - (e) Pertinent past and present medical history;
 - (f) Pertinent findings on examination at each visit;
 - (g) Medication(s), ~~equipment, and/or supplies~~ or treatment prescribed and/or provided-administered;
 - (h) Name and title of individual prescribing or administering medication(s);
 - (i) Equipment and/or supplies prescribed or provided;
 - (j) Name and title of individual prescribing or providing equipment and/or supplies;
 - (k) Detailed description of treatment provided;
 - (l) Subjective and objective findings;
 - (m) Clinical assessment and diagnosis;
 - (n) Recommendations for additional treatments, procedures, or consultations;
 - (o) Radiographs (x-rays), diagnostic tests and results;
 - (p) Plan of treatment and/or care, and outcome; ~~and~~
 - (q) Specific claims and payments received for services;
 - (r) Correspondence pertaining to client dismissal or termination of healthcare practitioner/patient relationship;
 - (s) Advance directives, when required under WAC 388-501-0125;
 - (t) Patient treatment agreements (examples: Opioid agreement, medication and treatment compliance agreements); and
 - (u) Informed consent documentation.
- (2) Keep legible, accurate, and complete charts and records.
- (3) Meet any additional record requirements of the Department of Health (DOH).
- (4) 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~~
- (5) Make charts and records available to the department, its contractors or designees, and the United States Department of Health and Human Services (DHHS) upon request, for six years from the date of service or longer if required specifically by federal or state law or regulation. The department does not separately reimburse for copying of healthcare records, reports, client charts and/or radiographs, and related copying expenses; ~~and~~
- (6) Permit the department access to its physical facilities and its records to enable the department to conduct audits, inspections or reviews without prior announcement. [formerly WAC 388-502-0230]

TERMINATION OF PROVIDER

AMENDED SECTION

WAC 388-502-0030 ~~Denying, suspending, and terminating a provider's enrollment~~

Termination of a provider agreement – For cause

- (1) ~~The department terminates enrollment or does not enroll or reenroll a provider if, in the department's judgement, it may be a danger to the health or safety of clients.~~
- (2) ~~Except as noted in subsection (3) of this section, the department does not enroll or reenroll a provider to whom any of the following apply:~~
- ~~_____ (a) Has a restricted professional license;~~
 - ~~_____ (b) Has been terminated, excluded, or suspended from medicare/medicaid; or~~
 - ~~_____ (c) Has been terminated by the department for quality of care issues or inappropriate billing practices.~~
- (3) ~~The department may choose to enroll or reenroll a provider who meets the conditions in subsection (2) of this section if all of the following apply:~~
- ~~_____ (a) The department determines the provider is not likely to repeat the violation that led to the restriction or sanction;~~
 - ~~_____ (b) The provider has not been convicted of other offenses related to the delivery of professional or other medical services in addition to those considered in the previous sanction; and~~
 - ~~_____ (c) If the United States Department of Health and Human Services (DHHS) or medicare suspended the provider from medicare, DHHS or medicare notifies the department that the provider may be reinstated.~~
- (4) ~~The department gives thirty days written notice before suspending or terminating a provider's enrollment. However, the department suspends or terminates enrollment immediately if any one of the following situations apply:~~
- ~~(a) The provider is convicted of a criminal offense related to participation in the medicare/medicaid program;~~
 - ~~(b) The provider's license, certification, accreditation, or registration is suspended or revoked;~~
 - ~~(c) Federal funding is revoked;~~

- ~~(d) By investigation, the department documents a violation of law or contract;~~
- ~~(e) The MAA medical director or designee determines the quality of care provided endangers the health and safety of one or more clients; or~~
- ~~(f) The department determines the provider has intentionally used inappropriate billing practices.~~
- ~~(5) The department may terminate a provider's number if:
 - ~~(a) The provider does not disclose ownership or control information;~~
 - ~~(b) The provider does not submit a claim to the department for twenty-four consecutive months;~~
 - ~~(c) The provider's address on file with the department is incorrect;~~
 - ~~(d) The provider requests a new provider number (e.g., change in tax identification number or ownership); or~~
 - ~~(e) The provider voluntarily withdraws from participation in the medical assistance program.~~~~
- ~~(6) Nothing in this chapter obligates the department to enroll all eligible providers who request enrollment.~~

- (1) The department may immediately terminate a provider's core provider agreement (CPA) for any one or more of the following reasons, each of which constitutes cause:
 - (a) Provider exhibits significant risk factors that endanger client health and/or safety. These factors include, but are not limited to:
 - (i) Moral turpitude;
 - (ii) Sexual misconduct as defined in WAC 246-934-100 or in profession specific rules of the Department of Health (DOH);
 - (iii) A Statement of Allegations or Statement of Charges by DOH;
 - (iv) Restrictions placed by DOH on provider's current practice such as chaperone required for rendering treatment, preceptor required to review practice, or prescriptive limitations;
 - (v) Limitations, restrictions, or loss of hospital privileges or participation in any healthcare plan and/or failure to disclose the reasons to the department;
 - (vi) Negligence, incompetence, inadequate or inappropriate treatment, or lack of appropriate follow-up treatment;
 - (vii) Patient drug mismanagement and/or failure to identify substance abuse/addiction or failure to refer the patient for substance abuse treatment once abuse/addiction is identified;
 - (viii) Use of healthcare providers or healthcare staff who are unlicensed to practice or who provide healthcare services which are outside their recognized scope of practice or the standard of practice in the state of Washington;
 - (ix) Failure of the healthcare provider to comply with the requirements of WAC 388-502-0016;
 - (x) Failure of the healthcare practitioner with an alcohol or chemical dependency to furnish documentation or other assurances as determined by the department to adequately safeguard the health and safety of medical assistance clients that the provider:
 - (A) Is complying with all conditions, limitations, or restrictions to the provider's practice both public and private; and
 - (B) Is receiving treatment adequate to ensure that the dependency problem will not affect the quality of the provider's practice.
 - (xi) Infection control deficiencies;
 - (xii) Failure to maintain adequate professional malpractice coverage;
 - (xiii) Medical malpractice claims or professional liability claims that constitute a pattern of questionable or inadequate treatment, or contain any gross or flagrant incident of malpractice; or

- (xiv) Any other act which the department determines is contrary to the health and safety of its clients. [formerly -0030(5)(a)]
- (b) Provider exhibits significant risk factors that affect the provider's credibility or honesty. These factors include, but are not limited to:
- (i) Failure to meet the requirements in WAC 388-502-0010 and WAC 388-502-0020;
 - (ii) Dishonesty or other unprofessional conduct;
 - (iii) Investigatory (e.g. audit), civil, or criminal finding of fraudulent or abusive billing practices;
 - (iv) Exclusion from participation in Medicare, Medicaid, or any other federally funded healthcare program;
 - (v) Any conviction, no contest plea, or guilty plea relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct;
 - (vi) Any conviction, no contest plea, or guilty plea of a criminal offense;
 - (vii) Failure to comply with a DOH request for information or an on-going DOH investigation;
 - (viii) Non-compliance with a DOH or other state healthcare agency's Stipulation to Disposition, Agreed Order, Final Order, or other similar licensure restriction;
 - (ix) Misrepresentation or failure to disclose information on the enrollment application for a core provider agreement (CPA), failure to supply requested information, or failure to update CPA as required;
 - (x) Failure to comply with a department request for information;
 - (xi) Failure to cooperate with a department investigation, audit or review;
 - (xii) Providing healthcare services which are outside the provider's recognized scope of practice or the standard of practice in the state of Washington;
 - (xiii) Unnecessary medical/dental or other healthcare procedures;
 - (xiv) Discriminating in the furnishing of healthcare services, supplies, or equipment as prohibited by 42 USC §2000d; and
 - (xv) Any other dishonest or discreditable act which the department determines is contrary to the interest of the department or its clients.
- (2) If a provider is terminated for cause, the department pays for authorized services provided up to the date of termination only.

- (3) If the department terminates a provider who is also a full or partial owner of a group practice, the department also terminates all providers linked to the group practice. The remaining practitioners in the group practice may reapply for participation with the department subject to WAC 388-502-0010(2).
- (4) A provider who is terminated for cause may dispute a department decision under the process in WAC 388-502-0060.

NEW SECTION

WAC 388-502-0040 Termination of a provider agreement – For convenience

- (1) Either the department or the provider may terminate the provider's participation with the department for convenience with thirty calendar days written notice [formerly 388-502-0030(4)] served upon the other party in a manner which provides proof of receipt or proof of valid attempt to deliver. Examples of when the department may terminate for convenience include, but are not limited to:
 - (a) Funding from state, federal or other sources is withdrawn, reduced, or limited in any way;
 - (b) The provider does not submit a claim to the department for eighteen consecutive months;
 - (c) The provider's address on file with the department is incorrect;
 - (d) The ownership or controlling interest of the provider has substantially changed, or there have been significant additions or deletions to group membership; or
 - (e) The provider requests new participation with the department (e.g., change in tax identification number or ownership).
- (2) Terminations for convenience are not eligible for the dispute resolution process described in WAC 388-502-0050.
- (3) If a provider is terminated for convenience, the department pays for authorized services provided up to the date of termination only.

INFORMAL DISPUTE RESOLUTION PROCESS

NEW SECTION

WAC 388-502-0050 Provider dispute of a department decision

The process described in this section applies only when department rules allow a provider to dispute a department decision under this section.

- (1) In order for the department to review a decision previously made by the department, a provider must submit the request to review the decision:
 - (a) Within twenty-eight calendar days of the date on the department's decision notice;
 - (b) To the address listed in the decision notice; and
 - (c) In a manner that provides proof of receipt.
- (2) A provider's dispute request must:
 - (a) Be in writing;
 - (b) Specify the department decision that the provider is disputing;
 - (c) State the basis for disputing the department's decision; and
 - (d) Include documentation to support the provider's position.
- (3) The department may request additional information or documentation. The provider must provide the additional information or documentation within twenty-eight calendar days of the date on the department's request.
- (4) The department closes the dispute without issuing a decision and with no right to further review under subsection (6) of this section when the provider:
 - (a) Fails to comply with any requirement of subsections (2), (3), and (4) of this section;
 - (b) Fails to cooperate with, or unduly delays, the dispute process; or
 - (c) Withdraws the dispute request in writing.
- (5) The department will send the provider a written notice of dispute closure or written dispute decision.
- (6) The provider may request the deputy assistant secretary of the health and recovery services administration (HRSA) or designee review of the written dispute decision. See WAC 388-502-0270 - review of department's provider dispute decision.
- (7) This section does not apply to disputes regarding overpayment. For disputes regarding overpayment, see WAC 388-502-0230.

REAPPLYING FOR PARTICIPATION

NEW SECTION

WAC 388-502-0060 Reapplying for participation

- (1) Providers who are denied enrollment or removed from participation are not eligible to reapply for participation with the department for five years from the date of denial or termination.
- (2) Providers who are denied enrollment or removed from participation due to sexual misconduct as defined in chapter 246-16 WAC or in profession-specific rules of the department of health (DOH) are not eligible to be enrolled for participation with the department.
- (3) Providers who are denied enrollment or removed from participation more than once are not eligible to reapply for participation with the department.

PROVIDER PAYMENT REVIEWS AND DISPUTE RIGHTS

AMENDED

WAC 388-502-0230 Provider payment reviews and appeal dispute rights.

- (1) As authorized by chapters 43.20B and 74.09 RCW, the ~~medical assistance administration (MAA) department~~ monitors and reviews all providers who furnish medical, dental, or other healthcare services, drugs, equipment and/or related supplies to eligible ~~medical assistance~~ clients. ~~MAA~~ The department may review all documentation and/or data related to payments made to providers for healthcare services, drugs, equipment and/or supplies for eligible clients and determines whether the providers are complying with the rules and regulations of the program(s) and providing appropriate quality of care, and recovers any identified overpayments. Examples of provider reviews are:
 - (a) A review of all ~~billing/medical/dental/service client records for medical assistance clients and/or payments;~~
 - (b) A random statistical ~~sampling of billing/medical/dental/service billing and/or records for medical assistance clients, extrapolated per WAC ~~388-502-0240~~ (9), (10), and (11); and/or~~
 - (c) A review focused on selected ~~billing/medical/dental/service~~ records for ~~medical assistance~~ clients.

- (2) ~~The Washington State Health Professions Quality Assurance Commissions serve in an advisory capacity to MAA in conducting provider reviews and monitoring.~~
- (3)(2) ~~MAA~~ The department may determine that a provider's billing does not comply with program rules and regulations, ~~or the provider is not meeting quality of care practices.~~ ~~MAA~~ As a result of that determination, the department may ~~do, but is not limited to,~~ take any of the following actions, or others as appropriate:
- (a) ~~Conduct pre-pay reviews of all claims the provider submits to MAA~~ the department;
 - (b) ~~Refer the provider to MAA's~~ the department's auditors (see ~~WAC 388-502-0240~~ chapter 388-502A);
 - (c) ~~Refer the provider to Medicaid's~~ the Washington State Medicaid Fraud Control Unit;
 - (d) ~~Refer the provider to the appropriate state health professions quality assurance commission;~~
 - (e) ~~Impose provisional stipulations for the provider to continue participation in medical assistance programs;~~
 - (f)(e) ~~Terminate the provider's participation in medical assistance programs~~ (see WAC 388-502-0030);
 - (g)(f) ~~Assess a civil penalty against the provider, per RCW 74.09.210; and~~
 - (h)(g) ~~Recover any moneys that the provider received as a result of inappropriate overpayments~~ as authorized under chapter 43.20B RCW.
- (4) ~~When any part of the time period that is reviewed or monitored falls on or before June 30, 1998, the following process applies. A provider who disagrees with a department action regarding overpayment recovery may request an administrative review hearing to dispute the action(s).~~
- (a) ~~The request for an administrative review hearing must be in writing and:~~
 - (i) ~~Be sent within twenty-eight days of the date of the notice of action(s);~~
 - (ii) ~~State the reason(s) why the provider thinks the action(s) are incorrect;~~
 - (iii) ~~Be sent by certified mail (return receipt) or other means that provides proof of delivery to:~~

~~—The Medical Assistance Administration
—Attn: Deputy Assistant Secretary
—P.O. Box 45500
—Olympia WA 98504-5500~~

- ~~(b) The administrative review hearing consists of a review by MAA's deputy assistant secretary of all documents submitted by the provider and MAA. At the deputy assistant secretary's discretion, the administrative review hearing may be conducted in person, as a telephone conference, in written submissions, or a combination thereof.~~
- ~~(c) When a final decision is issued, the office of financial recovery collects any amount the provider is ordered to repay.~~
- ~~(d) The administrative review hearing referenced in this subsection is the final level of administrative review.~~
- ~~(5)(3) When the entire time period that is reviewed or monitored falls on or after July 1, 1998, the following process applies. A provider who disagrees with a department action regarding overpayment recovery may request a hearing to dispute the action(s) per RCW 43.20B.675.~~
- ~~(a) The request for hearing must be in writing and;~~
- ~~(i) Be sent within twenty-eight days of the date of the provider's receipt of notice of action(s), by certified mail (return receipt) or other means that provides proof of delivery to:~~
- ~~The Office of Financial Recovery
PO Box 9501
Olympia, WA 98507-5501; and~~
- ~~(ii) State the reason(s) why the provider thinks the action(s) are incorrect.~~
- ~~(b) The office of administrative hearings schedules and conducts the hearing under the Administrative Procedure Act, chapter 34.05 RCW. MAA-The department offers a pre-hearing/alternative dispute conference prior to the hearing.~~
- ~~(c) The office of financial recovery collects any amount the provider is ordered to repay.~~
- ~~(6) A provider who disagrees with a department action regarding termination may appeal the action per WAC 388-502-0260. The provider may request a dispute conference; the request must be:~~

- (a) ~~In writing;~~
- (b) ~~Sent within thirty days of the date the provider received the termination notice;~~
- (c) ~~Include a statement of the action(s) appealed and supporting justification; and~~
- (d) ~~Sent to:~~

DSHS Central Contract Services
P.O. Box 45811
Olympia, WA 98504-5811

- (8) ~~See WAC [388-502-0220](#) for rate reimbursement appeals. See WAC [388-502-0240](#) for appeals of audit findings. See WAC [388-502-0260](#) for appeals related to contracts other than MAA's the department's core provider agreements.~~

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