
Implementation of Revised Policies Related to Audit Look–Back Period and Provider Response Time for Documentation Requests

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This informational bulletin is to notify you of two policies that the Center for Medicare and Medicaid Services (CMS), Medicaid Integrity Group (MIG), 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 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.

Mo HealthNet regulation 13 CSR 70.-3.030 (33) states "for providers other than long-term care facilities, failing to retain in legible form for at least five (5) years from the date of service, worksheets, financial records, appointment books, appointment calendars (for those providers who schedule patient/client appointments), adequate documentation of the service, and other documents and records verifying data transmitted to a billing intermediary, whether the intermediary is owned by the provider or not. For long-term care providers, failing to retain in legible form, for at least seven (7) years from the date of service, worksheets, financial records, adequate documentation for the service(s), and other documents and records verifying data transmitted to a billing intermediary, whether the intermediary is owned by the provider or not. The documentation must be maintained so as to protect it from damage or loss by fire, water, computer failure, theft, or any other cause".

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 Time for Documentation 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.

Provider Bulletins are available on the MO HealthNet Division (MHD) (Formerly the Division of Medical Services) Web site at <http://dss.mo.gov/mhd/providers/pages/bulletins.htm>. Bulletins will remain on the Provider Bulletins page only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletin page.

MO HealthNet News: Providers and other interested parties are urged to go to the MHD Web site at <http://dss.missouri.gov/mhd/global/pages/mednewssubscribe.htm> to subscribe to the electronic mailing list to receive automatic notifications of provider bulletins, provider manual updates, and other official MO HealthNet communications via E-mail.

MO HealthNet Managed Care: The information contained in this bulletin applies to coverage for:

- MO HealthNet Fee-for-Service
- Services not included in MO HealthNet Managed Care

Questions regarding MO HealthNet Managed Care benefits should be directed to the patient's MO HealthNet Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MO HealthNet card or by calling the Interactive Voice Response (IVR) System at 573-635-8908 and using Option One for the red or white card.

**Provider Communications Hotline
573-751-2896**