



Troy Medicare Policy and Procedure

Title: Record Retention Policy		Policy Number: CMP018	
Primary Department: Compliance	LOB: Medicare Advantage	Author: S Scott	
Effective Date: 11/4/2022	Original Date: 11/1/2022	Review Date(s): 12/21/2023, 11/19/2024	Archive Date:
Interactive Related Department(s)			
<input checked="" type="checkbox"/> All Departments <input type="checkbox"/> Compliance <input type="checkbox"/> Medical Management <input type="checkbox"/> Provider Operations <input type="checkbox"/> Sales and Marketing	<input type="checkbox"/> Appeals and Grievances <input type="checkbox"/> Pharmacy <input type="checkbox"/> Member Services <input type="checkbox"/> Quality Management <input type="checkbox"/> Utilization Management	<input type="checkbox"/> Care Management <input type="checkbox"/> Enrollment <input type="checkbox"/> Plan Administration <input type="checkbox"/> Claims <input type="checkbox"/> Other _____	

POLICY PURPOSE

Troy Health, Inc. (dba Troy Medicare) is committed to comply with the contractual requirements and regulations for Medicare Advantage organizations to maintain certain records for a period of 10 years plus the current contract year.

The purpose of this policy is to provide guidance about the record retention requirements and the use of evidence to support operations in Federal audits.

Troy Medicare is committed to complying with federal and state rules and regulations.

SCOPE

This policy applies to all Troy Medicare employees and delegated entities.

REFERENCES

- 42 CFR § 422.504(d), 423.505(d)
- CMS Program Audit Protocols

RESPONSIBLE PARTIES

- Chief Compliance Officer
- Chief Operations Officer
- Chief Financial Officer

DEFINITIONS

- **Federal Agency** – a term used to describe one or more Federal government agencies that may audit a Medicare Advantage organization. These agencies include the Health and Human Services (HHS), the Centers for Medicare or Medicaid Services (CMS), the

Comptroller General from the Government Accountability Office (GAO), the Office of Inspector General (OIG), and the Office of Civil Rights (OCR).

POLICY

There are multiple federal agencies (aka “Federal Agency”) that have the right to audit, inspect, and evaluate Medicare Advantage organizations like Troy Medicare. This right extends for 10 years through the final contract period or completion of audit, whichever is later unless there is a special need to keep a particular group of records, such as allegation of fraud, dispute, or similar fault by Troy Medicare for future review.

Troy Medicare, in compliance with its contract with CMS, has agreed to maintain certain records for 10 years, plus the current contract period due to the potential of Federal Agency audits. These records could be used to provide evidence and support of compliance with all aspects of the Medicare Advantage adherence to regulations.

CMS or its designee will perform a Medicare Program Audit based on published audit protocols. Audits are conducted approximately every 3 years to confirm compliance with the terms of Troy Medicare’s CMS contract to provide services under the Medicare Advantage and Part D Prescription Drug Programs.

Other types of audits do not use industry protocols and may be more severe in nature. The OIG has oversight and enforcement for fraud, waste, and abuse and federal exclusions. The OCR has oversight over HIPAA enforcement, discrimination, and human rights. The GAO office has oversight over financial matters and use of federal dollars.

Troy Medicare will comply with providing the requested records, participate with interviews, and allow auditors full access to records.

PROCEDURE

The following examples of the types of documents that apply to the 10-year retention policy:

1. Compliance Program Effectiveness
 - a. Prevention, detection, and correction controls and activities
 - b. Compliance Oversight
 - c. Risk Assessments
 - d. Code of Conduct/ Compliance Policies and Procedures
 - e. FDR Oversight
 - f. Compliance Work Plans
 - g. Employee and / or contractor Compliance Training Records (General Compliance, FWA and HIPAA)
 - h. OIG and SAM exclusion screening records (pre-employment and monthly)
2. Enrollment / Disenrollment
 - a. Enrollment applications for all currently enrolled and 10 years of formerly enrolled with date received.
 - b. Written notices of application status and disenrollment status
 - c. Voluntary disenrollment requests with date received
 - d. Documentation of involuntary disenrollment decisions
 - e. Transaction Reply Reports
 - f. Monthly membership reports

3. Part C Utilization Management
 - a. Pre-service organization determination requests
 - b. All notices and written correspondence to members and providers
 - c. Evidence of verbal notification
 - d. Evidence of decisions
4. Part C Claims
 - a. Electronic and paper claims from members and providers
 - b. Explanation of benefits (member)
 - c. Explanation of payments (providers)
5. Part D Coverage Determinations
 - a. All requests for a coverage determination
 - b. Evidence to support coverage determination decisions
 - c. Evidence of verbal notification
 - d. Notices issued to members and providers
 - e. Physician supporting statements for formulary exception requests
6. Part D Appeals
 - a. All requests for redetermination
 - b. Evidence to support redetermination decisions
 - c. Evidence of verbal notifications
 - d. Notices issued to members and providers
 - e. All documentation from the adverse coverage determination
7. Care Management
 - a. Evidence of HRA completions
 - b. Model of Care
 - c. Individualized Care Plan for each enrollee
 - d. Documentation to support ICPs (case notes, ICT documentation, system information (UM, claims, PDE))
 - e. Communications amongst ICT members
 - f. ICT meeting agendas/minutes
 - g. MOC training materials
 - h. MOC training evidence
8. Part C and Part D Grievances
 - a. Grievance (letter, call documentation) with evidence of receipt date/time
 - b. AOR or other legal representation document, if applicable
 - c. Grievance investigation and resolution notes
 - d. Supporting documentation
 - e. Evidence of oral notice, if expedited
 - f. Written response to member
9. Part C Appeals
 - a. Appeal (written form or letter)
 - b. Evidence of adverse organization determination
 - c. AOR or other legal representation document, if applicable
 - d. Supporting documentation
 - e. Date/time of decision
 - f. If overturned, evidence of effectuation
 - g. If adverse, evidence of submission to IRE
 - h. Evidence of oral notice, if expedited
 - i. Notice of dismissal, if applicable
 - j. All written notices to members and providers
10. Member Services

- a. Call documentation
- b. Verbal grievances and resolutions
- 11. Finance/Actuary Services
 - a. Utilization, costs, and computation of annual bid
 - b. Any books that pertain to risk of financial loss, payable amounts
 - c. Direct and indirect costs
 - d. Ownership and operation systems
 - e. Financial statements
 - f. Federal income tax returns
 - g. Assets
 - h. Contracts and agreements
 - i. Costs of operations
 - j. Cash flow, income
 - k. Prescription drug events (PDEs)
 - l. Claims payment
- 12. Sales and Marketing
 - a. Agent training records
 - b. Compensation structure

ATTACHMENTS/RELATED POLICIES/STANDARD OPERATING PROCEDURES

- None

APPROVALS

Sally Scott

Chief Compliance Officer

Dec 2, 2024

Date

Christina Ja

Policy Committee

Dec 2, 2024

Date

Revision History:

Date	Author	Revision Notes
1.1.2023	S Scott	Initial policy
12.21.2023	E Young	Added 1.g and 1.h to Procedure section
11.19.2024	S Scott	Annual review. Updated regulatory references.