CHAPTER 5: CARE AND QUALITY MANAGEMENT

UNIT 3: MEDICARE ADVANTAGE PROCEDURES

FOR PENNSYLVANIA AND WEST VIRGINIA PROVIDERS ONLY

IN THIS UNIT

ALL PROVIDER TYPES

What Is My Service Area?

The *Highmark Provider Manual* contains information, policies, and procedures that apply to Highmark network participating providers in Pennsylvania, Delaware, West Virginia, and contiguous counties. The symbols below are used in the manual to identify information that is specific to one state. In some instances, information may be designated as applicable to two states only. **Where no symbol is present, the information is relevant to all states.**

- The **PA ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Pennsylvania and contiguous counties.
- The **DE ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in Delaware and contiguous counties.
- The **WV ONLY** symbol indicates the information in the section is applicable to providers participating in Highmark networks in West Virginia and contiguous counties.

5.3 INTRODUCTION AND OVERVIEW

Introduction

This unit outlines Highmark and Centers for Medicare & Medicaid Services (CMS) procedures and processes specifically for Medicare Advantage members. This information is applicable to all Highmark Medicare Advantage products in Pennsylvania and West Virginia.

What Is My Service Area?

CMS requirements overview

CMS requires specific procedures for Medicare Advantage member notification and appeal processes to ensure that beneficiaries with coverage under a Medicare Advantage plan have adequate notice of appeal rights when coverage of their health care services is denied, reduced, or terminated.

When it has been determined that it is no longer medically necessary for a member to continue receiving care in a hospital, skilled nursing facility (SNF), from a home health agency (HHA), or from comprehensive outpatient rehabilitation facilities (CORFs), CMS requires the provider to notify that member of the termination of services and provide a statement of appeal rights.

In addition, CMS requires notification when it is deemed that services may be denied prior to the services being rendered and when Medicare beneficiaries, including Medicare Advantage, are receiving observation services as outpatients for more than twenty-four (24) hours.

Compliance terms

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, CMS has created a contracting checklist for Medicare Advantage plans to follow in developing providers' contracts and related policies and procedures.

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.

Highmark maintains a complete listing of the required Medicare Advantage compliance terms that may be included in Highmark's policies and procedures. Highmark's providers are required to comply with all such provisions.

- **Pennsylvania Medicare Advantage Compliance Language**
- **West Virginia Medicare Advantage Compliance Language**

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5.3 INTRODUCTION AND OVERVIEW, Continued

FOR MORE INFORMATION

To learn more about Highmark's Medicare Advantage products, please see **Chapter 2.2: Medicare Advantage Products and Programs**.

In addition, Member Evidence of Coverage (EOC) Booklets for Highmark Medicare Advantage plans are made available in the **Appendix** of the *Highmark Provider Manual* to assist you in servicing our Medicare Advantage members. The EOCs explains their rights, benefits, and responsibilities as a member of our Plan.

To access the manual's Appendix, scroll down to the bottom of the manual's home page, and then click on the arrow in the **ADDITIONAL RESOURCES** box. Select **Appendix** from the options. You will also find **Medicare Advantage Compliance Language** in this location.

What Is My Service Area?

5.3 EXPEDITED REVIEW OF INITIAL DETERMINATIONS AND APPEALS

What Is My Service Area?

Policy

Providers should be knowledgeable about the expedited review of initial determinations and appeals for Highmark's Medicare Advantage products. Although these processes are largely member-driven, the physician may represent the member and initiate the expedited review. Also, the physician is responsible for the crucial role of providing requested medical records on a timely basis.

When asking for an expedited review, the enrollee or the physician must submit either an oral or written request directly to the organization responsible for making the determination. The physician may also provide oral or written support for an enrollee's own request for an expedited determination.

Background

The Centers for Medicare & Medicaid Services (CMS) requires all Medicare Advantage programs to implement processes for member-initiated expedited review of initial determinations and appeals. As Medicare Advantage programs, Highmark has processes in place for expedited review of initial determinations and appeals for members with all Medicare Advantage products.

Highmark must automatically provide an expedited determination to any request made or supported by a physician. The physician must indicate either orally or in writing that applying the standard time for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. The physician need not be appointed as the enrollee's authorized representative in order to make the request.

Expedited review rights

Members of Medicare Advantage programs, or their representatives, may request a 72-hour expedited review of a service if they believe the member's health, life, or ability to regain maximum function may be jeopardized by waiting for the standard review process.

In accordance with CMS guidelines, members may request the initial expedited review without speaking to the PCP first.

What these processes do not apply to

The processes for expedited review of initial determinations and appeals do not apply to claim denials if services have already been received. Members or providers may appeal claims denials through their respective standard appeal processes.

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5.3 EXPEDITED REVIEW OF INITIAL DETERMINATIONS AND APPEALS, Continued

Your role

You may be contacted by a Highmark Clinical Services care manager or physician advisor to supply a copy of the member's medical records in the case of an expedited review. If so, you must supply the records immediately.

Additionally, if you are contacted for information by a physician advisor about an expedited appeal, you must return his or her call. Failure to do so could result in corrective action and/or sanctioning.

What Is My Service Area?

Appealing on behalf of a member

You or a treating physician may wish to initiate an appeal on behalf of a Medicare Advantage member if you believe services are medically necessary and covered under the member's benefit plan. If you choose to initiate the appeal on behalf of the member, then the appeal is automatically considered an expedited appeal.

If a denial decision is upheld

If a denial decision is upheld, the network is required to forward the case to the CMS appeals contractor within twenty-four (24) hours of the decision.

The appeals contractor may request additional information. In such cases, a Medicare Advantage appeals administrator may contact your office for additional information. If you are contacted, please respond to the request immediately.

Process for expedited review or appeals

The table below explains the process for expedited reviews of initial determinations or appeals for Medicare Advantage members.

Note: Appeal administrators will automatically forward member appeals that do not meet expedited review criteria through the standard appeal process.

STEP	WHO DOES IT...	WHAT HAPPENS...
1	Member or treating physician	Decides to pursue an expedited initial determination or expedited appeal.
2	Member	Does member want to pursue the review or the appeal or appoint someone as a representative? • If the member is pursuing the review, go to **Step 4**. • If the member is appointing a representative, go to **Step 3**.

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5.3 EXPEDITED REVIEW OF INITIAL DETERMINATIONS AND APPEALS, Continued

What Is My Service Area?

Process for expedited review or appeals (continued)

STEP	WHO DOES IT…	WHAT HAPPENS…
3a	Member or Physician OR	3a. For expedited appeals the member or the physician does not require a representative statement to make a request. Members or physicians may request an expedited review or appeal by phone, fax, or by mail. If an appeal request does not meet expedited criteria, it will be processed as a standard appeal and then a representative statement will be requested for a physician or other appointed representative request only.
3b	An appointed representative	3b. The appointed representative may submit a **Representative Statement Document** by following instructions located on the form directly or sending a written equivalent. Both member and representative must sign the document. Fax or mail the signed document to the contact information in Step 4.
4	Member or appointed representative	Contacts the Expedited Review department at: **1-800-485-9610** May send a physician's statement supporting the urgent need for services to: Fax: 1-800-894-7947 Mail: Expedited Review Department P.O. Box 535073 Pittsburgh, PA 15253-5073
5	Clinical Services care manager and/or physician reviewer	Investigates the review. (The 72-hour period begins upon receipt of this request.) Is there enough information to render a decision? • If yes, go to **Step 7**. • If no, request additional information from provider of care and go to **Step 6**.
6	Care provider	Forwards member's medical records to care manager or physician advisor.
7	Clinical Services care manager and/or physician reviewer	• Renders decision. • Notifies member by telephone and letter. • Notifies physician.

Where can I get forms?

A current copy of the **Representative Statement Form** is available under the CMS' forms section of the CMS website at:

https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf

5.3 MEDICARE ADVANTAGE MEDICAL POLICY

What Is My Service Area?

Overview

The Centers for Medicare & Medicaid Services (CMS) requires that Medicare Advantage plans utilize National and Local Coverage Determinations (NCDs/LCDs) when providing indications and limitations of coverage.

Highmark maintains medical policy guidelines for our Medicare Advantage products based on National and Local Coverage Determinations. Medicare Advantage Medical Policy guidelines have been integrated into the claims processing system, allowing for cost-effective claims processing and ensuring consistent, accurate administration of our customers' health care benefits.

Plan exclusions and restrictions

The following exclusions and restrictions apply to Highmark's Medicare Advantage plans:

1. Services considered not reasonable and necessary according to the standards of Original Medicare, i.e., Local and National Coverage Determinations (LCD/NDC), Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) and Current National Correct Coding Initiatives (NCCI), and/or other CMS guidance.
2. Experimental medical and surgical procedures, equipment, and medication unless covered by Original Medicare, i.e., Local and National Coverage Determinations (LCD/NDC), Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) and Current National Correct Coding Initiatives (NCCI), and/or other CMS guidance.

Accessing Medicare Advantage Medical Policy

You can access Highmark's Medicare Advantage Medical Policy from the Provider Resource Center under **CLAIMS, PAYMENT & REIMBURSEMENT**.

Prior to rendering service, it is important to review medical necessity criteria outlined in our medical policy guidelines.

5.3 ADVISING MEMBERS OF THEIR INPATIENT RIGHTS AT DISCHARGE

What Is My Service Area?

Policy

Medicare Advantage plans must notify their members of their Medicare appeal rights at or near the time of a hospital or facility admission and discharge. The Centers for Medicare & Medicaid Services (CMS) policy requires acute care facilities to give all Medicare and Medicare Advantage inpatients the **Important Message From Medicare** ("*Important Message*") **no later than two (2) days after admission** to the inpatient level of care. A follow-up copy must also be delivered to the patient **no more than two (2) days prior to discharge**.

The member will need to sign and date the *Important Message* to indicate that he or she received and understood it. The acute-care facility must then provide the member with the signed *Important Message* and retain a copy of the signed document in the member's medical record.

Important Message

The *Important Message* explains the member's rights as an inpatient as well as his or her right to appeal a discharge decision. It also indicates the circumstances under which the member will or will not be liable for charges for continued stay in the acute-care facility. CMS requires facilities to maintain a copy of the signed *Important Message* in their files. This can be done electronically or via paper, according to each facility's standard record retention policy.

Process

The following steps are required for both medical and behavioral health services:

STEP	ACTION
1	Give all Medicare Advantage inpatients the *Important Message From Medicare* at or near the time of admission, but no later than two (2) days after admission to the inpatient level of care.
2	Provide a follow-up signed copy of the *Important Message From Medicare* to all Medicare Advantage patients (or, if necessary, to their representative) prior to discharge, but no more than two (2) days before discharge. Retain a copy of the signed document in the member's medical record or in some other location/format in order to be able to demonstrate that the requirement was met.

Member must comprehend

The member must be able to understand the purpose and contents of the notice in order to be able to sign indicating receipt. The facility is responsible to explain the *Important Message* and to ensure that the member understands its content. Members who do understand must sign and date the form to indicate receipt and understanding.

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5.3 ADVISING MEMBERS OF THEIR INPATIENT RIGHTS AT DISCHARGE, Continued

Member must comprehend (continued)

If the facility determines that the patient does not understand that he or she can appeal the discharge decision, the facility must provide the *Important Message* document to another individual acting as the patient's representative. The representative must then sign and date it to indicate receipt and understanding.

If the member decides to accept the discharge, he or she leaves the facility and goes home or to an alternative level of care.

What Is My Service Area?

Member disagrees with discharge decision

If the member disagrees with the discharge decision, he or she has until midnight on the day of the scheduled discharge (while he or she is still an inpatient) to decide to pursue an expedited review (appeal). If the member decides to pursue the appeal, additional steps are necessary.

This procedure applies only to patients who disagree with the discharge decision and wish to initiate an expedited review of the discharge decision:

STEP	ACTION
1	If the patient disagrees with the discharge decision, no later than midnight on the day of discharge the patient or authorized representative contacts the Quality Improvement Organization (QIO) as directed on the *Important Message From Medicare*.
2	The QIO notifies the facility and Highmark that the request was received. The QIO will notify the facility to forward relevant records and complete and deliver the **Detailed Notice of Discharge**.
3	The facility will deliver the **Detailed Notice of Discharge** to the member no later than noon of the day the facility is notified of the review request. This notice provides the member with the clinical and coverage reasons why the member's physician has determined that the level of care is no longer reasonable or medically necessary. The member is not required to sign this document.
4	No later than one (1) day after receiving all the necessary information, the QIO completes its review and communicates its decision to the member, facility, and the health plan.

TIP SHEET

Timeline for discharge notification process

For a detailed timeline for the delivery of the *Important Message* and *Detailed Notice of Discharge*, if applicable, click on the **Tip Sheet** icon. The timeline outlines the responsibilities of each individual who has a role in the process. This tip sheet is also available in the **Tip Sheet Index**, which is accessible in **ADDITIONAL RESOURCES** at the bottom of the manual home page.

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5.3 ADVISING MEMBERS OF THEIR INPATIENT RIGHTS AT DISCHARGE, Continued

If member disagrees with QIO decision

If the Medicare Advantage member disagrees with an adverse QIO review decision, the member may request reconsideration while still an inpatient in the hospital.

What Is My Service Area?

Locating forms

Current copies of the *Important Message From Medicare* and the *Detailed Notice of Discharge* are available on the CMS website at:

https://www.cms.gov/medicare/medicare-general-information/bni/hospitaldischargeappealnotices.html

In addition, a Highmark branded Detailed Notice of Discharge is available. This form can also be found on the Resource Center – select **FORMS**, and then **Miscellaneous Forms**. Scroll to the **DETAILED NOTICE OF DISCHARGE** heading.

FOR MORE INFORMATION

Beneficiary and Family Centered Care QIOs (BFCC-QIOs) handle case reviews. The BFCC-QIO for the region that includes Pennsylvania is **Livanta**. West Virginia is serviced by **Kepro**.

Quality Innovation Network QIOs will offer health care quality improvement learning opportunities, technical assistance, and free resources to support providers. Quality Insights is the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) that services Pennsylvania and West Virginia. For more information, please visit their website at **qualityinsights.org**.

In addition, you may call Highmark's Provider Service Center at:

- **Pennsylvania:**
  - Freedom Blue PPO: **1-866-588-6967**
  - Community Blue Medicare HMO : **1-888-234-5374**
  - Community Blue Medicare PPO and Plus PPO: **1-866-588-6967**
  - Security Blue HMO (Western Region only): **1-866-517-8585**
- **West Virginia:** Freedom Blue PPO: **1-888-459-4020**

Procedure for SNFS, HHAs, and CORFs

The CMS also requires skilled nursing facilities (SNFs), home health agencies (HHAs), and comprehensive outpatient rehabilitation facilities (CORFs) to follow special procedures to ensure that Medicare Advantage patients are given adequate notice of discharge and appeal rights. Please see the next section of this unit.

5.3 NOTICE OF MEDICARE NON-COVERAGE (NOMNC)

Introduction

The Centers for Medicare & Medicaid Services (CMS) requires skilled nursing facilities (SNFs), home health agencies (HHAs), and comprehensive outpatient rehabilitation facilities (CORFs) to follow special procedures to ensure that Medicare Advantage patients are given adequate notice of discharge and appeal rights. The member must be given appropriate notice when it has been determined that coverage of their health care services is denied, reduced, or terminated.

CMS has issued a *Notice of Medicare Non-Coverage* (NOMNC) form that providers must use to notify both Medicare beneficiaries and enrollees of Medicare Advantage plans that Medicare coverage for specific services currently being received will end.

Time frame

The NOMNC form should be issued **no later than two (2) days before** the proposed end of services.

What Is My Service Area?

Valid delivery

Valid delivery means that the member or appointed or authorized representative* must be able to understand the purpose and contents of the notice in order to sign for receipt of it. The member or appointed or authorized representative must be able to understand that he or she may appeal the termination decision. If the member or appointed or authorized representative is not able to comprehend the contents of the notice, it must be delivered to and signed by a representative.

**An appointed or authorized representative requires an AOR (Appointment of Representative Form) or a POA (Power of Attorney).*

Valid delivery methods

The NOMNC form can be delivered using the following methods:

- In person to a member or appointed or authorized representative
- Via telephone when unable to provide the NOMNC form to the member or appointed or authorized representative in person

If the NOMNC form is delivered by telephone, then the facility must confirm the telephone contact by acknowledging the conversation in writing and mailing it on the same day.

IMPORTANT!

Providers **cannot** leave any of this information in a voicemail message. CMS considers only direct verbal notifications to be valid.

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5.3 NOTICE OF MEDICARE NON-COVERAGE (NOMNC), Continued

Provider information required

The provider must document the name, address, and telephone number of the provider delivering the notice at the very top of the first page of the form. The field for this information is located immediately below the logo of the product under which the member has coverage. The form is not considered valid without this information.

Providers choosing to use a NOMNC form that is not specifically branded for Highmark products must add their name, address, and telephone number in this same location on the first page of the form.

What Is My Service Area?

Additional information section

Highmark has chosen to add fields in the "Additional Information" section for the provider to document the details supporting the valid delivery of the notice. This documentation is designed to protect the provider, the member, and the health plan, especially when the notice must be delivered to a member's representative who is not physically present in the facility. The facts required in the Additional Information section of the form are as follows:

- Details of the conversation with the member or representative
- The name and telephone number of the Quality Improvement Organization (QIO)
- The date and time by which the QIO must be contacted
- The name and title of the individual delivering the NOMNC to the member or representative on behalf of the facility
- The date and time of the conversation during which the NOMNC was delivered to the member or representative
- The method of delivery (verbal, telephonic, etc.)
- If delivered by telephone, also include the telephone number called
- The date on which written confirmation was sent as follow up to telephone delivery

Note: Although some of these fields are most immediately applicable to situations in which the NOMNC is delivered to a member or representative not present in the facility, the relevant information should be documented in all cases.

Telephone delivery: Obtaining the member's signature

When the NOMNC form is delivered via telephone, the member's signature can be obtained as follows:

- The member or representative may come to the facility to sign the NOMNC form at a later date; or
- The facility should make a copy of the NOMNC form for the facility's records, and then send the original to the member or representative via certified mail requesting that a receipt be returned to the facility if the member or representative is unable to come to the facility for signature.

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5.3 NOTICE OF MEDICARE NON-COVERAGE (NOMNC), Continued

Retain Copy

Facilities should retain a copy of the completed and signed NOMNC form in their records.

What Is My Service Area?

SNFs managed by naviHealth

For skilled nursing facilities managed by naviHealth, a copy of the completed and signed NOMNC form should **also** be faxed to naviHealth at **1-844-496-7209**.

Locating form

The **Notice of Medicare Non-Coverage** forms applicable to Highmark Medicare Advantage plans are located on the Provider Resource Centers for your service area. Select **FORMS**, and then Miscellaneous Forms. Scroll to the **NOTICE OF MEDICARE NON-COVERAGE** heading to access the form.

5.3 MEDICARE OUTPATIENT OBSERVATION NOTICE (MOON)

Overview

On August 6, 2015, Congress passed the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, which requires all hospitals and critical access hospitals (CAHs) to provide written and oral notification to all Medicare beneficiaries receiving observation services as outpatients for more than twenty-four (24) hours. The written notice must include the reason the individual is receiving observation services, and must explain the implications of receiving outpatient observation services, in particular the implications for cost-sharing requirements and subsequent coverage eligibility for services furnished by a skilled nursing facility.

What Is My Service Area?

Medicare Outpatient Observation Notice (MOON)

The **Medicare Outpatient Observation Notice (MOON)** was developed by the Centers for Medicare & Medicaid Services (CMS) to serve as the standardized written notice. Effective March 8, 2017, the MOON must be presented to Medicare beneficiaries, including those with Medicare Advantage plans, to inform them that the observation services they are receiving are outpatient services and that they are not an inpatient of the hospital or CAH. Hospitals and CAHs must deliver the notice **no later than thirty-six (36) hours** after observation services are initiated or sooner if the individual is transferred, discharged, or admitted.

The hospital or CAH must obtain the signature of the patient or a person acting on behalf of the patient ("representative") to acknowledge receipt of the notification. If the individual or representative refuses to sign it, the written notification is signed by the hospital staff member who presented it.

To access the MOON form

The CMS approved standardized MOON form (CMS-10611) and accompanying instructions are available on the CMS website at:

https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html?redirect=/bni

5.3 PRESERVICE ORGANIZATION DETERMINATIONS

Overview

The Medicare Advantage member has a right to an advance determination by their health plan to verify whether services are covered prior to receiving the services. In circumstances where there is a question whether or not an item or service is covered under a member's Medicare Advantage benefit plan, a provider **must** advise the member to request a preservice organization determination from their health plan, or the provider can request the determination on the member's behalf.

If coverage for the item or service is denied, the health plan must provide the member with a standard written denial notice that states the specific reasons for the denial and informs the member of his or her appeal rights.

Please Note: The *Advance Beneficiary Notice of Noncoverage* (ABN) used for the Original Medicare program is not applicable to Medicare Advantage plans.

What Is My Service Area?

Notification of non-coverage determinations

The Centers for Medicare & Medicaid Services (CMS) issued clarification on May 5, 2014, that the practice of providers giving a preservice denial notice to members in advance of performing a service is not compliant with CMS regulations for Medicare Advantage plans.

The *Preservice Denial Notice* that providers were previously directed to issue to Highmark members is no longer valid and must not be used. The notification of a non-coverage determination must be issued to the member by Highmark.

If you believe that a service or item is not covered or may not be covered for a Highmark Medicare Advantage member, you must advise the member that a written coverage decision ("preservice organization determination") is required from Highmark before the service or item can be provided. Per CMS, exceptions to this policy are services or items that are never covered by Medicare or the member's Medicare Advantage plan. The exceptions for Highmark Medicare Advantage members are listed on the next page.

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5.3 PRESERVICE ORGANIZATION DETERMINATIONS, Continued

Exceptions to preservice organization determination requirements

Preservice organization determinations **are not required** for Highmark Medicare Advantage members receiving the services listed below. These services are clearly listed as exclusions for Medicare Advantage members in Highmark's Evidence of Coverage (EOC) booklets.

1. Private duty nurses
2. Personal items in member's room at a hospital or a skilled nursing facility, such as a telephone or television
3. Full-time nursing care in the member's home
4. Custodial care provided in a nursing home, hospice, or other facility setting when the member does not require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps the member with activities of daily living, such as bathing or dressing
5. Homemaker services including basic household assistance, including light housekeeping or light meal preparation
6. Fees charged by member's immediate relatives or members of the member's household
7. Meals delivered to the member's home
8. Radial keratotomy, LASIK surgery, vision therapy, and other low vision aids
9. Reversal of sterilization procedure and non-prescription contraception supplies
10. Acupuncture*
11. Naturopath services (uses natural or alternative therapies)
12. Services provided to veterans in Veterans Affairs (VA) facilities
13. Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines
14. Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease
15. Medical determination of refractive state (Medical Refraction)

The services listed above are not eligible for payment and can be billed to the member.

Acupuncture is **not excluded for the Community Blue Medicare HMO product in Pennsylvania.*

What Is My Service Area?

IMPORTANT!

Providers are required to direct members to obtain or request a preservice organization determination prior to the receipt of all non-covered services other than those listed above. **Failure to obtain a Notice of Denial of Medical Coverage will result in the member being held harmless from any payment liability.**

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5.3 PRESERVICE ORGANIZATION DETERMINATIONS, Continued

Requesting preservice organization determinations

Highmark members can be directed to call the Member Service phone number on the back of their identification card to initiate a preservice organization determination. Or, if you prefer to act on behalf of the member, you should call Highmark Provider Services as follows:

- **Pennsylvania:**
  - Freedom Blue PPO: **1-866-588-6967**
  - Community Blue Medicare HMO : **1-888-234-5374**
  - Community Blue Medicare PPO and Plus PPO: **1-866-588-6967**
  - Security Blue HMO (Western Region only): **1-866-517-8585**
- **West Virginia:** Freedom Blue PPO: **1-888-459-4020**

Please Note: This process is not applicable to services or items that require prior authorization. Requests for prior authorization are to be submitted via NaviNet®.

What Is My Service Area?

Time frame for reviews

Upon receipt of a request for a coverage determination, Highmark will review the request and provide notification of the decision as quickly as the member's health condition requires.

For a **standard non-urgent request**, Highmark will notify the member of the determination **within fourteen (14) calendar days** after receiving the request. Highmark will extend the time frame up to fourteen (14) calendar days if the member requests an extension, or if Highmark can justify a need for additional information and can document how the delay is in the best interest of the member. For example, the receipt of additional medical evidence from a non-contracting provider may change Highmark's decision to deny.

In cases involving the need for **urgent care**, Highmark will provide notification of the decision **within seventy-two (72) hours** after receipt of the request. A case involving urgent care is one in which making the determination under the standard time frames could seriously jeopardize the member's life, health, or ability to regain maximum function or, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that could not be adequately managed without the care or treatment that is the subject of the request. If a physician indicates a case as one involving urgent care, it will be handled as such.

For non-participating providers, Highmark will extend the urgent case turnaround time of seventy-two (72) hours or the non-urgent case turnaround time of fourteen (14) calendar days up to an additional fourteen (14) calendar days if the member requests the extension. Contracted providers are obligated under the terms of their contract to respond to requests from the Plan for the purpose of reviewing a member's appeal.

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5.3 PRESERVICE ORGANIZATION DETERMINATIONS, Continued

Time frame for reviews (continued)

For non-participating providers, Highmark may also extend the urgent seventy-two (72) hour or non-urgent fourteen (14) calendar day time frames up to an additional fourteen (14) calendar days if a need for additional information can be justified and it is documented that the delay is in the interest of the member. Contracted providers are obligated under the terms of their contract to respond to requests from the Plan for the purpose of reviewing a member's appeal.

What Is My Service Area?

Notice of Denial of Medical Coverage

If a review results in a non-coverage determination, Highmark will issue a *Notice of Denial of Medical Coverage*. This standardized written notice will state the specific reasons for the denial and inform the member of his or her appeal rights.

When a provider initiates a coverage determination on behalf of a member, the provider will receive a copy of the *Notice of Denial of Medical Coverage* that is issued to the member.

If the member initiated the coverage determination, the *Notice of Denial of Medical Coverage* will be issued to the member. The provider will receive a copy of the notice issued to the member, provided that Highmark is able to obtain the provider's information at the time the request is made.

5.3 NON-EMERGENT AMBULANCE TRANSPORT

Prior authorization requirements

Effective January 1, 2017, prior authorization from Highmark is required for non-emergent ambulance transports for Highmark Medicare Advantage plan members in Pennsylvania and West Virginia.

All non-emergent ambulance transportation, whether a one-time trip or scheduled repetitive transports, require prior authorization from Highmark, with the exception of non-emergent transports originating at a hospital (inpatient discharge, ER discharge).

When non-emergent ambulance trips originate at a hospital (i.e., inpatient discharge, ER discharge), the hospital/facility may serve as a delegate and authorize the transport without having to obtain prior authorization from Highmark.

Note: This exception does not apply to hospital-based treatments, such as dialysis and cancer treatment; **transports to and from ongoing hospital-based treatment (e.g., dialysis, chemotherapy) require prior authorization from Highmark.**

What Is My Service Area?

Medical necessity criteria

Non-emergent ambulance transportation is covered under Highmark's Medicare Advantage plans if it meets the Centers for Medicare & Medicaid Services (CMS) medical necessity guidelines.

Non-emergent transportation by ambulance is appropriate if the member (beneficiary) is bed-confined. This means he/she meets **all three** of the following CMS criteria for bed confinement:

- the member is unable to get up from bed without assistance;
- the member is unable to ambulate; **and**
- the member is unable to sit in a chair or wheelchair.

OR

The member's condition is such that other means of transportation (Access, wheelchair/stretcher vans, taxi, personal vehicle) could **endanger the member's health** and, therefore, ambulance transport is medically necessary.

Available procedure codes

The following HCPCS codes for non-emergent ambulance transports are subject to prior authorization as per the requirements above:

- **A0426** – Ambulance service, Advanced Life Support (ALS), non-emergency transport, Level 1
- **A0428** – Ambulance service Basic Life Support (BLS), non-emergency transport

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5.3 NON-EMERGENT AMBULANCE TRANSPORT, Continued

Required prior authorization form

The **Non-Emergent Ambulance Prior Authorization for Medicare Advantage Members** form must be completed and signed by the treating provider. The form contains fields to enter member, ambulance, and transport information such as:

- Member Name/Date of Birth/Highmark Member ID
- Ambulance Provider Name/NPI/Address
- Start Date of Service
- Origin and destination of transports
- Number of transports requested (to and from destination are **two** trips)

This form also serves as the Certificate of Medical Necessity (CMN). The second page is completed to certify that the services are medically necessary and must be signed and dated by the treating physician or authorized person. Medical records must support the documentation entered on the form. The completed form must be kept on file and made available upon request.

This form is also available on the Provider Resource Center – select **FORMS**, and then **Miscellaneous Forms**.

What Is My Service Area?

Requesting authorization

The treating provider is responsible for obtaining prior authorization, and the ambulance provider is responsible for verifying that the service was authorized.

Requests for prior authorization can be submitted by the following methods:

- NaviNet® Auth Submission
- Fax: **1-888-236-6321**
- Telephone: **1-800-547-3627**

The request form is required when submitting requests by fax. It is recommended that you complete this form prior to submitting requests via NaviNet or calling Highmark. The completed form will provide the information needed during the NaviNet submission process or when requesting authorization by phone.

Tips for submitting requests via NaviNet

If submitting a prior authorization request via NaviNet, select **Authorization Submission** from the NaviNet Plan Central menu, and then **Auth Submission** from the fly-out menu.

- Select **Outpatient** (Category) and **Planned Medical** (Service) on the NaviNet Selection Form.
- Enter all of the required details that are outlined on the Non-Emergent Ambulance Prior Authorization for Medicare Advantage Members form in the Comments section of the NaviNet Request Form.

The submission/request will pend for review; Highmark may contact you if additional information is needed.

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5.3 NON-EMERGENT AMBULANCE TRANSPORT, Continued

Decision notification

Highmark will make a determination **within forty-eight (48) hours** of receiving the request. The ordering/treating provider will be notified of the decision by the method used to submit the request (phone/fax/NaviNet). Decision letters are sent via mail to the ambulance provider and to the member.

Authorizations will provide confirmation of the ambulance provider, transport origin and destination, number of transports approved, and start/end dates. If authorization is denied, the decision letter will provide a detailed written explanation outlining which specific policy requirements were not met.

What Is My Service Area?

Prior authorization not required

Prior authorization is **not required** for:

- Commercial lines of business/plans
- HCPCS codes for ambulance services not noted above
- Emergent transportation
- Transports originating from a hospital setting (i.e., inpatient discharge, ER discharge). This does not include hospital-based treatments (i.e., dialysis, cancer treatment) that do require prior authorization from Highmark.

5.3 AUTHORIZATION REQUESTS FOR OUTPATIENT THERAPY SERVICES

What Is My Service Area?

Overview

For Highmark's Medicare Advantage members in Pennsylvania and West Virginia, registration and authorization requirements under the Physical Medicine Management Program apply for physical therapy, occupational therapy, and manipulation services. WholeHealth Networks, Inc. (WHN), a subsidiary of Tivity Health Support, LLC., provides medical management for these services.

Highmark's Clinical Services staff continues to perform medical management for speech therapy provided to our Medicare Advantage members. Speech therapy requires authorization from the initial treatment visit. A complete treatment plan is required for authorization.

NaviNet® is the preferred method for submission for all authorization requests to Highmark and to WHN.

Physical therapy, occupational therapy, and manipulation services

Medicare Advantage members must be registered with WHN with their first visit **each calendar year** for physical therapy, occupational therapy, and/or manipulation services. Registration provides an "auto-approval" for eight (8) visits for manipulation services or for eight (8) visits for physical therapy and occupational therapy combined. If additional visits are needed in the calendar year, a request for authorization must be submitted to WHN. Registrations and authorization requests are submitted to WHN via NaviNet.

For complete details, including instructions for submitting requests, please see the applicable administrative guide for your service area:

- **Pennsylvania:** Physical Medicine Management Program Administrative Guide
- **West Virginia:** Physical Medicine Management Program Administrative Guide

The guide is also available on the Provider Resource Center. Select **Clinical Reference Materials** from the main menu, and then click on **Physical Medicine Management Program**. Additional reference materials, including training modules for submitting requests, are available on this site.

Speech therapy

For Medicare Advantage members, speech therapy requires authorization to begin treatment. The authorization requests for speech therapy are reviewed by Highmark's Clinical Services department. Your authorization requests for speech therapy services can be submitted to Highmark via NaviNet.

Note: Clinical Services reserves the right to request a full plan of treatment as deemed necessary.

Continued on next page

5.3 AUTHORIZATION REQUESTS FOR OUTPATIENT THERAPY SERVICES, Continued

What Is My Service Area?

Submitting speech therapy requests via NaviNet

To submit authorization requests for speech therapy through NaviNet:

STEP	ACTION
1	The authorization request to begin treatment must be initiated by the member's physician who is requesting the therapy services.
2	Select **Authorization Submission** on Plan Central.
3	Select **Auth Submission** from the fly-out menu.
4	On the **Selection Form**, select **Outpatient** from the "Category" options, and then **Speech Therapy** from the dropdown options for "Service."
5	If the plan of treatment has already been developed by the speech therapist, that information can be entered into the **Request Form** comment block titled "Treatment Plan."
6	Submit the request.

Telephone requests

If you are not yet NaviNet-enabled, authorization requests for speech therapy for Medicare Advantage members can be submitted to Highmark by contacting Clinical Services at:

Pennsylvania:

- Freedom Blue PPO: **1-866-588-6967**
- Community Blue Medicare HMO: **1-888-234-5374**
- Community Blue Medicare PPO and Plus PPO: **1-866-588-6967**
- Security Blue HMO (Western Region only): **1-866-517-8585**

West Virginia Freedom Blue PPO: **1-800-269-6389**

The authorization request to begin treatment must be initiated by the member's physician who is requesting the therapy services.

5.3 MEDICAL RECORD DOCUMENTATION REQUIREMENTS

Overview

Highmark 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 Highmark policies and procedures.

What Is My Service Area?

Documentation requirements

For each encounter, Medicare Advantage 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.

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.

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.

Continued on next page

5.3 MEDICAL RECORD DOCUMENTATION REQUIREMENTS, Continued

What Is My Service Area?

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 include but are 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

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5.3 MEDICAL RECORD DOCUMENTATION REQUIREMENTS, Continued

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 signature (e.g., medical student) 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 Example: *marycsmith MD*	• Prior to 2008 (Stamped signatures are not permitted on medical records after 2008.)

What Is My Service Area?

5.3 RECORD RETENTION POLICY

Overview

Highmark complies with, and requires its contracted providers to comply with, the 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 program and the ability to service our Medicare Advantage members.

What Is My Service Area?

Policy

CMS revised its regulations with respect to records retention and access to records, increasing the period from six (6) to ten (10) 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 Medicare Advantage organizations are to maintain records and allow CMS access to them for **ten (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 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.

5.3 CHRONIC CARE MANAGEMENT SERVICES

Overview

Effective January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) may reimburse providers for certain chronic care management services. According to a CMS memorandum dated April 10, 2015, however, reimbursement for such chronic care management services is dependent on the agreement in place between the provider and the Medicare Advantage plan.

Provider agreements

Highmark's Medicare Advantage Provider Agreements require providers to deliver care coordination services to members with complex or serious medical conditions, including those members with multiple chronic conditions. In pertinent part, providers are contractually obligated to perform the following:

- Assist in the development and implementation of member treatment plans
- Conduct a health assessment of all new members within ninety (90) days of the effective date of their enrollment, when applicable
- Inform members of follow-up care, when applicable
- Provide members with training in self-care, when applicable

Provider agreement reimbursement provisions

As detailed above, the responsibilities of providers to deliver care coordination services, including chronic care management services, are already part of providers' responsibilities to perform health services pursuant to the terms of the Medicare Advantage Provider Agreements, and for which payment is made under Highmark's professional provider fee schedule. This existing contractual obligation is not changed as a result of the decision by CMS to allow for separate payment for chronic care management services. Therefore, Highmark will not make a separate payment for providing chronic care management services.

What Is My Service Area?

5.3 ADVANCE DIRECTIVES

Overview

Network providers are required to comply with the requirements of this section with respect to their Highmark Medicare Advantage patients. Providers are urged to adhere to these same standards with respect to their other Highmark patients in all types of plans.

What Is My Service Area?

Definitions

An **advance directive** is written instructions, such as living wills and medical (or durable) powers of attorney, recognized under state law and signed by a patient, that explains the patient's wishes concerning the provisions of health care if the patient becomes incapacitated or is unable to make those decisions known.

An advance directive can tell physicians and family members what life-sustaining treatments one does or does not want at some future time if one becomes incapable of making or communicating treatment decisions. An essential component of the advance directive is the selection of a person to make health and personal care decisions for one who lacks sufficient capacity to make or communicate choices.

A **living will** is a witnessed, notarized statement by which an individual specifies in advance what life-prolonging measures or other medical care he/she wants, or does not want, in the event the individual: 1) is certified by one or more examining physicians to have a terminal condition or to be in a persistent vegetative state; and 2) is unable to communicate his/her wishes.

A **medical (or durable) power of attorney** is a witnessed, notarized statement by which an individual appoints someone (typically a family member or trusted friend) to make health care decisions on the individual's behalf in the event that the individual becomes unable to make such decisions. If called to act, the appointed representative is to make decisions consistent with the wishes and values of the incapacitated individual, and to act in the individual's best interest where such wishes are unknown.

Some advance directives combine the functions of both a medical power of attorney and a living will.

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5.3 ADVANCE DIRECTIVES, Continued

Policy

Primary care physicians/practitioners (PCPs) must ask Medicare Advantage program members whether they have executed an advance directive and selected a surrogate. PCPs must then review the advance directive and determine their role as described in the procedure below.

Advance directive discussions must be documented in a prominent place in the medical record. A copy of the executed advance directive must be placed in a prominent part of the medical record.

If a provider cannot implement an advance directive, in whole or in part, as a matter of conscience, then the provider must:

- Issue a clear and precise written statement of this limitation, describing the range of medical conditions or procedures affected by the conscientious objection;
- Discuss this with the patient and document the discussion in a prominent part of the individual's medical record; and assist the member in locating another network provider, if the member so desires, or contact Highmark Customer Service at the telephone number located on the back of the member's ID card so that we may assist in locating another network provider.

A provider may not condition the provision of care or otherwise discriminate against a Medicare Advantage member based on whether or not the individual has executed an advance directive.

What Is My Service Area?

Monitoring

During an office site visit, a nurse from Quality Management will review medical records to determine whether:

- Discussion of the advance directive with the member is documented in a prominent part of the medical record; and
- A copy of the advance directive, signed by the member and physician, is on file, if applicable.

Clinical studies may also be conducted to evaluate ongoing use and discussion of advance directives.

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5.3 ADVANCE DIRECTIVES, Continued

What Is My Service Area?

Procedure

STEP	ACTION
1	Ask the member whether he or she has executed an advance directive. Document the response in the member's chart. • If the member *has completed* an advance directive, go to Step 2. • If the member *has not completed* an advance directive, initiate a discussion about completing an advance directive and selecting a surrogate decision-maker. Document the discussion in the member's chart. Process complete.
2	Review the advance directive. • If you **are willing** to honor the request as it is written, document the discussion and place a copy of the advance directive in a prominent part of the member's medical record. Process complete. • If you **are not willing** to honor the request as it is written, document the discussion in a prominent part of the member's chart and go to Step 3.
3	If possible, notify the member of the decision not to honor the advance directive. Member Service will make every effort possible to place the member with another provider who is able to honor the member's wishes.

Highmark West Virginia responsibilities

Highmark Senior Solutions Company, through Highmark West Virginia, provides Freedom Blue Medicare Advantage members, at the time of initial enrollment, written information on their rights to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

Members are informed that complaints alleging denial of care or provision of care not authorized by an advance directive, or discrimination based on the existence of a directive, may be filed with the West Virginia Bureau of Public Health, Office of Health Facility Licensure and Certification at **1-304-558-0050**.

Highmark West Virginia may monitor compliance with this section by review of a provider's medical records during a site visit.

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5.3 ADVANCE DIRECTIVES, Continued

What Is My Service Area?

WV forms and additional information

Select the appropriate link for copies of forms recognized under West Virginia law:

- State of West Virginia Medical Power of Attorney
- State of West Virginia Living Will
- State of West Virginia Combined Medical Power of Attorney & Living Will

For additional copies or more information about advance directives in West Virginia, providers may contact the following:

- West Virginia Bureau of Senior Services at **1-304-558-3317**; or
- West Virginia Center for End-of-Life Care at **1-877-209-8086**.

Providers may direct their patients who request additional information about advanced directives to the West Virginia Bureau of Senior Services or the West Virginia Center for End-of-Life Care at the numbers listed above or to similar other state agencies for members residing outside of West Virginia.

Additional information about advance directives

Providers should contact their state health department, professional licensing board, health facility licensing agency, Medicare survey and certification agency, or legal counsel to learn the requirements for advance directives in their state and to obtain forms, if available.

Providers can direct their Highmark members to contact **Blues On Call** at **1-888-258-2428** for general (not state-specific) educational information on advance directives.

5.3 THE AIS HOME VISIT PROGRAM

Introduction

The AIS Home Visit Program 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.

The program is intended to bring a more comprehensive approach to our members and provide home-based palliative care and support services that enhance the member's quality of life.

What Is My Service Area?

What is the AIS Home Visit Program?

The AIS Home Visit Program is a specialized component of the overall care management program available to Highmark Medicare Advantage members. The program is focused on caring for the medical and non-medical needs of our Medicare Advantage members who are facing a serious or chronic life-limiting illness. This includes members diagnosed with cancer, heart disease, end-stage renal kidney disease, stroke, or other neurological disorders including, but not limited to, advanced frailty. The program seeks to enhance palliative care services to control pain and symptoms, provide emotional support, facilitate decision making related to care, and coordinate services.

Highmark has partnered with Aspire Health to provide home-based care and support services for Highmark Medicare Advantage members, including those enrolled in Freedom Blue PPO, Community Blue Medicare HMO, Community Blue Medicare PPO and Plus PPO, and Security Blue HMO (available in the PA Western Regional only). While in the program, members are able to receive curative care treatment and all other eligible services available through their Medicare Advantage plan.

Highmark wants to ensure our members have continuous and coordinated care that intervenes early in the patient's diagnosis. The AIS Home Visit Program takes a comprehensive approach to helping our members and families through expert symptom management, discussions about "goals of care," coordination of care, and education. Care is provided by a team of physicians, nurse practitioners, social workers, and chaplains who work together with a member's existing physicians to develop a plan of care that best fits the needs of each member and their families. The program can provide unlimited visits based on clinical need.

Referrals to the AIS Home Visit Program may be made by a member's PCP or specialty provider, family members, self, community case managers, internal Highmark staff, or others.

Continued on next page

5.3 THE AIS HOME VISIT PROGRAM, Continued

What Is My Service Area?

Participation guidelines

The AIS Home Visit Program is available to Highmark Medicare Advantage members for whom their provider would "not be surprised" of death within one year (as stated in CPT II code 1150F). Attestation demonstrates medical necessity.

Participation in the program is voluntary and no authorization is required. The member may be referred to the AIS Home Visit Program by their PCP or a specialty provider, family members, self, a community case manager, a Highmark Health Coach, or others.

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

How does AIS differ from hospice?

Palliative care strives to alleviate discomfort and pain to improve the quality of life for members. Palliative care can be provided during any stage of an illness and most frequently to members 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 services provided through the AIS Home Visit 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 member may still be receiving curative treatment.
Is available when life expectancy is **six months or less**.	Is available when the provider attests to "no surprise" of member 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 Home Visit Program.**	**Is a Highmark program.** Services are covered under the member's Medicare Advantage plan. Members are not eligible for the AIS Home Visit Program if they are in an active hospice election period. **If a member revokes a hospice election, the member would then be eligible for the AIS Home Visit Program.**

Note: 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.

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5.3 THE AIS HOME VISIT PROGRAM, Continued

What Is My Service Area?

Hospice services

All Medicare certified hospice providers will be able to continue providing hospice care to Highmark Medicare Advantage members. The AIS Home Visit Program does not provide hospice services; however, the program refers its members who elect hospice services to local hospice providers. Members and their caregivers will continue to have their choice of hospice providers when they elect hospice care.

Additional information and referrals

Additional information on the AIS Home Visit Program is available on the Provider Resource Center – select **CARE MANAGEMENT PROGRAMS** from the main menu.

Providers can refer members for AIS Home Visit Program services by faxing the **AIS Home Visit Referral Form** to **1-888-878-3824**. This form is also located on the AIS Home Visit Program page on the Provider Resource Center.

Members may contact Member Services at the number on the back of their ID cards for information on AIS Home Visit Program participation.

5.3 UNCONFIRMED DIAGNOSIS CODE (UDC) PROGRAM

Introduction

The Unconfirmed Diagnosis Code (UDC) Program is a clinically-based program that promotes provider/Highmark collaboration to evaluate previously reported and/or suspected diagnosis conditions. These conditions require annual evaluation and/or treatment but may not have been reported to Highmark in the current year. This improves continuity, quality and timely coordination of care for chronic conditions.

The goal of the UDC Program is to ensure that quality health care is provided to Highmark Medicare Advantage and Commercial Affordable Care Act (ACA) members with complex chronic health conditions by accurately identifying, treating, documenting, and reporting the appropriate ICD-10-CM diagnosis codes to Highmark.

What Is My Service Area?

Program overview

Using analytics, the program will identify and list persistent (previously reported) and/or suspected diagnosis condition(s) of program members. In-network primary care physicians (PCPs) and physicians with select specialties ("participants") are asked to address the diagnosis condition(s) with the program member during their scheduled visit within the current program period.

Participants will be provided with the diagnosis condition(s) in various formats and tools ("UDC Forms"). Participants must complete and return the UDC Forms as indicated in the instructions and program materials. Evaluating each program member for the diagnosis condition(s) listed on the form helps Highmark improve overall health care quality and possibly reduce future health care costs, as well as allows Highmark to report the accurate health status of each program member to the Centers for Medicare & Medicaid Services (CMS).

The program is available to all participants who have program members with diagnosis conditions that need to be evaluated during the current program period. Participants will have the potential to receive additional compensation ("program compensation") by taking steps toward providing quality health care through assessment of the program members and ensuring accurate documentation of confirmed diagnosis conditions during every office visit as a part of this program.

FOR MORE INFORMATION

Complete program information is available on the NaviNet® Provider Resource Center – select **EDUCATION/MANUALS** from the main menu, and then **Risk Adjustment Programs**.

5.3 IDENTIFYING MEMBERS WITH END STAGE RENAL DISEASE

Definition

End stage renal disease (ESRD) is permanent kidney failure that requires kidney dialysis or a transplant to maintain life. Medicare beneficiaries generally cannot join a Medicare Advantage plan if they have this condition. However, if they develop this condition while they are a Medicare Advantage member, they will continue to be enrolled. It is important to identify all members with ESRD as soon as possible to ensure adequate treatment. Your role in identifying members with ESRD is crucial.

What Is My Service Area?

Policy

When a Medicare Advantage patient is determined to have chronic kidney failure and receives treatment in a Medicare-approved dialysis center or receives a kidney transplant, the attending physician should help the dialysis center complete an **ESRD Medical Evidence Report, CMS-2728-U3**.

It takes approximately four months for the CMS-2728-U3 forms to be processed through all systems in order to set up the initial record and pay appropriate reimbursement rates for members with ESRD. **However, it is the responsibility of the patient's dialysis center to send completed CMS-2728-U3 forms to the ESRD Network Organizations in a timely manner.**

Procedure

STEP	ACTION
1	The physician ordering dialysis contacts the dialysis center.
2	The dialysis center is responsible for submitting the original copy of the completed CMS-2728-US to the servicing Social Security office. The dialysis center also submits copies of and is responsible for verifying the information on the form and resolving any questionable items before sending the information to the ESRD networks that transmit the information to CMS.
3	The information that CMS receives from the ESRD Network Organizations is documented in CMS's Group Health Plan system (GHP) which is responsible for assigning ESRD status.