

# PROVIDER BULLETIN

No. 12-29

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TO: Nebraska Medicaid, CHIP, HCBS Waiver and PAS Providers

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

BY: Betsie Steenson, Program Integrity Unit  
Division of Medicaid & Long-Term Care

RE: Maintaining and Providing Complete Medical Records

**Please share this information with administrative, clinical, and billing staff.**

Providers must keep and maintain complete records of all services performed for Nebraska Medicaid clients. These records are also required to be supplied in a timely manner for audit or review when requested by the Nebraska Department of Health and Human Services, the federal Department of Health and Human Services, or other approved agency.

Incomplete or missing medical records were the cause of the majority of the errors found in the most recent Payment Error Rate Measurement (PERM) review. A total of 50% of the errors based on medical record review were due to providers submitting incomplete medical records to support their claims and 6.25% of the medical record review errors were due to no medical records being submitted to support claims.

Nebraska Medicaid requires that providers keep, maintain, and provide complete medical records for all Medicaid clients (see 471 NAC 3-002.01). This is necessary to receive payment for services provided.

Federal regulations, in set bracket, require that medical documentation be maintained for six years [45 CFR 164.530(j)].

Regulations also set forth the need to provide documentation for services provided to Medicaid and CHIP clients when requested (see 471 NAC 2-001.03). Requests for records must be answered in a timely fashion. If a return by date is given in the record request, all requested materials should be supplied by that date, or contact the person making the request to discuss allowing 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 (see 471 NAC 3-002.03).

Failure to properly document services rendered to Medicaid 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 (see 471 NAC 2-002.03 and 471 NAC 2-002.04).

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 are being conducted by Medicaid Integrity Contractors (MICs), the audits that will be conducted by Recovery Audit Contractors (RACs), and the Department's regular Program Integrity efforts.

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 the DHHS program specialist for the program in question. The contact information for program specialists is at <http://dhhs.ne.gov/medicaid/Documents/medicaidpolicystaff.pdf>. If you have any questions about this provider bulletin, please contact Betsie Steenson at (402) 471-9353.