Chapter 15. Medicare Advantage Compliance

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15.1 Introduction

The regulations governing the Medicare Advantage program set forth required terms for both Medicare Advantage plans and contracted providers. In order to make contracted providers aware of such terms, the Center for Medicare & Medicaid Services ("CMS") has created a contracting checklist for Medicare Advantage plans to follow in developing providers' contracts and related policies and procedures. That checklist is included in Chapter 11 of the CMS Medicare Managed Care Manual (Section 100.4), a copy of which is available on the CMS website.

In certain cases, regulatory language must be included in the actual contractual document governing the relationship between the Medicare Advantage plan and the provider. In other cases, CMS allows a Medicare Advantage plan to include required terms in its policies and procedures that are made available to contracted providers.

The provisions that follow are a complete listing of the required Medicare Advantage compliance terms that may be included in policies and procedures. Provider is required to comply with all such provisions, including, but not limited to, taking all necessary actions as may be specifically noted or such actions as may be required and requested by Highmark Health Insurance Company ("HHIC") in order for HHIC to meet its obligations as a Medicare Advantage plan. All requirements set forth in this document shall apply to all Medicare Advantage plans, including HHIC.

(1) Provider will safeguard the privacy of any information that identifies a particular member and acknowledges that HHIC has procedures to maintain records in an accurate and timely manner. Pursuant to 42 C.F.R. §422.118, or its successor, the following shall apply: (a) HHIC must establish and maintain procedures to, and Provider must, abide by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information; (b) HHIC and Provider must safeguard the privacy of any information that identifies a particular member; (c) HHIC must establish and maintain procedures, and Provider must comply with the procedures that specify, (i) for what purposes the information will be used within the organization and (ii) to whom and for what purposes it will disclose the information outside the system; (d) HHIC must establish and maintain procedures to, and Provider must, ensure that medical information is released only in accordance with Federal or State law, or pursuant to court orders or subpoenas; (e) HHIC must establish and maintain procedures to, and Provider must, maintain records and information in an accurate and timely manner; and (f) HHIC must establish and maintain procedures to, and Provider must, ensure timely access by Medicare Advantage members to the records and information that pertain to them. (Required by 42 C.F.R. §422.118 or its successor).

(2) HHIC may offer benefits in a continuation area for those members who move permanently "out of area." (Required by 42 C.F.R. §422.54(b) or its successor).

(3) Provider will not deny, limit or condition the furnishing of a service to a member, and HHIC will not deny, limit or condition the coverage or furnishing of benefits to an individual eligible to enroll in HHIC's Medicare Advantage plan(s), on the basis of any factor that is related to health status, including, but not limited to, the following: (a) medical condition, including mental as well as physical illness; (b) claims experience; (c) receipt of health care; (d) medical history; (e) genetic information; (f) evidence of insurability, including conditions arising out of acts of domestic violence; and (d) disability. (Required by 42 C.F.R. §422.110(a) or its successor).

(4) HHIC will make timely and reasonable payment to or on behalf of the member for emergency and urgently needed services obtained by a member from a non-contracted provider or supplier as provided in 42 C.F.R. §422.100(b)(1)(ii) or its successor. (Required by 42 C.F.R. §422.100(b)(1)(ii) or its successor).

(5) HHIC will make timely and reasonable payment for renal dialysis provided by a non-contracted provider while a member is temporarily outside HHIC's service area. (Required by 42 C.F.R. §422.100(b)(1)(iv) or its successor).

(6) HHIC provides Members with direct access (through self referral) to mammography screening and influenza vaccine. (Required by 42 C.F.R. §422.100(g)(1) or its successor).

(7) HHIC will not impose, and Provider will not collect any, cost-sharing on members for influenza and pneumococcal vaccines. (Required by 42 C.F.R. §422.100(g)(2) or its successor).

(8) HHIC does and will maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to meet the needs of the member population served. (42 C.F.R. §422.112(a)(1) or its successor).

(9) HHIC gives members who are women direct access to a women's health specialist within its provider network for routine and preventive services provided as basic benefits. (Required by 42 C.F.R. §422.112(a)(3) or its successor).

(10) HHIC must ensure that (a) the hours of operation of its contracted providers are convenient to the members served and do not discriminate against Medicare enrollee; and (b) plan services are available 24 hours a day, 7 days a week, when medically necessary. (Required by 42 C.F.R. §422.112(a)(7) or its successor). As applicable, Provider will maintain business hours and/or ensure Provider's services are available in accordance with the preceding requirements.

(11) HHIC must adhere to the CMS marketing provisions contained in 42 C.F.R. §422.80(a), (b) and (c), or its/their successor(s).

(12) HHIC must ensure that services are provided in a culturally competent manner to all members including those with limited English proficiency or reading skills and diverse cultural and ethnic backgrounds. (Required by 42 C.F.R. §422.112(a)(8) or its successor).

(13) HHIC must ensure continuity of care and integration of services through arrangements to include procedures to ensure that members are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures that members may take to promote their own health. (Required by 42 C.F.R. §422.112(b)(5) or its successor). As applicable, Provider will comply with these procedures.

(14) HHIC has written policies regarding the implementation of advance directive rights, including, but not limited to, a statement that providers shall document in a prominent place in the applicable Member's medial record if the Member has executed an advance directive. (Required by 42 C.F.R. §422.128(b)(1)(ii)(E) or its successor). Provider will comply, as applicable, with that policy.

(15) HHIC's contract with CMS must contain a provision that it will provide all benefits covered by Medicare, and Provider must render services, in a manner consistent with professionally recognized standards of health care. (Required by 42 C.F.R. §422.504(a)(3)(iii) or its successor).

(16) HHIC must provide, and Provider shall comply with all, policies and procedures and contractual requirements providing for continuation of member health care benefits (a) for all members, for the duration of the contract period for which CMS payments have been made; and (b) for members who are hospitalized on the date HHIC terminates, or in the event of insolvency, through discharge. Such requirements may be met in any manner as described in 42 C.F.R. §422.504(g)(3) or its successor. (Required by 42 C.F.R. §422.504(g)(2)(i) and (ii), and §422.504(g)(3) or its/their successor(s)).

(17) All provider payment and incentive arrangements must be specified in the contractual arrangement between HHIC and Provider. (Required by 42 C.F.R. §422.208 or its successor).

(18) The payments that Provider receives from HHIC for covered services rendered to members enrolled in a Medicare Advantage are, in whole or part, from federal funds and, and therefore, Provider and HHIC are subject to certain laws as applicable to individuals and entities receiving federal funds. (Required by 42 C.F.R. §422.504(h) or its successor).

(19) HHIC is required to disclose information to members in the manner and the form prescribed by CMS as required under 42 C.F.R. §422.111. (Required by 42 C.F.R. §422.504(a)(4) or its successor).

(20) HHIC is required to disclose all information that is necessary for CMS to administer and evaluate HHIC's Medicare Advantage program(s) and to simultaneously establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare services. (42 C.F.R. §422.64(a) and §422.504(f)(2) or its/their successor(s)). Such information includes, but is not limited to, plan quality and performance indicators for the benefits under HHIC's Medicare Advantage program(s) including (a) disenrollment rates for members electing to receive benefits under such program for the previous two years, 42 C.F.R. §422.504(f)(2)(iv)(A) or its successor; (b) information on member satisfaction, 42 C.F.R. §422.504(f)(2)(iv)(B) or its successor; and (c) information on health outcomes, 42 C.F.R. §422.504(f)(2)(iv)(C) or its successor. As required and/or requested, Provider will cooperate with HHIC and CMS in providing any of the preceding information that is under its control and/or in its possession.

(21) HHIC must make a good faith effort to provide notice of termination of a contracted Provider at least 30 calendar days before the termination of the effective date to all members who are patients seen on a regular basis by the applicable Provider whose contract is terminating (which in the case of a primary care provider, means all members who are patients of such provider), irrespective of whether the termination was for cause or without cause. (Required by 42 C.F.R. §422.111(e) or its successor).

(22) HHIC must comply with reporting requirements in 42 C.F.R. §422.516, or its successor, and 42 C.F.R. §422.504(l)(2) & (l)(3), or its/their successor(s), for submitting and certifying data to CMS. Provider will certify the accuracy, completeness and truthfulness of all data that HHIC is obligated to submit to CMS. (Required by 42 C.F.R. §422.504(a)(8), or its successor, and §422.504(l)(2) & (l)(3) or its/their successor(s)). As required and/or requested, Provider will further cooperate with HHIC and CMS in providing any of the preceding information that is under its control and/or in its possession.

(23) HHIC must establish a formal mechanism to consult with the physicians who have agreed to provide services under HHIC Medicare Advantage program(s), regarding HHIC's medical policy, quality assurance programs and medical management procedures and ensure that the following standards are met: (a) practice guidelines and utilization management guidelines are – (i) based on reasonable medical evidence or a consensus of health care professionals in the particular field; (ii) consider the needs of the enrolled population; (iii) are developed in consultation with contracted physicians; and (iv) are reviewed and updated periodically; (b) decisions with respect to utilization management are communicated to providers and, as appropriate, to members; and (c) decisions with respect to utilization management, member education, coverage of services, and other areas to which

guidelines apply are consistent with such guidelines. (Required by 42 C.F.R. §422.202(b) or its successor). In addition, HHIC must operate a quality assurance and performance improvement program and have an agreement for external quality review as required by 42 C.F.R. Subpart D or its successor. (Required by 42 C.F.R. §504(a)(5) or its successor). Provider shall cooperate with all such medical policy, medical management procedures and quality assurance and performance improvement programs.

(24) HHIC must give a physician written notice of the following when and if HHIC suspends or terminates an agreement under which the physician provides services to members. The written notice must include the following: (a) the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physicians and numbers and mix of physicians needed to maintain an adequate network; and (b) the affected physician's right to appeal the action and the process and timing for requesting a hearing. (Required by 42 C.F.R. §422.202(d)(1) or its successor).

(25) Any without cause termination by HHIC or Provider requires at least sixty (60) days prior written notice. (Required by 42 C.F.R. §422.202(d)(4) or its successor).

(26) HHIC and Provider must comply with federal laws and regulations designed to ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law; the False Claims Act (31 U.S.C. §3729 et. seq.); and the anti-kickback statute (42 U.S.C. §1320a-7b(b)). (Required by 42 C.F.R. §422.504(h)(1) or its successor).

(27) HHIC and Provider may not employ or contract with an individual (which in the case of HHIC includes, as applicable, Provider) who is excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act, or with an entity (which in the case of HHIC includes, as applicable, Provider) that employs or contracts with such an individual, for the provision of any of the following: (a) health care; (b) utilization review; (c) medical social work; and/or (d) administrative services. (Required by 42 C.F.R. §422.752(a)(8) or its successor).

(28) HHIC has established and will maintain (a) a grievance procedure as described in 42 C.F.R. §422.564, or its successor, for addressing issues that do involve organization determinations; (b) a procedure for making timely organization determinations; and (c) appeal procedures that meet the requirements of this subpart for issues that involve organization determinations. HHIC must ensure that all members receive notification about the (a) grievance and appeal procedures that are available to them; and (b) complaint process available to the member under the QIO process as set forth under 1154(a)(14) of the Social Security Act. (Required by 42 C.F.R. §422.562(a) or its successor). Provider will comply with Medicare requirements regarding Member grievances, appeals, and complaints and will cooperate with HHIC in meeting its obligations to include, but not be limited to, the

gathering and forwarding of information in a timely manner as well as compliance and adherence to any decisions rendered.

15.2 Medical Record Documentation Requirements

15.2.1 Overview

HHIC participating providers are expected to maintain a single standard medical record in such form and containing such information as required by all applicable federal and state laws that govern operations and all applicable HHIC policies and procedures.

15.2.2 Documentation Requirements

For each encounter, medical records must include, but not be limited to, all of the following:

- Documentation that is appropriate and legible to someone other than the writer
- Appropriate, timely and legible provider signatures and credentials on the documentation
- Date of service (or review for consultation, laboratory or testing report) clearly documented in the medical record which correlates to the date of reported claim
- Documentation supporting the need for the service reported on the claim
- The member name (on each page) and date of birth

15.2.3 CMS Signature and Credentials Requirements

The Centers for Medicare & Medicaid Services (CMS) has stated that stamped signatures are not acceptable on any medical records. The prohibition applies to all providers who bill the Medicare Program. CMS will accept handwritten signatures, electronic signatures, or facsimiles of original written or electronic signatures.

CMS also requires that the provider of service for face-to-face encounters must be appropriately identified on medical records via their signature and physician credentials.

15.2.4 Acceptable Provider Signatures

Valid provider signatures include (i) electronic signatures which include credentials, (ii) handwritten signatures including credentials, (iii) printed name including credentials accompanied by provider initials and (iv) facsimiles of original written or electronic signatures that include credentials.

TYPE	ACCEPTABLE
• Hand-written signature including credentials	• Mary C. Smith, MD; or MCS, MD Examples: • *Mary C. Smith, MD* • **Mary C. Smith MD** *MCS, MD*
• Electronic signature, including credentials	• Requires authentication by the responsible provider Examples, includes but not limited to, "Approved by," "Signed by," "Electronically signed by"
	• Must be password protected and used exclusively by the individual provider
• Printed name including credentials, accompanied by handwritten initials	**Example** • **Mary C. Smith MD** *MCS*
• Facsimile	• Other than an original signature, such as included on medical record copy

15.2.5 Invalid Provider Signatures

The following table provides information on invalid provider signatures:

TYPE	UNACCEPTABLE unless…
• Typed name with credentials Example **Mary C. Smith MD**	• The provider includes a written signature or initials plus credentials
• Non-physician or non-physician extender (e.g., medical student)signature Example *John Jones, PA*	• Co-signed by supervising physician (Refer to acceptable examples in the preceding table)
• Provider of services signature without credentials Example *Mary C. Smith*	• Name is linked to provider credentials or name with credentials on practitioner stationery
• Signature stamp, including credentials *marycsmith MD*	• Prior to 2008 (stamped signatures are not permitted on medical records after 2008)

15.2.6 Compliance

If a provider fails to comply with these documentation requirements, remedial actions such as rejection of claims, review of claims on a retrospective basis and collection of any overpayments, and/or termination of provider agreements as noted in the provider contract may be initiated as appropriate.

15.2.7 Record Retention Policy for Medicare Advantage

Highmark complies, and requires its contracted providers to comply, with Centers for Medicare & Medicaid Services (CMS) policies and procedures including inspection of records.

Record retention is required to ensure efficient availability in case of immediate need. Compliance with CMS' requirements is paramount for continuing participation in the Medicare Advantage (MA) program and the ability to service our MA members.

CMS has revised its regulations with respect to records retention and access to records, increasing the period from six to ten years. Therefore, network providers must maintain records and information in an accurate and timely manner in accordance with 42CFR §422.504(d) and provide access to such records in accordance with 42CFR §422.504(e)(2).

42CFR §422.504(d) states MA organizations are to maintain records and allow CMS access to them, for 10 years from the termination date of the contract or the date of the completion of any audit,

42CFR §422.504(e)(2) states,

"HHS, the Comptroller General, or their designees may audit evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of the Medicare Advantage (MA) organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract."

If you wish to read the entire context of the requirement please visit The Code of Federal Regulations, Title 42, Volume 2, Chapter 1V – Centers for Medicare & Medicaid Services, Department of Health and Human Services, Part 422, Medicare Advantage Program, Subpart K, Contracts with Medicare Advantage Organizations.

Previous record retention regulations specified that records must be maintained for six years. This period is now ten years.

15.3 Advanced Illness Services (AIS) Program

15.3.1 Introduction

Effective January 1, 2011 Highmark Health Insurance Company (HHIC) implemented the Advance Illness Services (AIS) Program which is offered as part of all Highmark Medicare Advantage Plans.

The Program was developed to ensure that members with life-limiting illness have access to uniquely trained professionals who provide palliative care.

15.3.2 What is Advanced Illness Services?

The Advanced Illness Services (AIS) Program is a specialized component of the overall care management program available to Highmark Medicare Advantage members. Members who might enroll are those with cancer, heart disease, end-stage kidney disease, stroke or other neurological disorders, and other life-limiting illnesses, including advanced frailty.

The program's focus is on enhancing palliative services to control pain and symptoms, provide emotional support, facilitate decision-making related to care, and to coordinate services. Highmark case managers engage members, family, caregivers, and physicians to facilitate discussions about options at the end of life. The case manager monitors the provisions of AIS program services to assure the member's needs are being met.

The program offers 100 percent coverage for up to a maximum of ten (10) outpatient care visits provided by Highmark AIS contracted hospice providers over an unlimited time period. There is no member cost-sharing when services are received from an AIS network hospice provider.

15.3.3 AIS Participation Guidelines

The AIS program is available to Highmark Medicare Advantage members for whom their physician can attest to a substantial risk of death within one year (as stated in CPT II code 1150F). Attestation demonstrates medical necessity.

Participation in the program is voluntary and no referral is required. The patient may be referred to the AIS program by their PCP or a specialty provider, family members, self, a community case manager, a Highmark case manager, or others.

Members are not required to be homebound or meet a skilled level of care to be considered eligible for AIS program services. They may receive services within their home or while in a health care or assisted-living facility.

15.3.4 How does AIS differ from Hospice?

Palliative care strives to alleviate discomfort and pain to improve the quality of life for patients. Palliative care can be provided during any stage of an illness and most frequently to patients with life-limiting illness. It can be provided at the same time as curative care.

The table below outlines the differences between the palliative care services provided by hospice and those services provided through the AIS program.

Hospice…	Advanced Illness Services…
Focuses on controlling pain and symptoms for those who no longer seek curative treatment or for whom treatment to prevent the progression of illness is no longer appropriate.	Are primarily consultative with focus on controlling pain and symptoms, providing emotional support, facilitating decision-making related to care, and coordinating services while the patient may still be receiving curative treatment.
Is available when life expectancy is six months or less.	Is available when the physician attests that the patient has a substantial risk of death within one year.
Is a Medicare benefit. Medicare-covered services related to the member's terminal condition and also medical services unrelated to the terminal condition are paid under Medicare when the member is in an active hospice election period. While in an active hospice election period, the member is not eligible for the AIS program.	Is a Highmark program. Services are covered under the member's Medicare Advantage plan. Members are not eligible for the AIS program if they are in an active hospice election period. If a member revokes a hospice election, the member would then be eligible for AIS services.

While a member is in an active hospice election period covered under traditional Medicare, the member's Medicare Advantage plan will continue to cover supplemental or extra benefits, such as vision and dental, which are not covered by Medicare.

15.3.5 Authorization Required

An authorization from Highmark West Virginia's Healthcare Management Services (HMS) is required for members to participate in the AIS program. The authorization

request can be submitted through NaviNet by the physician or by the AIS hospice provider performing the services. Attestation is confirmed through the authorization request.

When submitting the authorization request, the provider is attesting that the patient has a substantial risk of death within one year. Submission of the authorization request indicates agreement with the following statement: "By submitting this request, you are attesting on behalf of the physician that this patient is eligible for Advanced Illness Services."

15.3.6 Submitting Authorization Requests in NaviNet

To request authorization for Advanced Illness Services through NaviNet, select Auth Submission from the options provided under Authorization Submission.

On the selection form, choose Advanced Illness Services as the category from the dropdown. The referring provider and the AIS network hospice agency providing the services will be required to complete the request. The primary diagnosis code will be defaulted to V66.7.

15.3.7 AIS Provider Directory

A directory of Highmark AIS network hospice providers is available on the Provider Resource Center.

15.3.8 Additional Information

To learn more about the Advanced Illness Services Program, please visit the Provider Resource Center to view our recorded Webinars available under Online Provider Training.