

PROVIDER BULLETIN

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TO: Nebraska Medicaid, CHIP, Waiver and PAS Providers

FROM: Vivianne M. Chaumont, Director
Division of Medicaid & Long-Term Care

BY: Betsie Steenson, Program Integrity Unit

RE: Maintaining and Providing Complete Medical Records

The Federal Deficit Reduction Act (DRA) has enabled more funds to be spent to ensure that fraud and abuse in Medicare and Medicaid are being identified and reduced through different audits such as the Payment Error Rate Measurement (PERM), the audits that will be conducted in the near future by Medicaid Integrity Contractors (MICs), and the Department's regular Program Integrity efforts. The purpose of this notice is to emphasize the need for all providers to keep and maintain complete records of all services performed for NMAP clients. These records are also required to be supplied in a timely manner for audit or review when requested by the Department, the federal Department of Health and Human Services, or other approved agency.

The Department puts forth in regulation the need to keep, maintain, and provide complete medical records for all NMAP clients. This is necessary to receive payment for services provided.

471 NAC 3-002.01 Approval: Payment for medical care and services through NMAP funds must be approved by the Department. Claims will be approved for payment when all of the following conditions are met:

5. The client's case record must contain information to meet state requirements

480 NAC 2-004.04 Providers: Providers of waiver services shall maintain the following materials for four years:

2. Documentation which supports requests for payment under the waiver.

While the State regulations may specify a period of time, like four years in the above citation, Federal regulations require that medical documentation be maintained longer in the HIPAA Privacy Rules, HHS Regulations, Documentation - §164.530(j).

Implementation specification: retention period. A covered entity must retain the documentation required by paragraph (j)(1) of this section for six years from the date of its creation or the date when it last was in effect, whichever is later.

Regulations also stipulate the need to provide documentation for services provided to Medicaid and CHIP clients when requested.

471 NAC 2-001.03 Provider Agreements: Each provider is required to have an approved agreement with the Department. By signing the agreement, the provider agrees to –

7. Maintain records on all services provided for which a claim has been made, and furnish, on request, the records to the Department, the federal Department of Health and Human Services, and the federal or state fraud and abuse units. Providers shall document services rendered in an institutional setting in the client's institutional chart before billing the Department.

Requests for records must be answered in a timely fashion. If a return by date is given in the record request, please supply all requested materials by that date, or attempt to contact the person making the request with a valid reason why an extension should be granted to allow more time to provide the requested documentation. If the requested documentation is not provided for review, or the documentation that is provided is found to be insufficient to support the service(s) that have been billed, refunds may be requested.

471 NAC 3-002.03 Post-Payment Review: Payment for a service does not indicate compliance with NMAP policy. Monitoring may be accomplished by post-payment review to verify that NMAP policy has been followed. A refund will be requested if post-payment review finds that NMAP payment has been made for claims/services not in compliance with NMAP policy. During a post-payment review, claims submitted for payment may be subjected to further review or not processed pending the outcome of the review.

Failure to properly document services rendered to NMAP clients may constitute a violation of the False Medicaid Claims Act, and the matter may be referred to the Medicaid Fraud and Patient Abuse Unit of the Attorney General's office, and/or result in sanctions imposed by the Department.

471 NAC 2-002.03 Reasons for Sanctions: The grounds for the Department to impose sanctions upon a provider include, but are not limited to, the following;

6. Failing to disclose or make available to the Department, or its authorized representatives, records of services provided to NMAP clients and records of payments by the Department, its agents and others made for those services, when requested.

471 NAC 2-002.04 Sanctions: The Department may invoke one or more of the following sanctions against a provider based on 471 NAC 2-002.03:

1. Termination from participation in the Medicaid program;
2. Suspension of participation in the Medicaid program;
3. Suspension or termination of participation in the NMMCP (NHC);
4. Suspension or withholding of payments to a provider;
5. Recoupment from future provider payments;
6. Transfer to a closed-end provider agreement not to exceed 12 months, or the shortening of an already existing closed-end provider agreement; or
7. Attendance at provider education sessions.

With HIPAA privacy laws, many providers are concerned about the validity of information requests. If you receive a request for records, and are not sure if it is a valid request, please contact your DHHS program specialist. If you have any questions about this provider bulletin, please contact Betsie Steenson at (402) 471-9353.