



CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICAID INTEGRITY GROUP

Center for Program Integrity
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CPI – INFORMATIONAL BULLETIN

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Center for Program Integrity (CPI)

SUBJECT: Implementation of Revised Policies Related to Audit Look-Back Period and Provider Response Time for Documentation Requests.

This informational bulletin is to notify you of two policies that the Center for Program Integrity is implementing to improve the process whereby Audit Medicaid Integrity Contractors (Audit MICs) conduct audits of Medicaid providers. CMS has developed national standards for:

- **Look -Back period for Audits** — establishes the period of time to five (5) years prior to the start date of the audit, during which time providers claims will be subject to audit
- **Documentation request** — expands the length of time for providers to respond to request for records

Background:

Section 1936 of the Social Security Act requires the Centers for Medicare & Medicaid Services (CMS) to contract with eligible entities to review and audit Medicaid claims and to identify overpayments. To accomplish this, CMS has contracted with Audit MICs. This informational bulletin provides States with information pertaining to audit procedures and the Providers' responsibility to respond to the Audit MIC requests for documentation. CMS believes that having a consistent national policy on look back and record production will allow States and providers to know exactly what to expect from our contractors.

Audit Look-Back Period

There are no federal statutory limitations on the time period that an Audit MIC may look back. Originally CMS directed the Audit MICs to follow the States' established look back policies when conducting audits, while reserving the right to exceed a State's look back period when facts warranted. The evolution of the MIC audit process, and lessons learned from collaborating with States, has influenced CMS' determination that establishing a consistent national audit look back period is necessary.

One of the considerations in developing this new policy was whether or not providers maintained records for five years. Research of State audit laws and regulations with regards to how long providers are required to maintain records revealed that most States have at least a five year record retention policy. Furthermore, the Health Insurance Portability and Accountability Act (HIPAA) requires “covered entities” (including providers) to maintain medical records for six years.

Therefore, effective October 1, 2010 the general policy of the Audit MICs will be to follow a five (5) year audit look-back period. The five year period begins on the date of issuance of the Notification Letter to the provider. For example, if an audit begins in October 2010, the look-back period for reviewing claims and request for records would go back to October 2005. CMS retains the right to adjust the five year look-back period if the facts warrant such action.

Provider Response to Document Requests

An Audit MIC initiates an audit through an engagement letter to the Provider, at which time the MIC requests records to support the claims audit. Current policy requires the Provider to submit the required documentation within ten (10) business days from the date the Provider would reasonably be expected to have received the engagement letter, plus an allowance of five (5) business days for delivery.

CMS has approved a revised policy which will allow the Provider thirty (30) business days to produce the records. The Audit MIC can authorize a fifteen (15) business day extension if requested, and appropriately justified, by the provider. If the provider needs more than forty-five (45) business days to produce the documents, CMS approval is required. In the latter case, the Audit MIC will send the written request to CMS.

And in other news, we are working to develop an internet-based Medicaid Integrity Manual (MIM) that will include additional granularity on these topics, as well as other topics regarding the Medicaid Integrity Program (MIP) activities. The purpose of the Manual is to promote continuity and consistency in the MIP by providing a comprehensive guide to its overall operations. The MIM will primarily serve as a reference tool to assist State Medicaid officials, providers, health care organizations, CMS components, and other Federal agencies in: (1) understanding the goals and objectives of the MIP; (2) improving the communication and transparency of the MIP; and (3) educating outside entities of the evolving functions of the MIP.

Thank you for your continued commitment to combating fraud, waste and abuse in the Medicaid program. Questions regarding this information can be directed to Randal Brasky, Division of Field Operations, Medicaid Integrity Group, at 312-886-4369, or via email to Medicaid_Integrity_Program@cms.hhs.gov.